STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495293	A. Building B. Wing	06/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Berkshire Health & Rehabilitation Center	705 Clearview Drive Vinton, VA 24179

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 22218 Based on resident interview, staff interview, and clinical record review, facility staff failed to implement a person-centered care plan that addressed the resident's actual reported pain for 1 of 33 current residents in the survey sample (Resident #50). Resident #50 was admitted with diagnoses which included cerebral infarction, bilateral hemiplegia/hemiparesis, morbid obesity, type 2 diabetes mellitus, chronic osteomyelitis right thigh, epilepsy, heart failure, abscess of bursa left hip, primary osteoarthritis, hypertension, and chronic kidney disease. On the most recent Minimum Data Set (MDS) full assessment with assessment reference date 5/20/24, the resident scored 10/15 on the Brief Interview for Mental status and was assessed as without signs of delirium, psychosis, or behavior affecting care. The resident reported almost constant pain which interfered with sleep and activities of daily living. The Comprehensive Care Plan revised 5/31/24 read Focus the resident has a risk for pain related to OA, chronic wounds, impaired mobility, lumbar DDD, dry eyes with interventions entered on 4/16/24:administer medications as ordered; Notify MD as indicated; observe for physical indicators of pain. The care plan was not revised to indicate the resident was reporting actual pain almost continuously. During interviews on 6/11 and 6/12/24, the resident reported experiencing unrelieved pain which the resident had reported to nurses. On 6/13/2/4, the MDS coordinator responsible for the resident's comprehensive care plan stated the care plan would be based on the MDS nurse interview with the resident. If the resident reported pain, the care plan would reflect that. The Care Area Assessment for pain attached to the 5/20/24 MDS documented that the resident reported almost constant pain. Given choice between Actual or Potential pain, the assessor chose Potential. The corporate regional director for MDS stated on 6/13/24 that the assessment would care plan would only reflect actual pain if the skilled daily nursing notes documented pain. The resident's Medication Administration Record indicated that the resident requested as needed pain medication with a reported level of 7 or 8 out of 10 almost daily. The skilled daily nursing notes document no pain most days when the resident has received PRN (as needed) pain medication since the previous day's note. The surveyor reported the concern with the care plan not addressing actual pain experienced by the resident during a summary meeting on 6/13/2024.

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495293	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/18/2024
NAME OF PROVIDER OR SUPPLIER: Berkshire Health & Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 705 Clearview Drive Vinton, VA 24179	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 21227 Based on interviews and document review, the facility staff failed to review and revise care plans for two (2) of 40 sampled residents (Resident #63 and Resident #121). The findings include: 1. The facility staff failed to review and revise Resident #63's care plan to address the removal and subsequent reimplementation of the use of a defined parameter mattress (DPM). Resident #63's Minimum Data Set (MDS) assessment, with an Assessment Reference Date (ARD) of 5/23/24, was signed as completed on 5/27/24. Resident #63 was assessed as usually able to make self understood and as usually able to understand others. Resident #63's Brief Interview for Mental Status (BIMS) summary score was documented as a six (6) out of 15; this indicated severe cognitive impairment. Resident #63 was assessed as being depended on others for toileting hygiene, dressing, and personal hygiene. Resident #63's fall/fall risk care plan had an intervention for a DPM dated as being created on 1/24/23. One of Resident #63's Device Assessment forms indicated the resident did not have a DPM in use on 3/9/23. Another Device Assessment form, dated 4/5/23, indicated Resident #63 had a DPM in use. Review of Resident #63's comprehensive care plan failed to show when the aforementioned DPM was removed and reimplemented. Resident #63's comprehensive care plan did not have an entry for the DPM dated 3/9/23 or 4/5/23. The following information was found in a facility policy and procedure titled Care Planning (with an effective date of 11/1/19): - A licensed nurse, in coordination with the interdisciplinary team, develops and implements an individualized care plan for each patient in order to provide effective, person-centered care, and the necessary health-related care and services to attain or maintain the highest practical physical, mental, and psychosocial well-being of the patient. - Care plans will be updated on an ongoing basis as changes in the patient occur . On 6/18/24 at 1:32 p.m., the survey team met with the facility's Administrator, Director of Nursing (DON), Assistant DON, and Regional Director of Clinical Services. During this meeting, the surveyor discussed the failure of the facility staff to review and revise Resident #63's care plan to address the removal and subsequent reimplementation of a DPM. 22218 2. For Resident #121, facility staff failed to ensure the resident was provided the opportunity participate in planning care in the facility. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During initial tour on 6/11/2024, the resident told the surveyor she had not participated in care planning or discharge planning. The resident reported expecting a meeting soon after arrival, then a care plan meeting after a couple of weeks. The resident stated she had not received a notice to schedule a care plan meeting, which she had expected. The resident stated she had also not received a copy of the care plan. Per the unit manager, there is a jump start meeting on admission (the resident was admitted ,d+[DATE]) to tell the resident what kind of services are available, then a care plan meeting at 21 days (which would be 5/24/2024). The surveyor did not find a copy of a care plan meeting in the clinical record. There was no mention of a jump start meeting in the progress notes. The surveyor was unable to locate a record of a care plan meeting at 21 days. On 6/13/2024 at 11 AM, the surveyor and director of nursing (DON) interviewed the resident together. The resident reported that she had not been invited to a care plan meeting or received a letter of invitation, although she was expecting one. The resident reported not receiving a copy of the initial care plan or a revised care plan, although she expected one. The surveyor was given a Care Plan Meeting created as a Late Entry on 5/24/2024 and effective date 5/21/2024 Care plan meeting held, family and rsd declined to attend, Those in attendance: [names withheld] LPN#3, activity director, Director of Rehab, Director of DC planning, CNA. Care plan reviewed and will continue POC. Face sheet, medication review list and care plan provided to resident. The resident stated that none of those documents had been provided. The DON was aware of the concern as of 6/13/2024.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0732 Level of Harm - Potential for minimal harm Residents Affected - Some	Post nurse staffing information every day. 21227 Based on interviews and the review of facility documents, the facility staff failed to ensure the daily staff posting contained the required information. The findings included: The surveyor reviewed the facility's posted nurse staffing data. The facility staff used a form titled DAILY NURSE STAFFING SUMMARY to post its daily nurse staffing data. The facility staff posts one form daily for each of its three (3) units. The surveyor reviewed the most recent 30 days of the facility's DAILY NURSE STAFFING SUMMARY forms. The forms failed to contain the following required information: - For the 6/12/24 Unit 1 posting the facility staff failed to document the hours worked by nursing staff. - For the 6/12/24 Unit 2 posting the facility staff failed to document the hours worked by nursing staff. - The facility staff failed to document the census for the following dates and units: 6/13/24 Unit 1; 6/12/24 Unit 1; 6/12/24 Unit 2; 6/11/24 Unit 1; 6/11/24 Unit 2; 6/10/24 Unit 2; 6/9/24 Unit 2; 6/9/24 (Unit not identified); 6/8/24 Unit 2; 6/7/24 Unit 1; 6/7/24 Unit 2; 6/6/24 Unit 1; 6/6/24 Unit 2; 6/5/24 Unit 2; 6/5/24 Unit 1; 6/3/24 Unit 1; 6/3/24 Unit 2; 6/1/24 Unit 1; 5/27/24 Unit 2; 5/27/24 Unit 1; 5/26/24 Unit 2; 5/26/24 Unit 1; 5/25/24 Unit 2; 5/25/24 Unit 1; and 5/24/24 Unit 2. The following information was found on the facility's DAILY NURSE STAFFING SUMMARY form: Post this document in a prominent place; accessible to patients and visitors. Complete at the beginning of each shift; update any changes to information as needed. On 6/18/24 at 1:32 p.m., the survey team met with the facility's Administrator, Director of Nursing (DON), Assistant DON, and Regional Director of Clinical Services (RDCS). The surveyor discussed the facility staff posting incomplete daily nurse staffing data.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 28169 Based on observations, interviews, and clinical record review, facility staff failed to ensure provider ordered medications were available for administration for 1 of 40 sampled residents (Resident #116). The findings were: The facility staff failed to ensure Resident #116's provider ordered medication Lactulose (a laxative, ammonia reducer for liver disease) was administered to Resident #116. Resident #116's admission record listed diagnoses to include but were not limited to alcoholic cirrhosis of liver with ascites, protein-calorie malnutrition, alcohol abuse, psychotic disorder with delusions due to known physiological condition, atrial fibrillation, schizoaffective disorder, bipolar disorder, anxiety disorder and major depressive disorder. Resident #116's quarterly minimum data set with an assessment reference date of 05/29/24 scored the brief interview for mental status a 15 out of 15. During a medication pass and pour observation with licensed practical nurse (LPN #5) on 06/11/24 at 8:23 a.m., Resident #116's Lactulose was not available in the medication cart. LPN #5 attempted to retrieve the medication from the facility's electronic interim box (Omnicell) but was unsuccessful. LPN #5 reported the unavailable medication to the charge nurse and requested the charge nurse notify the nurse practitioner (NP). LPN #5 reported the unavailable medication to Resident #116 who was listed as the Responsible Party (RP). The resident stated he had missed Lactulose doses in the past but did not provide a date or time. Resident #116's clinical record contained a provider order dated 05/02/24 for Lactulose Solution 10GM/15ml, give 60mls by mouth four (4) times a day for hepatic encephalopathy, cirrhosis (doses scheduled daily for 9:00 a.m., 1:00 p.m., 5:00 p.m., and 9:00 p.m.). The medication administration record (MAR) for June 2024 was reviewed with all doses documented as administered prior to the 9:00 a.m. dose on 06/11/24. On 06/11/24 at 12:05 p.m., the regional director of clinical services (RDCS) was notified of Resident #116's missed dose of Lactulose at 9:00 a.m. on 06/11/24. The RDCS reported the administrative team was researching the concern and that the resident would receive the 1:00 p.m. dose on 06/11/24. At the end of day meeting on 06/12/24 at 4:27 p.m., the administrator, director of nursing (DON), assistant director of nursing (ADON), and RDCS was informed of Resident #116's missed dose of Lactulose. The DON stated her expectation was the Lactulose prescription should be re-ordered and present in the medication cart. The Omnicell is the backup to dispense medications not available in the medication cart. For Resident #116's 9:00 a.m. dose on 06/11/24, the Omnicell did not recognize the specific resident to be connected to the Lactulose order which prevented the medication from being dispensed. The DON reported the issue had been corrected within the Omnicell system. No further information was provided prior to the exit conference.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. 28169 Based on observation, staff interview, clinical record review, and facility document review, the facility staff failed to ensure a medication error rate of less than 5%. There were two (2) medication errors in 30 opportunities for a medication error rate of 6.67%. These medication errors affected Resident #116 and #120. The findings were: 1. For Resident #116, the facility staff failed to ensure the provider ordered medication Lactulose (a laxative, ammonia reducer for liver disease) was administered. Resident #116's admission record listed diagnoses to include but were not limited to alcoholic cirrhosis of liver with ascites, protein-calorie malnutrition, alcohol abuse, psychotic disorder with delusions due to known physiological condition, atrial fibrillation, schizoaffective disorder, bipolar disorder, anxiety disorder and major depressive disorder. Resident #116's quarterly minimum data set with an assessment reference date of 05/29/24 scored the brief interview for mental status a 15 out of 15. During a medication pass and pour observation with licensed practical nurse (LPN #5) on 06/11/24 at 8:23 a. m., Resident #116's Lactulose was not available in the medication cart. LPN #5 attempted to retrieve the medication from the facility's electronic interim box (Omnicell) but was unsuccessful. Resident #116's clinical record contained a provider order dated 05/02/24 for Lactulose Solution 10GM/15ml, give 60mls by mouth four (4) times a day for hepatic encephalopathy, cirrhosis (doses scheduled daily for 9:00 a.m., 1:00 p.m., 5:00 p.m., and 9:00 p.m.). On 06/11/24 at 12:05 p.m., the regional director of clinical services (RDCS) was notified of Resident #116's missed dose of Lactulose at 9:00 a.m. on 06/11/24. The RDCS reported the administrative team was researching the concern and that the resident would receive the 1:00 p.m. dose on 06/11/24. At the end of day meeting on 06/12/24 at 4:27 p.m., the administrator, director of nursing (DON), assistant director of nursing (ADON), and RDCS was informed of Resident #116's missed dose of Lactulose. The DON stated her expectation was the Lactulose prescription should be re-ordered and present in the medication cart. The Omnicell is the backup to dispense medications not available in the medication cart. 2. For Resident #120, facility staff failed to administer the correct eye drops. Pataday eye drops were provider ordered however the resident received Alaway eye drops. Resident #120's admission record listed diagnoses to include but were not limited to non-traumatic intracranial hemorrhage, encephalopathy, acute kidney failure, gastrointestinal hemorrhage, periapical abscess without sinus, and major depressive disorder. Resident #120's annual minimum data set with an assessment reference date of 05/09/24 scored the brief interview for mental status a 15 out of 15. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 06/11/24 at 9:00 a.m., surveyor observed a licensed practical nurse (LPN #6) prepare and administer Resident #120's medications. LPN #6 administered Alaway eye drops, one drop in each eye. Surveyor reconciled Resident #120's administered medications with provider orders and noted a current order for Pataday Ophthalmic Solution 0.1 % (Olopatadine HCl). Instill 1 drop in both eyes one time a day for ocular pruritus. The pharmacy provider's director of quality (a licensed pharmacist) was contacted via phone on 06/11/24 at 11:20 a.m. The pharmacist reported that although both eye drops were used to treat the same symptom, the active ingredients were different and should not be used interchangeably. The pharmacist stated she would expect a provider order to specifically name which eye drop to be administered. On 06/11/24 at 11:40 a.m., the surveyor met with the director of nursing (DON), assistant director of nursing (ADON) and regional director of clinical services (RDCS) and discussed the concern with Resident #120's eye drop prescription versus the eye drop that was administered. On 6/11/24 at 12:05 p.m., the RDCS reported the nurse practitioner (NP) had written an order to administer Resident #120 the Alaway eye drops instead of Pataday. The RDCS provided a MEDICATION ERROR REPORT which read the eye drops administered were not the eye drops which was ordered for 06/11/24. On 06/14/24 at 2:35 p.m., the survey team met with the DON, Administrator, RDCS, and ADON and informed them the medication error rate was 6.67% with the errors effecting Resident #116 and #120. No further information was provided prior to the exit conference.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0776 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely, approved x-ray services, or have an agreement with an approved provider to obtain them. 49622 Based on staff interview, clinical record review, and facility document review, the facility staff failed to provide timely radiology or other diagnostic services to meet the needs of a resident for 1 of 40 sampled residents, Resident #30. The findings include: For Resident #30 (R30), the facility staff failed to schedule a timely CT (computed tomography) scan of the abdomen as ordered on 5/31/24 by the provider. Resident #30's diagnosis list included diagnoses that included, but were not limited to, chronic kidney disease-stage 3 (three), essential (primary) hypertension, peripheral vascular disease, anemia in chronic kidney disease, and type 2 (two) diabetes mellitus with diabetic chronic kidney disease. The most recent minimum data set (MDS) with an assessment reference date (ARD) of 3/23/24 assigned the resident a brief interview for mental status (BIMS) summary score of 14 out of 15 for cognitive abilities, indicating R30 was cognitively intact. A review of R30's clinical record on 6/11/24 revealed a diagnostic order summary that read in part, .CT Abdomen without contrast per Dr. [name omitted] . with an order status displayed as, Active and an order date of, 5/31/2024. Further review of the clinical record revealed a progress note, titled, Order Note dated, 5/31/24, that read in part, .[name omitted] Nephrology called with new orders per Dr. [name omitted] for CT of abdomen without contrast . [name omitted] NP (nurse practitioner) aware . After further review of the clinical record, surveyor could not locate a radiology/diagnostic report or any indications that a CT of the abdomen was performed on R30. On 6/18/24 at 9:10 AM, surveyor interviewed the director of nursing (DON) about the ordered CT on 5/31/24 for R30 and informed DON this surveyor could not locate any CT results in the clinical record. Surveyor requested documentation of the CT results. On 6/18/24 at 9:26 AM, Administrative/Corporate Staff #14 (ACS#14) informed surveyor they (facility) have been attempting to schedule the CT with [name omitted] (the hospital radiology department) and have not been able to get the appointment scheduled. On 6/18/24 at approximately 9:15 AM, surveyor interviewed Other Staff#5 (OS#5) and inquired about the order for the CT of the abdomen for R30. OS#5 stated the nephrologist did not give any inclination of how soon it had to be performed and informed surveyor that certified nursing assistant#3 (CNA#3) would be the one to schedule it (the CT appointment). Surveyor interviewed CNA#3 on 6/18/24 at approximately 9:20 AM and inquired about the scheduling for the CT of the abdomen for R30. CNA#3 stated she has been calling to get it scheduled and is waiting for radiology at [name omitted] (the hospital radiology department) to call her with the appointment. Surveyor requested documentation of attempts at scheduling the CT. (continued on next page)

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F 0776 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/18/24 at approximately 9:40 AM, CNA#3 gave surveyor a copy of two (2) progress notes. One progress note revealed an Effective Date: 6/3/2024 with a, Created By: CNA#3 [name omitted] .Created Date: 6/18/2024 09:35:29 (9:35 AM). The note read in part, .per [name omitted] nephrology Dr. [name omitted] office to schedule patient ct scan, per [name omitted] radiology to fax order prior to scheduling, order has been faxed office to call scheduler with apt (appointment), no new apt given at this time . The second progress note revealed an Effective Date: 6/18/2024 with a, Created By: CNA#3[name omitted] .Created Date: 6/18/2024 . The note read in part, .called [name omitted] ID Clinic CT order still being processed, unable to schedule at this time, per [name omitted] Radiology office to call scheduler with apt . On 6/18/24 at 9:45 AM, surveyor interviewed CNA#3 and inquired about the process for documenting today (6/18/24) on the communication with hospital radiology department on 6/3/24. CNA#3 stated she uses her notes and remembers. Surveyor requested a copy of the fax transmission of the order to hospital radiology department on 6/3/24. On 6/18/24 at 9:59 AM, CNA#3 informed surveyor she could not locate the fax confirmation to [name omitted] (the hospital radiology department) from 6/3/24. When asked what the next step in getting the CT scheduled would be, CNA#3 stated the next step would be to keep messaging the radiology department at [name omitted]. On 6/18/24 at 10:37 AM, surveyor interviewed the DON about her expectations for the timeliness of ordered diagnostics. The DON stated the expectation for ordered diagnostics is to get them as quickly as possible and she stated CNA#3 should have notified us (nursing/administrative staff) by email or called while we were in the building. DON brought surveyor copy of an email communication she had sent to CNA#3 dated, 6/3/24, that read in part, . [name omitted] Nephrology called with new orders per Dr. [name omitted] for CT of abdomen without contrast .NP aware . On 6/18/24 at approximately 11:00 AM, CNA#3 brought surveyor a copy of a progress note dated 6/18/24 that read in part, .per [name omitted] clinic patient is scheduled for CT scan on July 3rd @ (at) 8am at [name omitted] . This concern was discussed at the pre-exit meeting on 6/18/24 at 1:32 PM with the administrator, assistant director of nursing, director of nursing and the regional director of clinical services. No further information was provided to the survey team prior to exit.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 49622 Based on observation, staff interview, and facility document review, the facility staff failed to store, monitor, and discard refrigerated cold food properly and failed to maintain cleanliness of food preparation equipment in accordance with professional standards for food safety. The findings include: The facility staff failed to monitor and discard out-of-date, perishable food items stored in the walk-in and reach-in facility refrigerators, failed to store food in proper containers in the reach-in refrigerator, and failed to maintain cleanliness of the convection oven to protect the equipment from grease contamination in the facility main kitchen. On 6/10/24 at 12:42 PM, surveyor entered the facility kitchen for initial tour with Other Staff#1 (OS#1). Surveyor observed the walk-in-refrigerator at 12:47 PM and observed a large container of cottage cheese on the second (2nd) shelf with a best-used-by (BB) date of, 6/1/24. Two gallons of whole milk were also observed on the 2nd shelf with white, chunky, substances in both of them and BB dates of, 6/6/24. OS#1 removed the cottage cheese and two gallons of milk and stated she would throw them away. Surveyor observed the reach-in, kitchen refrigerator and observed an opened package of Smithfield sliced ham wrapped in plastic wrap on the 2nd shelf and asked OS#1 to open the package. Upon examination of the original wrapper, a BB date of, 4/15/24 was observed. OS#1 agreed the date read, 4/15/24 and removed the ham. Surveyor also observed a large, opened container of dill pickle relish with a BB date of, 3/4/24 on the 2nd shelf and OS#1 agreed the BB date was, 3/4/24 and removed the dill pickle relish. Two large, opened cans of fruit cocktail were observed on the third (3rd) shelf of the refrigerator in their original cans and surveyor inquired what the process was for storing food in the original can in the refrigerator. OS#1 stated the fruit cocktail was not supposed to be stored in the original cans and she removed the fruit cocktail. Surveyor observed the convection oven and observed the oven to have a moderate amount of grease on the top of the unit and a moderate amount of greasy, brown, sticky, substances on the inside of the glass oven doors and on the bottom inside of the unit. Surveyor asked OS#1 the process for cleaning the convection oven and she stated they (ovens) are cleaned with degreaser about once every two (2) weeks, and she agreed the oven had not been cleaned in a while. She stated the oven would be cleaned, this evening or in the morning. On 6/11/24 at 11:45 AM, surveyor entered facility kitchen and met with OS#1 and observed the convection oven. OS#1 stated she did not clean it, but she was going to clean it. The oven was observed to have a moderate amount of grease on the top of the unit and a moderate amount of greasy, brown, sticky, substances on the inside of the glass oven doors and on the bottom inside of the unit. These concerns were discussed on 6/11/24 at 4:14 PM, during the end of day conference and again on 6/18/24 at 1:32 PM, during the pre-exit meeting with the regional director of clinical services, administrator, director of nursing and assistant director of nursing. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495293	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/18/2024
NAME OF PROVIDER OR SUPPLIER: Berkshire Health & Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 705 Clearview Drive Vinton, VA 24179	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Surveyor requested and received a facility document, titled, .Food Storage: Cold Policy Statement, which read in part, .It is the center policy to insure [sic] all Time/Temperature Control for Safety (TCS), .and refrigerated food items, will be appropriately stored in accordance with guidelines of the FDA (food and drug administration) Food Code .The Dining Services Director/Cook(s) insures [sic] that all food items are stored properly in covered containers, labeled and dated . Surveyor requested, but did not receive, a facility policy for cleaning the convection oven and was informed by regional director of clinical services there was no policy for cleaning the convection oven. Surveyor requested and received a facility document titled, Monthly Cleaning Schedule, that revealed boxes with checkmarks in June for convection oven-top and convection oven-bottom. The document did not contain any specific dates or initials of when or who performed the oven cleaning. The document also revealed, the boxes for, reach-in cooler 1 and reach-in cooler 2 did not have any check marks for the month of June. No further information regarding this concern was presented to the survey team prior to the exit conference on 6/18/24.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495293	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/18/2024
NAME OF PROVIDER OR SUPPLIER Berkshire Health & Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 705 Clearview Drive Vinton, VA 24179	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 21227 Based on observations, staff interviews, clinical record review, and facility document review, (a) the facility staff failed to correctly perform hand hygiene during wound care for one (1) of 40 sampled residents (Resident #75), (b) the facility staff failed to follow enhanced barrier precautions during resident care for one (1) of 40 sampled residents (Resident #75), and (c) the facility staff failed to correctly perform hand hygiene and/or glove change during wound care for one (1) observation of an unsampled resident (Resident #82). The findings include: 1. The facility staff failed to appropriately change gloves and/or appropriately perform hand hygiene while providing Resident #75's wound care. The facility staff failed to wear a gown when removing wound dressings and transferring a resident on Enhanced Barrier Precautions (EBPs) (Resident #75). Resident #75's Minimum Data Set (MDS) assessment, with an Assessment Reference Date (ARD) of 6/8/24, was signed as completed on 6/17/24. Resident #75 was assessed as sometimes able to make self understood and as sometimes able to understand others. Resident #75 was assessed has having problems with both short-term and long-term memory. Resident #75 was assessed as being depended on others for toileting hygiene, dressing, personal hygiene, and bathing. On 6/14/24 at 9:35 a.m., the surveyor observed three staff members performing and/or assisting with wound care for Resident #75. Resident #75 had dressing changes to three (3) wounds. - Certified Nurse Aide (CNA) #1 was observed to reposition a trash can on the floor with their gloved hand; CNA #1 proceeded to support the positioning of Resident #75 by touching the resident without changing gloves or performing hand hygiene. - Licensed Practical Nurse (LPN) #9, after removing Resident #75's disposable undergarment and cleaning the resident's skin surrounding the resident's wounds, was noted to change gloves without performing hand hygiene after removing the soiled gloves and before donning the clean gloves. - LPN #11 was observed to provide wound care to Resident #75's left hip wound. LPN #11 did not perform hand hygiene when they change gloves between performing wound cleaning and applying the new dressing. - LPN #11 was observed to provide wound care to Resident #75's sacrum. LPN #11 did not perform hand hygiene when they change gloves between performing wound cleaning and applying the new dressing. - LPN #11 was observed to provide wound care to Resident #75's right ischium. LPN #11 did not change gloves between cleaning the wound and applying a topical medication to the cleaned wound. On 6/14/24 at 12:27 p.m., the Administrator and the Regional Director of Clinical Services (RDCS) confirmed that hand hygiene should be performed when changing gloves. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495293	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/18/2024
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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/14/24 at 12:52 p.m., the RDCS, LPN #9, and LPN #11 met with members of the survey team. The surveyor reviewed the aforementioned observations during Resident #75's wound care. LPN #11 reported they performed hand hygiene with soap and water while waiting on someone to obtain the topical medication for the right ischium wound. On 6/17/24 at 1:18 p.m., the Infection Preventionist (IP) reported that hand hygiene should be completed whenever gloves are changed. The following information was found in a facility policy titled Handwashing Requirements (with an effective date of 2/6/20): The following is a list of some situation that require hand hygiene: . After handling soiled equipment or utensils . After removing gloves or aprons . On 6/13/24 at 11:03 a.m., Certified Nurse Aide (CNA) #1 and CNA #2 was observed to remove Resident #75's wound dressings without wearing a gown. CNA #1 and CNA #2 was observed to use a lift to transfer the resident to a shower bed without wearing a gown. Resident #75 was on enhanced barrier precautions. Resident #75 had a sign outside their room which indicated staff should use enhanced barrier precautions when providing care. The Enhanced Barrier Precautions sign included the following information: Wear gown and gloves when entering room to provide the following high-contact resident care activities: dressing, bathing/showering, transferring . The following information was found in a facility document titled Enhanced Barrier Precautions (EBPs) (with an effective date of 9/26/19): - Employees providing high-contact patient care activities will follow Enhanced Barrier Precautions (EBPs). This level of precaution is indicated during the implementation of a containment strategy to prevent the potential transfer of a novel or targeted multi-drug resistant organism (MDRO). - EBPs require the use of gown and gloves by providers and staff during high-contact patient care activities as defined below: a. Dressing b. Bathing/showering c. Transferring . On 6/14/24 at 12:27 p.m., the Administrator reported gowns are to be worn when care is being provided to a resident on EBPs. On 6/18/24 at 1:32 p.m., the survey team met with the facility's Administrator, Director of Nursing (DON), Assistant DON, and Regional Director of Clinical Services. During this meeting, the surveyor discussed the aforementioned observations of staff not appropriately changing gloves and/or performing hand hygiene during wound care; the surveyor also discussed the observation of staff not wearing the appropriate PPE when providing care for a resident on EBP. 22218 2. During wound care observation of unsampled Resident #82, on 6/13/2024, the surveyor observed LPN #11 remove a wound dressing, clean the wound, and place a new dressing without performing hand hygiene between tasks. This resulted in placing a clean dressing with dirty gloves which had handled the soiled dressing and cleaned the wound. The administrator and director of nursing were notified of the concern during a summary meeting on 6/14/2024.