

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

August 22, 2014

Mr. John O'Donnell, Administrator  
Berlin Health & Rehab Ctr  
98 Hospitality Drive  
Barre, VT 05641-5360

Dear Mr. O'Donnell:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **August 7, 2014**. 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

PRINTED: 08/13/2014  
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 _____	(X3) DATE SURVEY COMPLETED  8/07/2014
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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  F 428 88-E	<p><b>INITIAL COMMENTS</b></p> <p>An unannounced, on-site investigation of a facility self-report was initiated by the Division of Licensing &amp; Protection on 7/23/2014 and concluded on 8/7/14. The following regulatory deficiencies were identified during the investigation:</p> <p><b>485.80(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON</b></p> <p>The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist.</p> <p>The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon.</p> <p>This REQUIREMENT is not met as evidenced by: Based on clinical record review and staff interview, the consultant pharmacist failed to report irregularities to the attending physician and the Director of Nursing in the drug regimens of 3 of 3 applicable residents taking antipsychotic medications. (Resident #2, #3 and #6) Findings include: 1. Per 7/23/14 medical record review, Resident # 2, who was readmitted to the facility on 4/18/14, had diagnoses which included bipolar disorder and schizophrenia. She had physician orders for Fluphenazine Decanoate 25 mg/ml 2 ml by intramuscular injection every 10 days and Fluphenazine Decanoate 2.5 mg one tablet</p>	F 000  F 428	<p>Preparation and/or execution of this Plan of Correction does not constitute the Provider's admission of /or agreement with the alleged violations or conclusions set forth in this statement of deficiencies. This Plan of Correction is prepared and/or executed as required by State and Federal Law.</p> <p>F428 485.80(c) Drug Regimen Review, Report Irregular, Act On.</p> <ol style="list-style-type: none"> <li>1. No residents have had a negative effect from alleged deficient practice.</li> <li>2. All residents have potential to be affected by the alleged deficient practice.</li> <li>3. Resident #2, #3, #6 Have all had AIMS testing completed.</li> <li>4. Initial audit completed for all residents receiving antipsychotics to ensure that AIMS testing is present.</li> <li>5. Random weekly audits to be completed by the DNS or designee to monitor compliance with AIMS testing.</li> <li>6. Consulting Pharmacist re-educated to the requirements of monthly audits of all medication records and reporting of irregularities to the attending Physician and the DNS.</li> <li>7. Nursing Staff re-educated to the requirements of AIMS testing for all residents on antipsychotics upon admission, with the start of a new antipsychotic and 6 months thereafter.</li> <li>8. Results of the audits will be reported to the QA committee by the DNS or designee for a minimum of 3 months at which time the committee will determine further frequency of the audits.</li> </ol>	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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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 off-site safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 30 days following the date these documents are made available to the facility. 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 428	Continued From page 1 during the day and one tablet at bedtime. (Fluphenazine Decanoate is an antipsychotic medication, brand name Prolixin). Per interview with the Unit manager (UM) on 7/23/14 at 2:19 PM, s/he confirmed that the facility did not complete an AIMS (Abnormal Involuntary Movement Scale- used to monitor for antipsychotic medication side effects) for Resident #2 on readmission; s/he confirmed that AIMS testing is indicated for residents on admission to the facility to establish a baseline and is repeated every 6 months or when there are medication dose changes or other indications. S/he confirmed that the pharmacist consult reviewed Resident #2's medication regime on 5/13/14, 6/8/14 and 7/12/14 and did not identify the irregularity. 2. Per 7/23/14 medical record review, Resident # 3 was admitted to the facility on 6/10/14 with diagnoses which included paranoid schizophrenia. S/he had physician orders for Fluphenazine Decanoate 10 mg three times per day, 2.5 mg two times per day and 2 (2.5 mg) tablets at bedtime along with Seroquel 50 mg 1 tablet twice daily (Both Fluphenazine Decanoate and Seroquel are antipsychotic medications). On 7/23/14 at 3:10 PM, the UM confirmed that no AIMS assessment had been conducted for Resident #3 on or since admission to the facility and that the pharmacist consultant did not identify the irregularity during two visits, one visit undated and the second on 7/22/14.	F 428	9. Corrective action will be completed by August 20, 2014.  F428 POC accepted 8/21/14 SDennis APRN/PMC		

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F 428	Continued From page 2  3. Per record review on 7/23/14 Resident #8 was admitted to the facility on 2/25/14 and was not on an antipsychotic medication at the time of admission. The problem list includes Conduct Disorder, Persistent Mental Disorder, and Psychotic Disorder with Delusions. On 4/14/14 the resident was placed on Risperdal 0.5 milligrams (mg) daily. The dose of Risperdal was increased to 1 mg daily on 5/23/14. The Pharmacy reviews conducted on May 13, June 8, and July 12, 2014 did not note the absence of an AIMS assessment when the medication was initiated or upon an increase of dose. The Unit Manager confirmed in an interview on 7/23/14 at 2:50 PM that there were no AIMS assessments and no Pharmacy recommendations related to those assessments present in the record.	F 428			
F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE  The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.  The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.  This REQUIREMENT is not met as evidenced by:	F 514	F514 483.75(l)(1)Resident Records -- Complete/Accurate/Accessible  1. No Residents have had a negative effect as a result of the alleged deficient practice. 2. All residents receiving oxygen have the potential to be effected by the alleged deficient practice.  3. Education provided to Licensed Nursing staff regarding protocol for monitoring portable oxygen tanks. 4. Portable oxygen monitoring sheets will be attached to all portable oxygen tanks when in use. LNA's will check the portable oxygen tanks every two hours and document such.		

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F 514	<p>Continued From page 3</p> <p>Based on clinical record review and staff interview, the facility failed to ensure that the clinical record for 1 resident (Resident #1) was complete and accurate regarding monitoring of portable oxygen. Findings include: Per 7/23/14 medical record review, Resident #1 was admitted to the facility with diagnoses that included Chronic Airway Obstruction (a chronic respiratory condition associated with shortness of breath which in advanced stages may require oxygen supplementation), muscle weakness, cognitive communication deficit, anxiety and other chronic medical conditions. Per review, the resident's current medical orders, originating on 4/15/14, state: oxygen at 2 liters/minute via nasal cannula to maintain an oxygen saturation level above 92%. The orders state "CNA's (certified nursing assistants) to check portable oxygen every 2 hours every shift." On 7/23/14 at 11:35 AM, Resident #1's portable oxygen tank was observed with the A wing UM (Unit Manager) with the needle gauge registering at the very low end on the scale (close to empty). The UM then requested that LNA #1 (Licensed Nursing Assistant) refill the tank. On 7/23/14 at 11:49 AM, LNA #1 reported that there is no place to document that a resident's portable O2 tanks was checked or filled. When asked if an LNA got delayed, how would other staff know when the tank was last checked or filled, s/he responded, "good point." Per 7/23/14 interview with LNA #2, who has been assigned to Resident #1's care, s/he reported that there is no place to document when a resident's oxygen tank was checked/filled and confirmed it's the LNA's responsibility to remember to see that it is done. On 7/23/14 at 12:22 PM, the UM stated its policy in the building that LNAs check the portable oxygen tanks every 2 hours and nurses check</p>	F 514	<ol style="list-style-type: none"> <li>5. Nurses will check portable oxygen tanks, every 4 hours and document such on the TAR.</li> <li>6. Random TAR audits will be completed 5 times per week by the DNS or designee to ensure documentation is complete.</li> <li>7. Results of the audits will be reported to the QA committee by the DNS or designee for a minimum of 3 months at which time the committee will determine further frequency of the audits.</li> <li>8. Corrective action will be completed by August 20, 2014.</li> </ol> <p>F514 POC accepted 8/21/14 SDennis APPN/PMC</p>	

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F 514	Continued From page 4 them every 4 hours. S/he confirmed that Resident #1's portable tank was on the "cusp" when observed earlier and confirmed that there is no place for LNAs or Nurses to document that the tanks were checked or filled. When asked how other staff would be able to tell when the tank was checked last in the event of an emergency, s/he confirmed that could be an issue.	F 514			

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STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFS	PROVIDER #  475020	MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	DATE SURVEY COMPLETE: 8/7/2014
NAME OF PROVIDER OR SUPPLIER  BERLIN HEALTH & REHAB CTR		STREET ADDRESS, CITY, STATE, ZIP CODE 98 HOSPITALITY DRIVE BARRE, VT	
ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES		
F 224	<p>483.13(c) PROHIBIT MISTREATMENT/NEGLECT/MISAPPROPRIATN</p> <p>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to report allegations of abuse to the designated state survey agency immediately, in accordance with regulations for 2 of 3 facility investigations involving 4 residents (Resident's #4, #5, #6 and #7). Findings include:</p> <ol style="list-style-type: none"> <li>1. Per 7/23/14 review of facility investigations for allegations of abuse, there were 2 investigations concerning resident to resident incidents that were not reported immediately to the State Agency (SA). In the first investigation, staff identified on 4/25/14 that an unwitnessed incident occurred between two residents. After shouting was heard, Resident #4 pointed to Resident #5 and then to his/her hand. Resident #4's hand was observed to be scratched. The facility was aware of the incident on 4/25/14 but did not report it to the SA until 4/28/14 (three days after the incident).</li> <li>2. Per 7/23/14 review, the facility investigated another resident to resident incident that occurred on 5/24/14. In this instance, Resident #6 was observed by facility staff to reach out and put her hand up to the face of Resident #7 in a "lightly slapping" gesture. The facility reported the incident to the SA on 5/30/14 (six days after the event).</li> </ol> <p>Per 7/23/14 interview at 4:25 PM, the Director of Nursing (DNS) reported that the facility follows regulations as their policy for reporting allegations of abuse and confirmed that reports of the two incidents of possible abuse should have been made to the SA within 24 hours.</p> <p>*This is an "A" level deficiency.</p>		

A 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

The above isolated deficiencies pose no actual harm to the residents