

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

January 27, 2014

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

Dear Ms. Voci:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **December 31, 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

PRINTED: 01/07/2014
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 C 12/31/2013
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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 and an investigation of a self report of an untimely death was completed by the Division of Licensing and Protection on 12/31/13. No regulatory findings were related to the self report. Regulatory violations were cited related to the complaint investigation.	F 000	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 is prepared and/or executed as required by state and federal law.	
F 282 SS=D	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 care. This REQUIREMENT is not met as evidenced by: Based on staff interview and medical record review the facility failed to provide services by qualified persons in accordance with each resident's written plan of care for 1 of 3 sampled residents. (Resident #2) The findings include: Resident #2 was admitted on 05/20/13 with diagnoses to include Myocardial Infarction, Congestive Heart Failure, Adult Failure to Thrive, Osteoarthritis, Anemia, General Weakness, Dementia and Status Post Pneumonia. Per medical record review for Resident #2, a Bisacodyl Suppository was given on 6/6/13 for no bowel movement for 7 days and the results were pending. Also, on 07/15/13, the resident was again given a suppository for no bowel movement for 5 days.	F 282	Resident #2 has been discharged No Residents were adversely affected by this alleged deficient practice.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Revera Inc</i>	TITLE <i>Exec Dir</i>	(X6) DATE <i>1/27/14</i>
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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.

pkc

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F 282	Continued From page 1 Per standing orders for Resident #2 signed by the physician and effective 10/1/13 to 10/1/14 the following is the Bowel Program: For no bowel movement (BM) in 3 days Milk of Magnesia 30 millimeters orally every morning, if no results repeat in the evening. For no BM in 4 days, give Bisacodyl suppository rectally in the morning, if no results, give fleets enema during the day, check for stool, evaluate abdomen, call Medical Doctor if no results. Per interview with Unit Manager on 12/30/13 @ 1:15 PM, s/he confirms that there is no evidence in Resident #2's medical record documenting the results of the suppository administered on 06/06/13. Per interview with Unit Manager on 12/30/13 @ 1:15 PM, s/he confirms that for dates 06/06/13 and 07/15/13 the facility failed to follow physician orders/total plan of care related to bowel protocol.	F 282	All Residents have the potential to be affected. The facility will re-educate the Bowel Protocol with the Licensed Nurses. DON or Designee will complete random weekly audits on Residents bowel activity x1 month. Results of the audits will be reviewed monthly with the QA Committee where it will be determined by the IDT if further auditing is required.	
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.	F 514	Corrective action will be completed by <i>F282 POC accepted 1/21/14 mbenbrand R/PML</i>	1/24/14

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F 514	<p>Continued From page 2</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on medical record review and staff interview the facility failed to maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete, accurately documented, readily accessible and systemically organized for 1 of 3 sampled residents. (Resident #2) The findings include:</p> <p>Per medical record review on 12/30/13 there is no documentation evidencing that Resident #2 died on 7/31/13 @ 8:00 AM. Per interview with the Nursing Home Administrator on 12/30/13 @ 3 PM, confirmation was made that a file in the administration office, containing faxed documents to Licensing and Protection, contained a hand written note dated 22 days after the death of the resident, 8/21/13, written by the Licensed Practical Nurse on duty at the time of the resident's death.</p>	F 514	<p>Resident #2 is deceased</p> <p>No Residents were adversely affected by this alleged practice.</p> <p>Licensed Nurses will be re-educated to ensure completion of supporting documentation of a Resident(s) death in the clinical record on the date they expire.</p> <p>DON or Designee will review/audit applicable Residents records to ensure supportive documentation with each Resident(s) expiration. Results of the audits will be reviewed in QA monthly x3 where it will be determined if further auditing is required.</p> <p>Corrective action complete by</p> <p><i>F514 POC accepted 1/21/14 mbertrand/RN/PME</i></p>	01/24/14