

Division of Licensing and Protection
103 South Main Street, Ladd Hall
Waterbury, VT 05671-2306
<http://www.dail.vermont.gov>
Voice/TTY (802) 871-3317
To Report Adult Abuse: (800) 564-1612
Fax (802) 871-3318

June 12, 2013

Mr. Timothy Shackleford, Administrator
Berlin Health & Rehab Ctr
98 Hospitality Drive
Barre, VT 05641-5360

Dear Mr. Shackleford:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **April 22, 2013**. Please post this document in a prominent place in your facility.

Sincerely,



Pamela M. Cota, RN
Licensing Chief



DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

RECEIVED
Division of

PRINTED: 05/31/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 475020	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	JUN 11 13 Licensing and Protection	(X3) DATE SURVEY COMPLETED C 04/22/2013
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NAME OF PROVIDER OR SUPPLIER BERLIN HEALTH & REHAB CTR	STREET ADDRESS, CITY, STATE, ZIP CODE 98 HOSPITALITY DRIVE BARRE, VT 05641
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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F 000	INITIAL COMMENTS	F 000		
F 280 SS=B	<p>An unannounced, on-site complaint investigation was conducted by the Division of Licensing and Protection on 04/22/2013. The facility was found to be in substantial compliance, but the following are minor regulatory findings.</p> <p>483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP</p> <p>The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.</p> <p>A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.</p> <p>This REQUIREMENT is not met as evidenced by: Based on medical record review, staff interviews and facility policy and procedures reviews, the facility failed to revise the care plan to reflect changes in the status of wounds and skin care for 1 of 3 sampled residents (Resident # 1). The</p>	F 280	<p>Corrective Action</p> <p>F 280</p> <ol style="list-style-type: none"> 1. Resident #1 no longer resides in this facility 2. All residents with changes in the status of wounds and skin care have the potential to be affected by this alleged deficient practice 3. Nursing staff will be provided inservicing regarding the need for care plan revision for residents that have changes in wounds or skin care 4. Random weekly audits of residents with alterations in skin integrity will be done by the DNS or designee to measure the effectiveness of the plan 	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE Administrator	(X6) DATE 6-6-13
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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.

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F 280	Continued From page 1 specifics are as follows: Per medical record review of Resident # 1 on 04/22/2013 at 10:25 am, there is no evidence to support that the care plan was revised to reflect the multiple changes in skin/ wound status for this resident around several open areas, none of which were classified by either the wound nurse or the physician as pressure ulcers. Resident # 1 was admitted on 02/27/2012 with readmission on 07/27/2012 with renal failure, morbid obesity, Diabetes, anemia and other cardiovascular diseases. MDS on admission indicates no pressure ulcers. MDS dated 03/19/2013 (quarterly review) codes pressure ulcers as 'none'. MDS done on discharge to the hospital with return anticipated dated 04/16/2013 also codes skin as having 'no pressure ulcers.' The nurses notes indicate several areas on skin that were identified by the physician as sebaceous cysts that erupted spontaneously and required nursing interventions. Per nurses' notes dated 04/11/2013, there is a change in protocol for wound care generated by the wound care team after their visit to Resident # 1 on this day. The nurses' notes and flow sheets indicate that the care was provided but the care plan was not revised at this time, nor since to reflect this. The last revision documented was on 04/01/2013. That fact that the care plan was not revised is confirmed by the Director of Nursing (DON) during interview on 04/22/2013 at 2:25 pm.	F 280	5. The DNS or designee will report the results of the audits to the QAA committee monthly x3. QAA committee to determine frequency of audits after this time 6. Corrective action will be completed by 6/10/13. <i>F280 POC accepted 6/12/13 G.Coleman RN / AME</i>		
F 282 SS=B	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of	F 282			

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F 282	Continued From page 2 care. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to regularly provide services for assessments and care planning for 1 of 3 residents (Resident # 1) to reflect monitoring of skin conditions. The following specifics are presented: Per medical record review of Resident # 1 on 04/22/2013 at 10:25 am, there is no evidence to support that the skin assessments were done by a registered nurse as per facility protocol based on the multiple changes in skin/ wound status for this resident around several open areas, none of which were classified by either the wound nurse or the physician as pressure ulcers. Resident # 1 was admitted on 02/27/2012 with readmission on 07/27/2012 with renal failure, morbid obesity, Diabetes, anemia and other cardiovascular diseases. MDS on admission indicates no pressure ulcers. MDS dated 03/19/2013 (quarterly review) codes pressure ulcers as 'none'. MDS done on discharge to the hospital with return anticipated dated 04/16/2013 also codes skin as having 'no pressure ulcers.' The nurses notes indicate several areas on skin that were identified by the physician as sebaceous cysts that erupted spontaneously and required nursing interventions. The Braden Scale that is an assessment tool to monitor the risk of developing pressure ulcers was documented as having been done on	F 282	F 282 1. Resident #1 no longer resides in this facility 2. All residents have the potential to be affected by this alleged deficient practice 3. Braden assessment tools will be updated and current for all residents 4. Nursing staff will be provided inservicing regarding the need for a documented assessment by a Licensed Nurse for residents with an alteration in skin integrity per facility protocol 5. Nursing staff will be provided education regarding the requirement for Braden assessment tools to be completed quarterly and will changes in skin condition	

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F 282	Continued From page 3 11/14/2012 and not again until 03/28/2013. Per review of agency protocol this assessment tool is to be done quarterly and with changes in skin conditions. That the assessments are not recorded as having been done in a timely manner or with changes in skin integrity is confirmed by the Director of Nursing (DON) during interview on 04/22/2013 at 2:25 pm.	F 282	6. Random weekly audits will be done by the DNS or designee to measure the effectiveness of the plan 7. The DNS or designee will report results of the plan to QAA committee monthly. QAA committee to determine frequency of audits at that time 8. Corrective action will be completed by 6/10/13. <i>F282 POC accepted 6/12/13 Gcdeman@ns/pme</i>		