

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

July 17, 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 **June 30, 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

JUL 16 14

PRINTED: 07/09/2014
FORM APPROVED
OMB NO. 0938-0391

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

Licensing and
Protection

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 R 06/30/2014
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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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INITIAL COMMENTS

An unannounced onsite follow up visit for the recertification survey of 4/23/14 was conducted by the Division of Licensing and Protection on 6/30/14. There were additional findings as follows:

{F 279}
SS=D

483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS

A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.

The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.

The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).

This REQUIREMENT is not met as evidenced by:

Based on staff interview and medical record review for 1 of 6 sampled residents (Resident #99), the facility failed to develop a comprehensive care plan that includes measurable objectives and timetables for the

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Preparation and/or execution of this Plan of Correction does not constitute the Providers 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.

{F 279}

F279 483.20(d), 483.20(k)(1) Develop Comprehensive Care Plans.

1. Resident #99 had no negative effect from alleged deficient practice.
2. All residents have potential to be effected by the alleged deficient practice.
3. Resident #99 care plans have been reviewed and revised to include diagnosis and treatment of glaucoma.
4. Initial audit completed to ensure that residents' plan of care reflect active medical diagnosis that require treatment.
5. Random weekly audits to be completed by the DNS or designee to monitor the effectiveness of the plan.
6. 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.
7. Corrective action will be completed by July 19, 2014.

F279 POC accepted 7/17/14 Jhosmervn/pmc

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

ADMINISTRATOR

(X8) DATE

7/14/14

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.

pmc

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{F 279} Continued From page 1 treatment of Glaucoma. The findings include the following:

Per medical record review on 6/30/14 at approximately 11 AM, Resident #99 was admitted on 1/21/14 with diagnosis to include Delirium, Degenerative Disease of the Basal Ganglia, Cognitive Communication Deficit, Muscle Weakness, Delusional Disorder, Psychosis, Lewy Bodies Dementia and Glaucoma. Resident #99 has a physician's order for Latanoprost eye drop solution to both eyes at bed time for the treatment of Glaucoma. Per medical record review of the Interdisciplinary Care Plan, there is no identified problem related to Glaucoma or a vision deficit.

Per interview with the Unit Manager on 6/30/14 at approximately 1 PM, confirmation is made that there is no Interdisciplinary Care Plan problem identifying Glaucoma, a vision deficit or the care needs related to glaucoma and vision deficit.

{F 281} 483.20(k)(3)(i) SERVICES PROVIDED MEET SS=E PROFESSIONAL STANDARDS

The services provided or arranged by the facility must meet professional standards of quality.

This REQUIREMENT is not met as evidenced by:
Based on staff interview and medical record review for 1 of 6 sampled residents, for Resident #99, the facility failed to meet professional standards of quality. The findings include the following:

Per medical record review on 6/30/14, Resident #99 has Physician orders dated 6/1/14 through

{F 279}

{F 281} F281 483.20(k)(3)(i) Services Provided Meet Professional Standards.

1. Resident #99 had no negative effect as a result of the alleged deficient practice.
2. All residents receiving medication have the potential to be effected by the alleged deficient practice.
3. Education provided to Licensed Nursing staff regarding protocol for obtaining medication from pharmacy.
4. Daily audits to be completed by the DNS or designee to monitor the effectiveness of the plan. Remedial measures imposed as needed.

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{F 281}	<p>Continued From page 2 6/30/14, for Latanoprost Solution 0.005% eye drops to be administered at bedtime. Instill 1 drop in both eyes.</p> <p>Per review of Medication Administration Record (MAR) and nursing progress notes on 6/30/14 at approximately 11 AM, documentation identifies that Latanoprost Solution was not available for administration for five (5) days, dated 6/25/14 through 6/29/14.</p> <p>Per interview with the Director of Nursing Services (DNS) on 6/30/13 at 2:54 PM, s/he confirms that when medication is not available in the facility the nursing staff is obligated to follow the policy for reorders of medications. DNS confirms during the interview that the expectation is that once the the medication is known to be unavailable for twenty four hours, the Unit Manager (UM) should notify the pharmacy of the need. DNS confirms on 6/30/14 at 2:54 PM, that this notification to the pharmacy did not occur.</p> <p>Per interview on 6/30/14 with DNS at 2:54 PM and UM at approximately 2 PM, both confirm that there is a meeting scheduled with the pharmacy to review the problem of untimely delivery of needed medications that are not stocked in the back-up supply.</p> <p>Based on the Merck Manual of Health and Aging, (Chapter 36 pages 519 and 520) evidences that if glaucoma is left untreated, eventually the central vision can be lost resulting in total blindness.</p> <p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</p> <p>The services provided or arranged by the facility</p>	{F 281}	<p>5. 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.</p> <p>6. Corrective action will be completed by July 19, 2014.</p> <p><i>F281 POC accepted 7/17/14 JHosmer RN/PMC</i></p> <p>F282 483.20(k)(3)(ii) Services By Qualified Persons/Per Care Plan.</p> <p>1. Resident #1 had no negative effect as a result of the alleged deficient practice.</p>

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{F 282}

Continued From page 3
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 observation, staff interview and medical record review for 1 of 6 sampled residents (Resident #1), the written Care Plan was not followed pertaining to a swallowing problem of Dysphagia, which places the resident at risk of aspiration. The findings include the following:

Per medical record review on 6/30/14 at 4:30 PM, Resident #1 was admitted on 5/27/13 with diagnoses to include Cerebral Vascular Accident, Dysphagia due to Cerebrovascular Disease and Aphasia.

Per observation on 6/30/14 at 12:11 PM, a Licensed Nurse Aide (LNA) was thickening coffee and juice for Resident #1. Liquids were ordered to be served at a nectar thickened consistency. The LNA was pouring powder from a bulk container into a 4-8 ounce glass of cranberry juice. The LNA did not measure the powder that was being placed into the juice. When asked how s/he could determine that the fluid was at the nectar consistency the response was "you just know".

The Food Service Director was present during this observation on 6/30/14 at 12:11 PM and confirmed that individual packets of thickener are available for proper measurement of powder as the thickening agent. S/he also confirms that the LNA did not follow the appropriate procedure for thickening the juice to nectar consistency.

{F 282}

2. Residents requiring thickened liquids have the potential to be effected by the alleged deficient practice.
3. Staff responsible for thickening liquids will be educated regarding appropriate procedure for thickening liquids.
4. Random weekly audits to be completed by the DNS or designee to monitor the effectiveness of the plan.
5. 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.
6. Corrective Action will be completed by July 19, 2014.

Faba POC accepted 7/17/14 Jhosmer RW/PMC

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{F 282} Continued From page 4

Per medical record review for Resident #1 on 6/30/14 at approximately 4:15 PM, the Registered Dietician documentation dated 4/10/14 identifies the assessed need for mechanically altered diet, dysphagia advanced, and provide nectar thickened liquids. The mechanically altered diet was noted as related to diagnoses of depression and dysphagia (a swallow problem). For Resident #1, a physician order dated 4/21/14 requests regular diet, dysphagia advanced, texture nectar consistency; fluids are to be nectar thickened.

The Interdisciplinary Care Plan for Resident #1 identifies a problem with swallowing related to dysphagia, thickened liquids to avoid aspiration, with the approach of all staff to be informed of the resident's special dietary and safety needs.

Per interview with the Unit Manager on 6/30/14 at approximately 4:20 PM, confirmation is made that Resident #1 has swallowing difficulties and fluids are to be nectar thickened consistency.

F 313 483.25(b) TREATMENT/DEVICES TO MAINTAIN
SS=D HEARING/VISION

To ensure that residents receive proper treatment and assistive devices to maintain vision and hearing abilities, the facility must, if necessary, assist the resident in making appointments, and by arranging for transportation to and from the office of a practitioner specializing in the treatment of vision or hearing impairment or the office of a professional specializing in the provision of vision or hearing assistive devices.

This REQUIREMENT is not met as evidenced

{F 282}

F313 483.25(b) Treatment/Devices to Maintain Hearing/Vision.

F 313

1. Resident #99 had no negative effect as a result of the alleged deficient practice.
2. Residents requiring treatment/devices to maintain hearing/vision have the potential to be effected by the alleged deficient practice.
3. Education provided to Licensed Nursing staff regarding protocol for obtaining medication from pharmacy.
4. Daily audits to be completed by the DNS or designee to monitor the effectiveness of the plan. Remedial measures imposed

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F 313 Continued From page 5
by:
Based on interview and medical record review for 1 of 6 sampled residents (Resident #99), the facility failed to ensure that s/he received eye drops as prescribed by the physician for the treatment of Glaucoma. The findings include the following:

Per medical record review on 6/30/14, Resident #99 has physician orders dated 6/1/14 through 6/30/14, for Latanoprost Solution 0.005% eye drops to be administered at bedtime; instill 1 drop in both eyes.

Per review of Medication Administration Record (MAR) and nursing progress notes on 6/30/14 at approximately 11 AM, documentation identifies that Latanoprost Solution was not available for administration for five (5) days, dated 6/25/14 through 6/29/14.

Per interview with the Director of Nursing (DNS) on 6/30/14 at 2:54 PM, s/he confirms that when medication is not available in the facility the nursing staff is obligated to follow the policy for reorders of medications. DNS confirms during the interview that the expectation is that once the medication is known to be unavailable for twenty four hours, the Unit Manager (UM) should notify the pharmacy of the need. DNS confirms on 6/30/14 at 2:54 PM, that the UM did not notify the pharmacy of the need for the eye drop medication when it was known to be unavailable.

Per interview on 6/30/14 with DNS at 2:54 PM and Unit Manager at approximately 11:15 AM, both confirm that there is a meeting scheduled with the pharmacy to review the problem of untimely delivery of needed

F 313
as needed.
5. 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.
6. Corrective action will be completed by July 19, 2014.

F313 POC accepted 7/17/14 JthomerRN/pmic

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F 313	Continued From page 6 medications that are not stocked in the back-up supply.	F 313		