

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 515137	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/08/2026
NAME OF PROVIDER OR SUPPLIER Berkeley Springs Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 456 Autumn Acres Road Berkeley Springs, WV 25411	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and staff interview, the facility failed to provide a safe, clean, comfortable, and homelike environment for residents on the 300 hall. This was a random opportunity for discovery. Room Numbers: #307, #308, #309, and #312. Facility census: 101. Findings included: room [ROOM NUMBER]Upon survey entrance and resident interviews on 07/06/26 at 11:50AM, the following was observed in room [ROOM NUMBER]The window sills had dust and cobwebs in the corners with a buildup of blackish debris. a) room [ROOM NUMBER]-During resident interviews on 07/06/26 at approximately 12:10 PM, the following was observed in room [ROOM NUMBER]The window sill had dust and cobwebs with a buildup of blackish debris. b) room [ROOM NUMBER]-During resident interviews on 07/06/26 at approximately 12:25 PM, the following was observed in room [ROOM NUMBER]The window sill had dust and cobwebs with a buildup of blackish debris. c) room [ROOM NUMBER]-During resident interviews on 07/07/26 at approximately 2:25 PM, the following was observed in room [ROOM NUMBER]The window sill had dust and cobwebs with a buildup of blackish debris. Further observation found a brownish smeared substance on the floor in the bathroom in front of the toilet. - A recheck of room [ROOM NUMBER]'s bathroom on 07/08/26 at 10:25 AM found the brownish smeared substance was still on the floor in front of the toilet base During a facility walk through with the administrator on 07/08/26 at 10:25 AM, he confirmed the black debris build up and dusty cobwebs on the above listed window sills. He also confirmed the brown smears in room [ROOM NUMBER]'s bathroom floor in from of the toilet base.		

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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 515137 If continuation sheet Page 1 of 11

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	PASARR screening for Mental disorders or Intellectual Disabilities Based on record review and staff interviews, the facility failed to include all the relevant diagnoses for residents on their Pre-admission Screen (PASARR). Out of the thirty four (34) residents in the initial pool, four (4) residents had incorrect or missing diagnoses. Resident identifiers #8, #11, #12 and #68. Facility census: 101. Findings include: a) Resident #8 On 07/06/26, during a record review of Resident #8's chart, their Pre-admission Screening (PAS) in section thirty (30) has option K (affective bipolar disorder) marked. This does not match the current active diagnosis on chart of Bipolar disorder, unspecified (F31.9), and it is missing a diagnosis of Unspecified dementia, unspecified severity without behavioral disturbances (F03.90). In a follow-up interview with the DON, she stated that the facility is conducting a house wide audit on admission paperwork and will ensure they capture all the admission and any new diagnoses a resident may have on the PAS. b) Resident #12 On 07/06/26, during a record review of Resident #12's chart, their Pre-admission Screening (PAS) in section thirty (30) has option A (none) marked. Nothing is listed in section N (other) to allow for any diagnosis that may not fit into other listed areas to be added to this form. The resident has F31.81 BIPOLAR II DISORDER, F33.1 MAJOR DEPRESSIVE DISORDER, and F41.1 GENERALIZED ANXIETY DISORDER all listed under their active diagnoses in their chart. These diagnoses were all required to be listed on the PASARR but were missing. In a follow-up interview with the DON, she stated that the facility was conducting a house wide audit on admission paperwork and will ensure they capture all the admission and any new diagnoses a resident may have on the PASARR. c) Resident #11: On 07/07/26 at 9:30 AM, during a record review of Resident #11's chart, their Pre-admission Screening (PAS) in section thirty (30) option K was marked NONE. This does not match the current active diagnoses on the chart: Schizophrenic Disorder(20.9), Vascular Dementia with Anxiety (F01.B4), and it is missing a diagnosis of Major Depressive Disorder recurrent, moderate(F31.9). d) Resident #68: On 07/07/26 at 2:35 PM, during a record review of Resident #68's chart, their Pre-admission Screening (PAS) in section thirty (30) option K was marked NONE. This does not match the current active diagnosis on chart of Bipolar Disorder, unspecified (F33.0), and it is missing a diagnosis of (continued on next page)		

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Generalized Anxiety disorder recurrent, mild(F41.1). In a follow up interview with the Corporate RN on 07/07/26 at 2:45 PM, she confirmed the missing diagnoses on Resident #11 and #68 then stated the facility was doing a house wide audit on admission paperwork and will ensure they capture all the admission and any new diagnosis a resident may have on the PASARR.		

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. Based on record review and staff interview, the facility failed to ensure resident care plans were revised for one (1) resident. The issues included the residents diet being changed twice and her weekly weight orders not being included. This failed practice had the potential to affect more than a limited number of residents. Resident Identifiers: #14. Facility Census: 101.a) CommuniCare policy titled Plan of Care Overview states: Plan of Care: for the purpose of this policy, the Plan of Care, also Care Plan is the written treatment provided for a resident that is resident focused and provides for optimal personalized care. It is the policy of this facility to provide resident centered care that meets the psychosocial, physical and emotional needs and concerns of the residents. Safety is a primary concern for our residents, staff and visitors. The purpose of the policy is to provide guidance to the facility to support the inclusion of the resident or resident representative in all aspects of person centered care planning, and that this planning includes the provision of services to enable the resident to live with dignity and supports the resident's goals, choices, and preferences including, but not limited to, goals related to their daily routines and goals to potentially return to a community setting. The facility will review care plans quarterly and / or with significant changes in care. The Minimum Data Set (MDS) Coordinator will oversee and coordinate the care team and Plan of Care (POC). Nurses are expected to participate in the resident plan of care for reviewing and revising the care plan of residents they provide care for as the resident's condition warrants. Care plan documents are resident specific / resident focused and reflect resident / representative opportunities for participation and preferences. b) Resident #14 Resident #14 care plan was not revised when her diet was changed from a therapeutic diet to a regular diet on 03/31/26. Resident #14 care plan was not revised, when her weight order was changed to weekly weights every Thursday starting on 06/18/26, due to weight loss. Resident #14 care plan was not revised when her order for finger foods with meals as available was discontinued on 06/29/26. During an interview with the Regional Director of Clinical Operations (RDCO) on 07/07/26 at 1:35 PM the surveyor showed her the care plan had not been updated for Resident #14 on three (3) separate occasions and she stated I will contact the Registered Dietitian (RD) and I will start an audit for care plan revision. We did miss these revisions.		

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on observation and staff interviews the facility failed to ensure Resident #71 had a dignified dining experience during the lunch meal on 07/06/26 and 07/07/26. The facility failed to serve Resident #71 at the time his roommate was served. Resident #71 was not served for 35 minutes after the roommate was served his meal. This failed practice was a random opportunity for discovery. Resident Identifiers: #45 and #71. Facility Census: 101. Findings Included: a) During an observation of the lunch meal at 12:10 PM on 07/06/26 Resident #45 was observed eating his meal while his roommate Resident #71 still had not received his tray. In an interview with Resident #45, about his lunch, he stated he was on vacation and was eating in his room this week. When asked of Resident #71 if he had already eaten his meal, he reported he had not received his tray yet. My tray always comes after the dining room gets theirs. It was further noted that Resident #71's meal arrived at 12:35PM. It was observed on 7/7/26 at 12:15 that Resident #45 received his tray in his room at 12:15PM but Resident #71 did not receive his noontime meal until 12:40PM. On 07/07/26 at 12:45PM Licensed Practical Nurse Employee #116 was interviewed. She confirmed she was aware that Resident #45 had decided to eat in his room this week, calling it his vacation. His meals arrive before his roommate and explained that (roommate)Resident #71 prefers to receive his meals in his room, which is served after the dining room while Resident #45 usually prefers to eat in the dining room. She also reported that due to resident #45's diagnosis of explosive disorder, he would be upset and have explosive behaviors if his food is not where he at his time to eat. Due to this issue, she stated she could not see a way to accommodate both residents to receive their meals at the same time. During an interview with the Administrator on 7/7/26, at 3:00pm He acknowledged that trays are delivered to the floors after meals are served in the dining room which causes conflicts in tray arrival times if a resident chooses to eat in his room instead. He stated this was unacceptable and that he would look into it.		

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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. Based upon Record review and staff interviews, the facility failed to ensure that care plans were person centered and had measurable goals. Resident identifiers #8. Census: 101. Findings include: a) Resident #8 On 07/08/2026 during routine chart review for Resident #8, it was determined that their care plan was not specific to the resident and did not have measurable goals associated with it. Page one (1) of their care plan in the goal section stated, resident will not experience any increase in signs and symptoms of mood disturbance through review period. The target date listed is 09/09/26. There was no mention of what types of disturbances or behaviors this resident has had in the past, or what ones that the staff should be on the look out for. In the intervention area on page one (1) it states observe and document s/sx of effectiveness and side effects. There is no mention of what sign, symptoms, or side effects to look out for or document. That section also states Honor residents preferred choices. The choices are not listed for anyone to know what the resident likes or dislikes. Page fourteen (14) in the goal section states resident will have fewer episodes of behaviors through review date. There is no mention of how many episodes are currently happening and there are missing signs and symptoms for the medications that the staff is to observe and document. Without this necessary information the staff is unable to provide the full care for this resident and ensure the care they are providing is working. There must be resident specific and measurable goals for each. In a follow up interview with the Administrator that same day, they stated that care plans are done when the resident admits to the facility as well as quarterly. They also update them as needed if a resident's status changes.		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. Based on medical record review, observation, and staff interview, the facility failed to ensure Resident's received treatment and care in accordance with professional standards of practice. Specifically, physician's orders were not followed in regards to G-tube (gastrostomy tube) placement and significant weight loss Resident #100 and #14. Facility census: 101. Findings Included: An observation on Medication administration for Resident #100 found Licensed Practical Nurse (LPN) # 74 administering medication and feeding through a G-tube. Enteral tube placement was not checked prior to administering medications or feeding. During an interview on 07/08/26 at approximately 8:10 AM with LPN #74 she verified placement was not checked prior to medication administration and feeding. A medical record review found a physician orders: - Enteral Feed, every shift check for resin 100cc hold feeding for one hour and recheck if residual remains greater than 100 ml notify physician with a start date 07/14/2025. - Enteral Feed, every shift verify enteral tube placement before feedings, flushes, and medication passes by checking gastric contents are not visualized 07/14/2025. During an interview on 07/08/26 at approximately 8:30 AM the Director of Nursing verified placement should have been checked prior to administration of medication or feeding. b) CommuniCare policy titled Resident Height and Weight states: Weight: the number of pounds / ounces that an individual weighs. This important vital is used for medication, nutrition and other treatments and must be managed correctly. Weights will be obtained monthly or as ordered by the physician or practitioner. Unless a compelling reason exists, obtain weight in the morning before meals and post voiding to obtain the most accurate body weight. Compare weight to previous weight obtained. If a variance of five (5) pounds or more is noted, reweigh resident to verify weight. Unstable residents will be reviewed by IDT team to determine frequency of obtaining weight. Update Interdisciplinary Care Plan as needed. Weight loss concerns are reported to the practitioner and discussed at the weekly clinical meetings. (continued on next page)		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	c) Resident #14 07/07/2026 10:18 AM Resident #14 has a significant weight loss. Her Body Mass Index (BMI) is classified as underweight at 17.3. Resident #14 care plan was not revised, when her weight order was changed to weekly weights every Thursday starting on 06/18/26, due to weight loss. 07/08/26 11:30 AM Resident #14 had a significant weight loss on 06/01/26, her weight was 88.8 pounds (#). She was reweighed by the facility on 06/03/26, and her weight was 88.6#. The Registered Dietitian completed a nutritional assessment on 06/15/26 and recommended weekly weights for Resident #14. The Physician approved this recommendation and the order was written to obtain weekly weights every Thursday starting on 06/18/26. There was no weekly weight attempted by the facility on 06/18/26. Interview with the Director of Nursing (DON) and the Regional Director of Clinical Operations (RDCO) today at 11:00 AM. I asked them why the weekly weight that the Physician ordered to start on 06/18/26 was not attempted by the facility, and the DON stated the order was not put in correctly by the nurse, so it did not show up the the Medication Administration Record (MAR) correctly. That is why it was missed.		

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. Based on record review, observations, and staff interview. The facility failed to ensure physician orders were being followed for treatment services to prevent pressure ulcers. This affected one(1) of three (3) residents reviewed. Resident identifier: #101. Facility census : 101. Findings include- a) Resident #101 Review of physician order.-Reads in part, resident to have heel boot to right/left heel at all times except for bathing. Review of care plan.-Reads in part, Focus-Resident #101 is at risk for pressure ulcers/injuries related to decreased mobility, poor nutritional intake, and favors right side.Intervention reads in part.-Resident to have heel boot on the right/left heel at all times except bathing. Date initiated: 01/17/23Date revised: 02/19/2023 -On 07/06/26 at around 12:30 PM during observation with Resident #101, both heel protectors were laying in chair not on. Resident was on the right side facing window. Reviewed physician order, which reads in part: to have heel protectors on at all times except for showers. -On 07/06/26 at around 3:20 PM Observed resident remains laying on right side facing the window, heel protectors not in place, remain one in chair and one on floor, resident also remains laying on right side. Spoke with nurse #124, she verified the heel protectors need to be on when in bed and they were not and that resident has been laying on the right side. She then placed the heel protectors on the resident. -On 07/07/26 at around 9:30AM. During observations, the resident had heel protectors lying in the chair and not on the heels per orders. -On 07/07/26 at around 12:30 PM. Residents heel protectors remained in the chair. Nurse #89 was in residents room to assist with meal, verified these were to be kept on at all times. She then placed them on the resident.		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on observation and staff interviews, the facility failed to ensure the resident environment remains as free of accident hazards as is possible r/t med cart left unlocked and unattended. This failed practice was a random opportunity for discovery. Facility Census:101Findings Included: a) On 07/06/26 approximately 3:10 PM It was observed in the 200 hallway, the med-cart was found unattended and left unlocked. Employee #148 was also in the 200 hall at the time the med cart was found unattended and unlocked, confirmed she had witnessed surveyor able to walk up and pull open the top drawer of the med cart. She then closed it and locked it to ensure the safety of residents until the nurse returned. In an interview with Licensed Practical Nurse, Employee #140 on 07/06/26 at 3:15PM she confirmed the med-cart was left unlocked while she went to get some ice for the cart and stated I am sorry I didn't realize it was unlocked. During an interview with the Facility Administrator on 7/6/26 at 3:35 PM, he acknowledged the med cart was left unlocked and stated thank you for letting me know.		

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. Based on observation and interviews, the facility failed to ensure the resident environment over which they had control was as free from accident hazards as possible in regards to bed safety. This was a random opportunity for discovery. Resident Identifiers: 101. Facility census: 101. Findings Include: a) Resident #101 During an initial tour of the facility an observation, completed on 07/06/26 at 1:16 PM, revealed Resident #101 was lying in bed with an approximate 12-inch gap between the mattress and foot rail. The bed was extended with a small suffer in place leaving about a 10 inch gap deep. During an interview on 07/06/26 at 1:20 PM, the Assistant Director of Nursing verified the gaps between the mattress and foot boards for Residents #101. He continued to say that he would have the maintenance director evaluate and fix the gap at this time.		