STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495318	A. BUILDING _____ B. WING _____	**07/16/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
BERRY HILL NURSING HOME	**621 BERRY HILL ROAD SOUTH BOSTON, VA 24592**

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 0690 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff interview, clinical record review, facility policy review and complaint investigation, the facility staff failed to position a urinary catheter bag to prevent infection for one of two residents in the survey sample. Resident #1's urine collection bag for his Foley catheter was positioned in the floor. The findings include: Resident #1 was admitted to the facility on [DATE] with a re-admission on 6/22/20. [DIAGNOSES REDACTED]. The minimum data set ((MDS) dated [DATE] assessed Resident #1 with moderately impaired cognitive skills. On 7/15/20 at 9:55 a.m., Resident #1 was observed in bed. The resident's catheter collection bag was attached to the lower rail of the bed with most of the bag positioned in the floor. The catheter bag was observed in the floor again on 7/15/20 at 10:30 a.m. On 7/15/20 at 11:00 a.m., accompanied by the licensed practical nurse (LPN #1), Resident #1 was observed in bed with the catheter bag in contact with the floor. LPN #1 was interviewed at this time about the positioning of the catheter bag. LPN #1 stated the Foley bag should not be in the floor. LPN #1 stated, We need to hang it (catheter bag) somewhere else. On 7/15/20 at 12:10 p.m., the registered nurse (RN #1) responsible for the facility's infection control program was interviewed about Resident #1's catheter with the collection bag in the floor. RN #1 stated the urine collection bags were never supposed to be in the floor. The facility's policy titled Closed Urinary Drainage System (April 2013) documented concerning catheter bag placement, .Attach drainage bag to bed frame, below level of resident's bladder, not touching floor . This finding was reviewed with the administrator on 7/15/20 at 1:00 p.m.
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.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interview, clinical record review, facility document review and complaint investigation, the facility staff failed to ensure medications were available for one of two residents in the survey sample. Resident #2 had no scheduled medications available or administered until the second day after her admission to the facility. The findings include: Resident #2 was admitted to the facility on [DATE] and was discharged to the hospital on [DATE]. [DIAGNOSES REDACTED]. The minimum data set ((MDS) dated [DATE] assessed Resident #2 as cognitively intact. Resident #2 was admitted to the facility on [DATE] at 9:11 p.m. The resident was admitted with physician orders [REDACTED]. Breo Ellipta 110-25 mcg (micrograms)/dose, 1 puff each day for [MEDICAL CONDITION] Meropenem 1 gram in normal saline intravenous every 8 hours for treatment of [REDACTED]. pressure [MEDICATION NAME] 10-325 mg every 6 hours as needed for pain [MEDICATION NAME] 3 mg each bedtime as needed for [MEDICAL CONDITION] 30 mg as needed [MEDICAL CONDITION][MEDICATION NAME] HFA 90 mcg/actuation 2 puffs every 6 hours as needed for dyspnea Resident #2's Medication Administration Record [REDACTED]. The [MEDICATION NAME] was not started until 2/16/20 at 8:00 a.m. There was no indication of why the resident's medications were not available on 2/14/20 for administration. On 7/15/20 at 11:35 a.m., the licensed practical nurse (LPN #2) that reviewed Resident #2's admission orders [REDACTED]. LPN #2 stated if prescriptions were faxed to the pharmacy before 4:00 p.m., the medicines were usually delivered that same night. LPN #2 stated if prescriptions were faxed after 4:00 p.m., they would not be delivered until the next night around midnight. LPN #2 stated Resident #2 was admitted late on the evening on 2/13/20 so the medicines were not available to administer on 2/14/20, as they were probably not delivered until around 12:00 a.m. on 2/15/20. LPN #2 stated she was not sure why a back-up pharmacy was not used to get the medicines. LPN #2 stated as needed pain medication was administered on 2/14/20 and probably came from the emergency supply box. The director of nursing (DON) was on vacation and not available for interview. On 7/15/20 at 12:20 p.m., the administrator was interviewed about Resident #2's medicine availability upon admission. The administrator stated if medications were not delivered on the night of the admission, nursing should have followed up with the back-up pharmacy. On 7/15/20 at 12:30 p.m., the physician's assistant (other staff #1) was interviewed about Resident #2's medications. The physician's assistant (PA) stated residents should not miss an entire day of medications when admitted . The PA stated delayed availability of medicines for new admissions has happened on several occasions. On 7/16/20 at 9:10 a.m., the administrator was interviewed again about the delayed start of medications for Resident #2. The administrator stated currently the pharmacy delivers medications once per day and that was usually around midnight. The administrator stated Resident #2's medication orders might not have been faxed timely to the pharmacy. The administrator stated the time Resident #1's medication orders were faxed to the pharmacy was not documented so she was not sure when pharmacy got the orders. The facility's policy titled Procurement of Emergency and After-Hours Medications (revised 8/1/14) documented in the event that antibiotics, pain or routine medications were not promptly available from the standard pharmacy the nurse should contact the on-call pharmacist. This policy documented, The 'on-call' pharmacist shall then make whatever arrangements necessary with a predetermined local pharmacy (back-up pharmacy) or if the back-up pharmacy cannot supply, with any other local retail pharmacy or hospital pharmacy, for procurement of the needed medications .Should attempts to contact the pharmacist 'on-call' fail .the nurse should take whatever steps necessary to secure the required medication, including contacting the 'back-up' pharmacy directly . These findings were reviewed with the administrator on 7/15/20 at 1:00 p.m.

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