

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

May 23, 2013

Ms. Meagan Buckley, Administrator
Berlin Health & Rehab Ctr
98 Hospitality Drive
Barre, VT 05641-5360

Dear Ms. Buckley:

Enclosed is a copy of your acceptable plans of correction for the complaint investigation concluded on **May 1, 2013**. Please post this document in a prominent place in your facility.

We may follow-up to verify that substantial compliance has been achieved and maintained. If we find that your facility has failed to achieve or maintain substantial compliance, remedies may be imposed.

Sincerely,



Pamela M. Cota, RN
Licensing Chief

PC:jl



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

FORM APPROVED
OMB NO. 0938-0381

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 475020	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 05/01/2013
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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 An unannounced onsite complaint investigation was initiated by the Division of Licensing and Protection on 4/17/13, and concluded on 5/1/13. There were regulatory violations identified as a result.	F 000		
F 223 SS=G	483.13(b), 483.13(c)(1)(i) FREE FROM ABUSE/INVOLUNTARY SECLUSION The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion. The facility must not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion. This REQUIREMENT is not met as evidenced by: Based on record review, resident and staff interviews, the facility failed to assure that Per record review on 4/17/13, Resident #1 was found by the staff on the morning of 4/6/13 to be sitting on the edge of the bed with a bedpan under his/her buttocks. According to staff statements, the LNAs laid the resident back down, removed the bedpan, and discovered that there were open areas on the resident's buttocks. The nurse was informed, and assessed the wounds as a horseshoe shaped series of skin tears on the right and left buttocks. Per interview on 4/17/13 at 11:30 AM, Resident #1 was not clear about who placed them on the bedpan or when, stating that they did not want to say, however stated that they had been sitting on the bedpan since the previous day. The facility	F 223	<p>Corrective Action</p> <p>F 223</p> <ol style="list-style-type: none"> 1. Resident #1 no longer uses a bedpan and Resident # 1 open areas are healing without complications. 2. All residents that use a bedpan have the potential to be affected by this alleged deficient practice. 3. Nursing staff have been re-educated about the rounds process to include bedpan use. 4. Random weekly interviews will be done with residents that use a bedpan. Interviews will be done by DNS or designee to measure effectiveness of the plan. 	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE administrator	(X6) DATE 5/15/13
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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.

pm

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F 223	Continued From page 1 Investigation into the incident was conducted, and no definite conclusion was drawn as to the actual time or person that placed the bedpan under the resident. Per review of the plan of care, there was an update made on 4/12/13, which stated that the VA hospital assessed this as a pressure wound caused by the bedpan. There was no update to the care plan to identify the new wound identified on 4/6/13, until the resident returned to the facility after hospitalization on 4/12/13. Although there was some discrepancy regarding the categorization of the wound as a skin tear or a Stage 2 pressure ulcer, there was no question as to the source of the wound being from sitting on the bedpan. Per interview on 4/17/13 at 4:10 PM, the Director of Nursing stated that the LNAs had been educated to have outgoing and incoming LNAs check all residents at change of shift rounds for incontinence, if a bedpan was in place, if call bell was in reach, and check for any resident needs at that time. Per this same interview, the DNS also confirmed that despite the unclear series of events leading up to the bedpan being discovered under the resident, and the discrepancy of what type of wound to call this, there was no doubt that the open areas were caused by the resident sitting on the bedpan for some extended period of time.	F 223	<ol style="list-style-type: none"> 5. The DNS or designee will report results of plan to QAA committee monthly X3. QAA committee to determine frequency of audits after this time. 6. Corrective action will be completed by 5/17/13. <p><i>F223 POC accepted 5/16/13 K Campos RN/PMC</i></p>	
F 309 SS=G	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.	F 309	<p>F 309</p> <ol style="list-style-type: none"> 1. Resident #1 no longer uses a bedpan and Resident # 1 open areas are healing 	

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F 309	<p>Continued From page 2</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and interviews, the facility failed to provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being for one of two residents sampled. (Resident #1). Findings include:</p> <p>Per record review on 4/17/13, Resident #1 was found by the staff on the morning of 4/6/13 to be sitting on the edge of the bed with a bedpan under his/her buttocks. According to staff statements, the LNAs laid the resident back down, removed the bedpan, and discovered that there were open areas on the resident's buttocks. The nurse was informed, and assessed the wounds as a horseshoe shaped series of skin tears on the right and left buttocks. Per interview on 4/17/13 at 11:30 AM, Resident #1 was not clear about who placed them on the bedpan or when, stating that they did not want to say, however stated that they had been sitting on the bedpan since the previous day. The facility investigation into the incident was conducted, and no definite conclusion was drawn as to the actual time or person that placed the bedpan under the resident. Per review of the plan of care, there was an update made on 4/12/13, which stated that the VA hospital assessed this as a pressure wound caused by the bedpan. There was no update to the care plan to identify the new wound identified on 4/6/13, until the resident returned to the facility after hospitalization on 4/12/13. Although there was some discrepancy regarding the categorization of the wound as a skin tears or a</p>	F 309	<p>without complications.</p> <ol style="list-style-type: none"> 2. All residents that use a bedpan have the potential to be affected by this alleged deficient practice. 3. Nursing staff have been re-educated about the rounds process to include bedpan use. 4. Random weekly interviews will be done with residents that use a bedpan. Interviews will be done by DNS or designee to measure effectiveness of the plan. 5. The DNS or designee will report results of plan to QAA committee monthly X3. QAA committee to determine frequency of audits after this time. 6. Corrective action will be completed by 5/17/13. 	
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F309 POC accepted 5/16/13
KCampos RN / pmc

STATEMENT OF DEFICIENCIES NO PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 475020	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 05/01/2013
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F 309	Continued From page 3 Stage 2 pressure ulcer, there was no question as to the source of the wound being from sitting on the bedpan. Per interview on 4/17/13 at 4:10 PM, the Director of Nursing stated that the LNAs had been educated to have outgoing and incoming LNAs check all residents at change of shift rounds for incontinence, if a bedpan was in place, if call bell was in reach, and check for any resident needs at that time. Per this same interview, the DNS also confirmed that despite the unclear series of events leading up to the bedpan being discovered under the resident, and the discrepancy of what type of wound to call this, there was no doubt that the open areas were caused by the resident sitting on the bedpan for some extended period of time.	F 309		