

Division of Licensing and Protection
103 South Main Street
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

April 16, 2015

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 **March 18, 2015**. 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

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

PRINTED: 04/02/2015
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 03/18/2015
--	--	--	---

NAME OF PROVIDER OR SUPPLIER BERLIN HEALTH & REHAB CTR	STREET ADDRESS, CITY, STATE, ZIP CODE 88 HOSPITALITY DRIVE BARRE, VT 05641
---	--

(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
--------------------	--	---------------	---	----------------------

F 000 INITIAL COMMENTS

An unannounced on site recertification survey and two complaint investigations were conducted on 03/16/15 - 03/18/15 by the Division of Licensing and Protection. The following are regulatory findings as a result.

F 156 SS=B 483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES

The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing.

The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5) (i)(A) and (B) of this section.

The facility must inform each resident before, or at the time of admission, and periodically during

F 000

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 156

F156 483.10(b)(5) - (10), 483.10(b)(1)

1. Resident #55 and resident #67 had no negative effect related to this alleged deficient practice
2. Residents eligible for Medicare benefits have the potential to be affected by this alleged deficient practice
3. Education to be provided to staff responsible for ensuring notification regarding Medicare benefits to include notification when Medicare benefits are not accessible
4. Random weekly audits will be conducted by the Executive Director or designee to monitor compliance with the plan

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

[Signature]

Administrator

4/19/15

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.

Apr 2 2015 12:34pm P004 Fax 80222472348 F156 - F463 POCs accepted 4/15/15 STEPHANIE RAINBOLD

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

PRINTED: 04/02/2015
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 03/18/2015
--	--	--	---

NAME OF PROVIDER OR SUPPLIER BERLIN HEALTH & REHAB CTR	STREET ADDRESS, CITY, STATE, ZIP CODE 98 HOSPITALITY DRIVE BARRE, VT 05641
---	--

(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
--------------------	--	---------------	---	----------------------

F 156 Continued From page 1

the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate.

The facility must furnish a written description of legal rights which includes:

A description of the manner of protecting personal funds, under paragraph (c) of this section;

A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels.

A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements.

The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care.

F 156

5. Results of the audits will be reported to the QAA committee monthly x3 months at which time the QAA committee will determine further frequency of the audits.

6. Corrective action will be completed by 4/18/15

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

PRINTED: 04/02/2015
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 03/18/2015
--	--	--	---

NAME OF PROVIDER OR SUPPLIER BERLIN HEALTH & REHAB CTR	STREET ADDRESS, CITY, STATE, ZIP CODE 98 HOSPITALITY DRIVE BARRE, VT 05641
---	--

(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
--------------------	--	---------------	---	----------------------

F 156 . Continued From page 2

F 156

The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits.

This REQUIREMENT is not met as evidenced by:

Based on financial record review and staff confirmation, the facility failed to timely inform 2 of 6 applicable residents, (Resident #55 and #67) in writing, that their Medicare benefits were not accessible. The findings include the following:

1. Per financial record review and interview with the Office Manger (OM) on 3/16/15 at approximately 8:15 AM, a Notice of Medicare Non-Coverage was provided to Resident #55 identifying that the Medicare benefit would end on 2/17/15. The letter provided to Resident #55 was not signed by the resident, their representative or any facility staff. The OM confirms there is no signature on the notice of Medicare non coverage nor is there documentation supporting that the notice was provided to Resident #55. Therefore, it is not possible to confirm that the notice was actually provided to the resident.
2. Per financial record review and interview with the Office Manger (OM) on 3/16/15 at approximately 8:30 AM, a Notice of Medicare Non-Coverage was provided to Resident #67 identifying that the Medicare benefit

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

PRINTED: 04/02/2015
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 03/18/2015
--	--	--	---

NAME OF PROVIDER OR SUPPLIER

BERLIN HEALTH & REHAB CTR

STREET ADDRESS, CITY, STATE, ZIP CODE

98 HOSPITALITY DRIVE
BARRE, VT 05641

(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
--------------------	--	---------------	---	----------------------

F 156 Continued From page 3
would end on 1/1/15. The letter provided to Resident #67 is not signed by the resident, their representative or any facility staff. The OM confirms there is no signature on the notice of Medicare non coverage nor is there documentation supporting that the notice was provided to Resident #67. Therefore, it is not possible to confirm that the notice was actually provided to the resident.

F 156

F 241 483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY
SS=D

F 241 483.15(a)

The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.

1. Resident #12 and resident # 159 had no negative effect related to this alleged deficient practice
2. Residents requiring assistance with meals and incontinent care have the potential to be affected by this alleged deficient practice
3. Education to be provided to staff regarding timely assistance with meals and incontinent care to maintain dignity and respect of individuality.
4. Random audits will be completed minimally 3x weekly by the Director of Nursing or designee to monitor effectiveness of the plan

This REQUIREMENT is not met as evidenced by:
Based on observation and confirmed by staff, the facility failed to promote care for 2 of 22 applicable residents (Resident #12 and #159), in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his/her individuality. The findings include the following:

1. During observation on 03/16/15 of the noon dining experience, Resident #159 was not assisted with the meal and/or drink in a timely manner. Resident #159 was brought near the entry way of the dining room at 12:50 PM and was calling out repeatedly for "some soup, please I'm hungry" until 1:05 PM. When the resident was brought over to the table the resident was observed reaching/waving [his/her] hands stating "where's the food". Staff stated "it's coming, just

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

PRINTED: 04/02/2015
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 03/18/2015
NAME OF PROVIDER OR SUPPLIER BERLIN HEALTH & REHAB CTR		STREET ADDRESS, CITY, STATE, ZIP CODE 98 HOSPITALITY DRIVE BARRE, VT 05641	
(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

F 241 Continued From page 4
wait a minute, we're plating your food now" but did not offer a drink at that time. Approximately 5 minutes later the food and drink was served to the resident, in which staff assisted the resident. When the nurse surveyor asked why the resident was not brought into the dining room and fed sooner the dietary staff stated that the resident sits at "the feeder table" but it was full, and needed to wait until one of the residents finished and left. Per interview on 03/17/15 at 4:26 PM the Food Service Supervisor stated that it is the protocol to offer drinks when the residents are seated and acknowledged that the resident was not provided care in full recognition of his/her individuality.

2. Per medical record review, Resident #12 was admitted on 9/24/14 and the Nursing assessment dated 1/2/15 identifies the resident to have severe cognitive impairment with difficulty making her/his needs known. Per observation on 3/16/15 at 1:45 PM through 2:17 PM, Resident #12 was in the B Wing solarium at the end of the North Hall. The resident was partially dressed in a tee-shirt with no clothing to her/his lower body. The resident's lower legs were stained with fecal material. Resident #12 was ambulating independently in the solarium with no footwear on as s/he moved from couch to chair. The bathroom had smeared feces on the floor and the toilet. A pair of black pants, smeared with feces was folded on the table in the solarium, the couch to the right of the toilet was also smeared with feces and the room had a strong odor of feces.

F 241
5. Results of the audits will be reported to the QAA committee monthly x3 months at which time the QAA committee will determine further frequency of the audits
6. Corrective action will be completed by 4/18/2015

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

PRINTED: 04/02/2015
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 03/18/2015
--	--	--	---

NAME OF PROVIDER OR SUPPLIER BERLIN HEALTH & REHAB CTR	STREET ADDRESS, CITY, STATE, ZIP CODE 98 HOSPITALITY DRIVE BARRE, VT 05641
---	--

(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
--------------------	--	---------------	---	----------------------

F 241 Continued From page 5
During this 30+ minute observation by the surveyor, a visitor (of another resident who resides on the unit), was sitting on the fecal smeared couch. At 2:16 PM, Resident #12 left the solarium independently and ambulated up the hall partially dressed. Licensed Professional Nurse (LPN) observed the resident and requested nursing staff to provide necessary care. LPN confirmed on 3/16/15 at 2:17 PM that the resident was incontinent of feces and was in need of personal care and in an environment that did not maintain or enhance the resident's dignity.

F 241

F 253 483.15(h)(2) HOUSEKEEPING & SS=E MAINTENANCE SERVICES

F 253

F253 483.15(h)(2)

The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.

1. No residents were negatively affected by this alleged deficient practice
2. Residents residing in the facility have the potential to be affected by this alleged deficient practice
3. The B wing solarium has been cleaned and disinfected to include the sofa and table
4. The broken blinds and/or window shades in rooms A1, A5, A17, B1, B10, B12, B15, B18, B19, and B20 have been replaced
5. The bathroom vents in identified resident rooms have

This REQUIREMENT is not met as evidenced by:
Based on observation and staff confirmation the facility failed to provide housekeeping and maintenance services necessary to maintain a sanitary, orderly and comfortable interior. The findings include the following:

1. Per observation on 3/17/15 at 8:50 AM, a pair of fecal smeared pants, belonging to Resident #12 was left on the table in the solarium on B Wing. The couch was also smeared with feces and foul odors were apparent on entering the room. Confirmation was made by both the Director of Housekeeping and the Licensed Practical Nurse at this time, that the fecal smeared pants belonging to Resident #12 was left on the table and the couch was still smeared

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

PRINTED: 04/02/2016
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 03/18/2015
--	--	--	---

NAME OF PROVIDER OR SUPPLIER BERLIN HEALTH & REHAB CTR	STREET ADDRESS, CITY, STATE, ZIP CODE 98 HOSPITALITY DRIVE BARRE, VT 05641
---	--

(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)	(X6) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 253 Continued From page 6
with feces from the incident that occurred on 3/16/15, all contributing to the foul odor in the room. (Refer to F241)

2. Per environmental rounds of all resident care areas on 3/17/15 in the presence of the nursing home Administrator, District Manager of Healthcare Services, Director of Maintenance and the Director of Housekeeping the following was identified/observed:

Broken blind slates and/or torn window shades in the following resident rooms:
A Wing: Rooms # 1, 5, and 17.
B Wing: Rooms # 1, 10, 12, 15, 18, 19 and 20.

Resident bathroom vents were found with caked on dust in vents in the following areas:
A Wing: Rooms #1 and 10.
B Wing: Rooms #1, 2, 3, 4, 9, 15, 17, 19, 20, 21 and 23.
C Wing: Rooms 1, 3, 4, 5, 6, 7, 10, 11, 12, 14, 15, 16, 17, 19, 21, 23 and 24.

Resident Bathroom Ceiling lights with missing globes/covers exposing bulbs in the following areas: A Wing: Room # 20. B Wing: Rooms #7 and 23.
No shade on a bedside lamp in room # B18 W.

Floor mats at resident bedside which were found torn and tattered exposing foam padding in the following rooms: B Wing Rooms #10 and 12.

Numerous dead flies visible in hallway ceiling lights (Plexiglas cover) on A and B Units.
Numerous missing bureau and bedside table handles on A and B Units making it difficult for residents to access their personal items.

F 253

6. been cleaned.
The resident bathroom ceiling lights in room A20, B7, and B23 have had covers replaced and the bedside lamp in room B18W has had the shade replaced

7. The floor mats in room B10 and B12 have been replaced and all others checked and replaced as needed

8. The hallway ceiling lights have been cleaned on A and B units

9. Furniture in identified resident's rooms have been repaired

10. Education to be provided to housekeeping and maintenance staff regarding requirements for an environment necessary to maintain a sanitary, orderly and comfortable interior

11. Random weekly audits will be done by the Executive Director or designee to monitor effectiveness of the plan

12. Results of the audits will be reported to the QAA committee monthly x3 months at which time the QAA committee will determine further frequency of the audits

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

PRINTED: 04/02/2015
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 03/18/2015
--	--	--	---

NAME OF PROVIDER OR SUPPLIER BERLIN HEALTH & REHAB CTR	STREET ADDRESS, CITY, STATE, ZIP CODE 98 HOSPITALITY DRIVE BARRE, VT 05641
---	--

(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
--------------------	--	---------------	---	----------------------

F 253 Continued From page 7
Confirmation was made by the administrative staff present during the tour that ended at 2:20 PM on 3/17/15.

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 record review and confirmed by staff interview the facility failed to meet professional standards of quality for 3 of 22 applicable residents in the Stage 2 sample, for Resident #12, #102 and #206. The findings are as follows:

1. Per medical record review, Resident #12 was admitted on 9/24/14 with diagnosis to include dementia. Nursing assessment dated 1/2/15 identifies the resident as having severe cognitive impairment with difficulty making her/his needs known. Licensed Practical Nurse (LPN) obtained a physician order dated 3/10/14, which states "Ok to obtain urine for U/A, C&S read back".

Per interview on 3/17/15 at 4:40 PM confirmation is made by the weekend Supervisor and the Unit Manager, that there is no documented evidence identifying that the urine sample was ever obtained. Supervisor also called the laboratory at 2:30 PM and confirmed that the lab has not received any urine sample for Resident #12.

2. Per medical record review, Resident #206 had a MD order dated 03/11/2015, to apply a dressing

F 253 13. Corrective action will be completed by 4/18/15

F 281 F281 483.20(k)(3)(i)

1. Residents #12, 102, and 206 had no negative affects related to this alleged deficient practice
2. Residents receiving physician orders for labs, dressings, dialysis, and weights have the potential to be affected by this alleged deficient practice
3. Education provided to nursing staff regarding the requirement of following physician orders
4. Random audits will be conducted minimally 3x weekly by the Director of Nursing or designee to monitor effectiveness of the plan
5. The results of the audits will be reported to the QAA committee monthly x3 months at which time the QAA committee will determine further frequency of the audits

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 03/18/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER BERLIN HEALTH & REHAB CTR	STREET ADDRESS, CITY, STATE, ZIP CODE 98 HOSPITALITY DRIVE BARRE, VT 05641
--	--

(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
--------------------	--	---------------	---	----------------------

F 281	Continued From page 8 (ABD pad) to cushion an unstageable ulcer on the mid spine. This dressing was discontinued on 03/12/2015 and was to have been replaced with a tegafoam, to be changed every other day. This order was not discovered until 03/17/2015 when it was confirmed by the unit manager during interview on 03/17/2015 that this order was not seen and Resident #206 had no cushioning agent applied to his/her back between 3/12/2015 and 3/17/2015. 3. Per record review, Resident #102 has a diagnosis of End Stage Renal Disease, which requires Hemodialysis three times per week at a local facility. There is a communication book that is to be sent back and forth from the Dialysis center to the nursing facility, reporting any information that was clinically significant to the resident. Part of the information that was to be documented in the book was how much fluid was removed during the procedure, and what the resident's weight was after the procedure, typically called a "dry weight". Per review of the physician's orders, dated 12/13/14 stated "Nursing measure: Please ensure resident has dialysis book with her on dialysis days", and an order dated 10/31/14 to "Please ensure dialysis book returns to nurse's station after dialysis and read the notes from dialysis. If book does not return, please call dialysis and write note about how dialysis went. Every evening shift Mon, Wed, and Fri.". The physician order of 01/19/15 presents "Document weights after dialysis using dialysis dry weight, every evening shift on Monday, Wednesday, and Friday." Per review of the dialysis book entries, in October 2014, there was missing pages or missing information including weights on 10/17, 10/20, 10/22, and 10/27. In November 2014, the following dates had	F 281	6. Corrective action will be complete by 4/18/15	
-------	---	-------	--	--

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

PRINTED: 04/02/2015
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 03/18/2015
NAME OF PROVIDER OR SUPPLIER BERLIN HEALTH & REHAB CTR		STREET ADDRESS, CITY, STATE, ZIP CODE 98 HOSPITALITY DRIVE BARRE, VT 05641	

(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
F 281	Continued From page 9 no page or was missing the required post weight information: 11/10, 11/17, 11/21, and 11/25. In December 2014, there was missing data on 12/01, 12/05, 12/08, 12/10, 12/12, 12/22, 12/24, and the week starting 12/28/14. In January 2015, there was missing data for 01/02, 01/09, 01/12, 01/23, 01/26, and 01/28/15. In February 2015, the following dates had no or incomplete information: 2nd, 16th, and 18th. In March 2015, there was incomplete documentation on 4th, 6th, 13th, and 15th. Per interview on 03/17/15 at 4:30 PM, the Unit Manager stated that this was being missed by the nursing staff due to the omission of entering into the system a supplemental order, that would have cued the evening nursing staff to review the book, and follow up with the dialysis center if no information came back with the resident. S/he confirmed that the physician's order was not being followed to record the post-dialysis weights, and that there were many missing entries. REFERENCE: Lippincott Manual of Nursing Practice (9th Edition) Wolters Kluwer Health/Lippincott Williams and Wilkins.	F 281		
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 observation, staff interview and record review, the facility failed to provide services in	F 282	F282 483.20(k)(3)(ii) 1. Residents #129 and 102 had no negative affect as a result of this alleged deficient practice 2. Residents requiring assistance with transfers and requiring weights have the potential to be affected by this alleged deficient practice	

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

PRINTED: 04/02/2015
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 03/18/2015
--	--	--	---

NAME OF PROVIDER OR SUPPLIER

BERLIN HEALTH & REHAB CTR

STREET ADDRESS, CITY, STATE, ZIP CODE

98 HOSPITALITY DRIVE
BARRE, VT 05641

(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
--------------------	--	---------------	---	----------------------

F 282 Continued From page 10
accordance with the plan of care for 2 of 22 residents in the Stage 2 sample (Resident #129 and #102). Findings include:

1. Per record review and confirmed through interviews, staff failed to follow the care plan for transfer assistance for Resident # 129. Per interview on 03/16/15 at 3:42 PM Resident #129 stated that a LNA was "rough with me and pushed me [down] in the wheelchair. Per review of the written statement by the LNA regarding the 03/01/15 incident presents with "I had [him/her] stand using the bed rail, [s/he] told me [s/he] hadn't done it like that before I let [him/her] know that [s/he] had and that [s/he] would be okay and would not let [him/her] fall...I cleaned [him/her] up while [s/he] was standing." In addition, the LNA also noted that the resident was having back spasm and was in a lot of pain approximately 2 hours previous and was medicated by the nurse. Per review of the care plan known as the ADL Profile, initiated by the physical therapist (PT) on 01/29/15, demonstrates that the resident needs moderate assist with 2 staff using a gait belt for transfers. Per interview on 03/18/15 at 1:38 PM the Unit Manager confirmed that transfer was not done according to the plan of care.

2. Per record review, Resident #102 was receiving dialysis for End Stage Renal Disease. As part of the plan of care interventions, it stated "Weights as ordered. Monitor." Per review of the physician's orders, dated 01/19/15 directing staff to document weights after dialysis. Per review there were several missing entries of weights in the record since 01/19/15. There were missing entries on 01/23, 01/26, 01/28, 02/02, 02/16, 02/18, 03/04, 03/06, 03/13, and 03/16/15. Per interview on 03/17/15 at 4:30 PM, the Unit

F 282

3. Education to be provided to nursing staff regarding the requirement to follow a resident's plan of care
4. Random weekly audits will be done by the Director of Nursing or designee to monitor the effectiveness of the plan
5. Results of the audits will be reported to the QAA committee monthly x3 months at which time the QAA committee will determine further frequency of the audits
6. Corrective action will be completed by 4/18/15

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

PRINTED: 04/02/2015
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 03/18/2015
--	--	--	---

NAME OF PROVIDER OR SUPPLIER BERLIN HEALTH & REHAB CTR	STREET ADDRESS, CITY, STATE, ZIP CODE 98 HOSPITALITY DRIVE BARRE, VT 05641
---	--

(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
--------------------	--	---------------	---	----------------------

F 282 Continued From page 11
Manager confirmed that nursing staff were not implementing the plan of care for "weights as ordered" for Resident #102. (See also F281)

F 282

F 309 483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING
SS=D

F 309 F309 483.25

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.

1. Resident #102 had no negative affect related to this alleged deficient practice
2. Residents receiving dialysis have the potential to be affected by this alleged deficient practice
3. Education provided to nursing staff regarding the requirements for communication between this facility and dialysis facility to ensure the resident receives necessary services in accordance with the comprehensive assessment and plan of care
4. Random weekly audits will be conducted by the Director of Nursing or the designee to monitor effectiveness of the plan

This REQUIREMENT is not met as evidenced by:
Based on record review and staff interview, the facility failed to ensure that each resident received the necessary care and services to attain or maintain the highest practicable physical well-being, in accordance with the comprehensive assessment and plan of care regarding Dialysis for 1 of 22 residents sampled (Resident #102). Findings include:

Per record review on 03/17/15, Resident #102 has a diagnosis of End Stage Renal Disease, which requires Hemodialysis three times per week at a local facility. There is a communication book that is to be sent back and forth from the Dialysis center to the nursing facility, reporting any information that was clinically significant to the resident. Part of the information that was to be documented in the book was how much fluid was removed during the procedure, and what the resident's weight was after the procedure, typically called a "dry weight". Per review of the

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

PRINTED: 04/02/2015
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 03/18/2015
--	--	--	---

NAME OF PROVIDER OR SUPPLIER BERLIN HEALTH & REHAB CTR	STREET ADDRESS, CITY, STATE, ZIP CODE 98 HOSPITALITY DRIVE BARRE, VT 05641
---	--

(X4) IO 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
--------------------	--	---------------	---	----------------------

F 309	Continued From page 12 physician's orders, it stated on 01/19/15 "Document weights after dialysis using dialysis dry weight, every evening shift on Monday, Wednesday, and Friday." Also the physician orders dated 12/13/14 stated to "Nursing measure: Please ensure resident has dialysis book with her on dialysis days", and order dated 10/31/14 to "Please ensure dialysis book returns to nurse's station after dialysis and read the notes from dialysis. If book does not return, please call dialysis and write note about how dialysis went. Every evening shift Mon, Wed, and Fri." Per review of the dialysis book entries, there were many missing days filled out in the book, and many missing "dry weights". In October 2014, there was missing pages or missing information including weights on 10/17, 10/20, 10/22, and 10/27. In November 2014, the following dates had no page or was missing the required post weight information: 11/10, 11/17, 11/21, and 11/25. In December 2014, there was missing data on 12/01, 12/05, 12/08, 12/10, 12/12, 12/22, 12/24, and the week starting 12/28/14. In January 2015, there was missing data for 01/02, 01/09, 01/12, 01/23, 01/26, and 01/28/15. In February 2015, the following dates had no or incomplete information: 02/02, 02/16, and 02/18. In March 2015, there was incomplete documentation on 03/04, 03/06, 03/13, and 03/16/15. Per interview on 03/17/15 at 4:30 PM, the Unit Manager confirmed that the physician's order from 01/19/15 was not being followed for this resident to record the post-dialysis weights, and that there were many missing entries. The Unit Manager stated that this was being missed by the nursing staff due to the omission of entering into the system a supplemental order, that would have cued the evening nursing staff to review the book, and follow up with the dialysis center if no information	F 309	5. The results of the audits will be reported to the QAA committee monthly x3 months at which time the QAA committee will determine further frequency of the audits 6. Corrective action will be completed by 4/18/15	
-------	--	-------	--	--

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

PRINTED: 04/02/2015
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 03/18/2015
--	--	--	---

NAME OF PROVIDER OR SUPPLIER BERLIN HEALTH & REHAB CTR	STREET ADDRESS, CITY, STATE, ZIP CODE 98 HOSPITALITY DRIVE BARRE, VT 05641
---	--

(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)	(X6) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 309 Continued From page 13
came back with the resident.

F 309

F 334 483.25(n) INFLUENZA AND PNEUMOCOCCAL IMMUNIZATIONS
SS=D

F 334 F334 483.25

The facility must develop policies and procedures that ensure that –

- (i) Before offering the influenza immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization;
- (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period;
- (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and
- (iv) The resident's medical record includes documentation that indicates, at a minimum, the following:
 - (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of influenza immunization; and
 - (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal.

1. Residents #124 and 84 had no negative affect related to this alleged deficient practice
2. Residents residing in the facility have the potential to be affected by this alleged deficient practice
3. Education will be provided to nursing staff regarding policies for Flu and Pneumococcal immunization
4. An initial audit was conducted for all current residents and vaccines offered as needed and declinations signed as appropriate
5. Random audits will be conducted by the Director of Nursing or designee for new admissions and as needed to ensure flu and pneumococcal vaccine policies are followed to monitor effectiveness of the plan

The facility must develop policies and procedures that ensure that –

- (i) Before offering the pneumococcal immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization;

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

PRINTED: 04/02/2015
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 03/18/2015
--	--	--	---

NAME OF PROVIDER OR SUPPLIER BERLIN HEALTH & REHAB CTR	STREET ADDRESS, CITY, STATE, ZIP CODE 98 HOSPITALITY DRIVE BARRE, VT 05641
---	--

(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
--------------------	--	---------------	---	----------------------

F 334 Continued From page 14

- (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized;
- (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and
- (iv) The resident's medical record includes documentation that indicated, at a minimum, the following:
 - (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and
 - (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal.
- (v) As an alternative, based on an assessment and practitioner recommendation, a second pneumococcal immunization may be given after 5 years following the first pneumococcal immunization, unless medically contraindicated or the resident or the resident's legal representative refuses the second immunization.

This REQUIREMENT is not met as evidenced by:
Based on staff interview and record review, the facility failed to ensure 2 of 5 applicable residents (Residents #124, 84) received influenza immunization. Findings include:

1. Per record review on 3/18/15 at 8:55 AM there is no evidence in the clinical record of Resident #124 that an influenza vaccine was administered.

F 334

- 6. The results of the audits will be reported to the QAA committee monthly x3 months at which time the QAA committee will determine further frequency of the audits
- 7. Corrective action will be completed by 4/18/15

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

PRINTED: 04/02/2015
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 03/18/2015
--	--	--	---

NAME OF PROVIDER OR SUPPLIER BERLIN HEALTH & REHAB CTR	STREET ADDRESS, CITY, STATE, ZIP CODE 98 HOSPITALITY DRIVE BARRE, VT 05641
---	--

(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
--------------------	--	---------------	---	----------------------

F 334 Continued From page 15
The resident signed an informed consent for the vaccination in October 2014. Per interview with the Unit Manager (UM) on 3/18/15 at 9:00 AM, the UM confirmed that there is no evidence in the clinical record that resident # 124 received an influenza vaccination. Additionally, on 3/18/15 at 9:59 AM the Director of Nursing Services (DNS) confirmed that there is no evidence that the resident received the influenza vaccine.

2. Per record review on 3/18/15 at 8:55 AM, the clinical record for resident # 84 contained an undated, unsigned informed consent form indicating refusal of the influenza vaccination. Per interview with the DNS on 3/18/15 at 9:59 AM, the DNS confirmed that there is no evidence in the clinical record that resident # 84 had received the influenza vaccination and that staff did not follow-up to ensure resident # 84 had received the influenza vaccination.

F 334

F 353 483.30(a) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS
SS=E
The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care.

The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans:

Except when waived under paragraph (c) of this section, licensed nurses and other nursing

F 353

- F353 483.30(a)
1. No residents had a negative affect related to this alleged deficient practice
 2. Residents residing on C wing have the potential to be affected by this alleged deficient practice
 3. Education to be provided to staff regarding general customer service and timely response to resident needs

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

PRINTED: 04/02/2015
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 03/18/2015
--	--	--	---

NAME OF PROVIDER OR SUPPLIER BERLIN HEALTH & REHAB CTR	STREET ADDRESS, CITY, STATE, ZIP CODE 98 HOSPITALITY DRIVE BARRE, VT 05641
---	--

(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
--------------------	--	---------------	---	----------------------

F 353 Continued From page 16
personnel.

Except when waived under paragraph (c) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty.

This REQUIREMENT is not met as evidenced by:
Based on resident observation, resident interviews and review of staffing, as well as the facility call light response record, between 3/16-18/2015, the facility failed to provide sufficient staff to meet the needs of the residents on 1 of 3 nursing units. The specifics are as follows:

Per resident interviews on 3/16/2015 and 3/17/2015, Residents # 197 and # 52 report that staff do not respond to lights in a timely manner, and even when they do respond quickly, staff are often called away by other staff to assist other residents. Residents report that staff answer lights and reset them but tell the residents they will be back and then don't return. One LNA is overheard in the afternoon of 03/17/2015 respond to a call light and tell the resident "you will have to wait, I have 2 others before you." Resident #197 reports during interview during Stage one of the survey on 03/16/2015 that s/he may not have to use the bathroom when the call light is first put on, but has learned to call in anticipation of the need so there will be no accidents while waiting for the call light to be answered. Residents further reported that meals delivered by nursing staff, are not delivered at consistent times, often greater than half hour or more than scheduled.

- F 353
4. Pagers for the unit have been replaced to ensure all nursing staff assigned to the unit are aware of resident needs
 5. Random audits will be conducted minimally 3x weekly by the Director of Nursing or designee to monitor effectiveness of the plan
 6. Results of the audits will be reported to the QAA committee monthly x3 months at which time the QAA committee will determine further frequency of the audits
 7. Corrective action to be completed by 4/18/15

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

PRINTED: 04/02/2015
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 03/18/2015
--	--	--	---

NAME OF PROVIDER OR SUPPLIER BERLIN HEALTH & REHAB CTR	STREET ADDRESS, CITY, STATE, ZIP CODE 98 HOSPITALITY DRIVE BARRE, VT 05641
---	--

(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
--------------------	--	---------------	---	----------------------

F 353 Continued From page 17

Per resident interview on 03/17/2015 at 8:57 am, Resident # 211 reports that s/he has not had mouth care since admission on 03/06/2015. Staff would not confirm this, but per observation by the surveyor, the tooth brush and paste for Resident # 211 is in the night stand and no tooth paste is missing, the tooth brush does not appear to have been used and the resident's mouth is not clean.

Per review of the facility call light alert system for Unit C, for the most recent 1 week period, (3/08-3/16/2015) time frames varied from 15 to 48 min. (03/15/2015 1:53 pm--"announced 11 times 31 minutes to respond). On 3/15/2015 a call light was initiated at 8:37 am, announced 16 times and responded to in 46 minutes. On 03/18/2015 call response time for C-15 was 61 minutes. C 15 W has a frayed call button and there are times when the call button was pushed with very long response times.

Per observation on 03/18/15 at 9:15 AM nursing staff were beginning to deliver meal trays to residents on the C wing, although the meal cart was delivered prior to 9:00 AM. Some residents did not receive breakfast until 9:30 AM.

The Unit Manager confirmed the above findings during interview on 03/17/2015 that the needs of the residents were not met in a timely manner.

F 364 483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, SS=B PALATABLE/PREFER TEMP

Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature.

F 353

F 364 F364 483.35(d)(1)-(2)

1. No residents were negatively affected by this alleged deficient practice

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

PRINTED: 04/02/2015
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 03/18/2015
--	--	--	---

NAME OF PROVIDER OR SUPPLIER BERLIN HEALTH & REHAB CTR	STREET ADDRESS, CITY, STATE, ZIP CODE 98 HOSPITALITY DRIVE BARRE, VT 05641
---	--

(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
--------------------	--	---------------	---	----------------------

F 364	Continued From page 18 This REQUIREMENT is not met as evidenced by: Based on observation and resident interviews during the survey between 03/16/2015 and 03/18/2015, the facility failed to serve food at the proper temperature on 1 of 3 nursing units. The specifics are as follows: Per resident interviews on 3/16-3/17/2015, Resident # 52 reported on 03/17/2015 at 10:33 am that hot food arrives in her/his room cold. Resident # 197 also reported during interview on 03/16/2015 at 11:49 am that hot food is often only luke warm when it arrives in resident rooms. Residents describe french toast as being so rubbery that the toast cannot be cut after they have been rewarmed, specifically on the morning of 3/17/2015. Per observation on the morning of 03/18/15, residents are heard to indicate that the "oatmeal is cold," in which breakfast was still being served between 9:30 and 10:00 am. Staff confirm that Unit C receives their food cart after the other 2 units, that breakfast trays are brought to Unit C by 8:45 am by the dietary staff and is expected to be distributed to the residents by the nursing staff. Dietary staff report that the food for Unit C is plated in the kitchen for breakfast at 8:15 am. Staff further confirm and agree with residents that there is a small dining area at the end of the hallway for residents to share their meals. But only 1 of 28 residents avail themselves of this on Unit C and prefer to eat in their rooms. See also F353, sufficient nursing staff to meet resident needs.	F 364	2. Residents residing in the facility on C wing have the potential to be affected by this alleged deficient practice 3. The meal service times and delivery method for C wing has been reviewed and revised to meet the needs and requests of the residents residing there. 4. Education to be provided to staff regarding timely service of meals and ensuring proper temperatures 5. Random audits/interviews will be conducted weekly by the Food Service Director or designee to monitor the effectiveness of the plan 6. Results of the audits/interviews will be reported to the QAA committee monthly x3 months at which time the QAA committee will determine further frequency of the audits 7. Corrective action will be completed by 4/18/15	
-------	---	-------	--	--

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

PRINTED: 04/02/2015
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 03/18/2015
--	--	--	---

NAME OF PROVIDER OR SUPPLIER BERLIN HEALTH & REHAB CTR	STREET ADDRESS, CITY, STATE, ZIP CODE 98 HOSPITALITY DRIVE BARRE, VT 05641
---	--

(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
--------------------	--	---------------	---	----------------------

F 441 SS=D	<p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS</p> <p>The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p>	F 441	<p>F441 483.65</p> <ol style="list-style-type: none"> No residents were negatively affected by this alleged deficient practice Residents residing in the facility have the potential to be affected by the alleged deficient practice The sharps container in room A16 was immediately replaced and all other rooms were audited. Education to be provided to nursing staff regarding proper disposable of sharps Education to be provided to staff regarding requirement for timely assistance with incontinence episodes Random weekly audits will be conducted by the Director of Nursing or designee to monitor effectiveness of the plan 	
---------------	---	-------	---	--

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

PRINTED: 04/02/2015
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 03/18/2015
--	--	--	---

NAME OF PROVIDER OR SUPPLIER BERLIN HEALTH & REHAB CTR	STREET ADDRESS, CITY, STATE, ZIP CODE 98 HOSPITALITY DRIVE BARRE, VT 05641
---	--

(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
--------------------	--	---------------	---	----------------------

F 441 Continued From page 20
This REQUIREMENT is not met as evidenced by:
Based on observation and staff interview, the facility failed to ensure medical waste was properly stored and that a safe, sanitary and comfortable environment is maintained to prevent the development and transmission of disease and infection for 2 of 22 applicable residents. Findings include:

- Per observation on 3/16/14 at 2:42 PM, an approximately 3 inch segment of plastic tubing containing a red substance was protruding from a wall-mounted sharps container in the bathroom of room 16 on "A" Unit. The room is occupied by two ambulatory residents. The observation was confirmed by the Regional Director of Quality Improvement on 3/16/15 at 2:47 PM.
- Per observation on 3/17/15 at 8:50 AM, a pair of fecal smeared pants, belonging to Resident #12 were left on the table in the solarium on B Wing. The couch was also smeared with feces and foul odors were apparent on entering the room. Confirmation was made by both the Director of Housekeeping and the Licensed Practical Nurse at this time, that the fecal smeared pants belonging to Resident #12 were left on the table and the couch was still smeared with feces from an incident that occurred the previous day, on 3/16/15. (Refer also to F241)

F 441 7. Results of the audits will be reported to the QAA committee monthly x3 months at which time the QAA committee will determine further frequency of the audits
8. Corrective action will be complete by 4/18/15

F 463 483.70(f) RESIDENT CALL SYSTEM - SS=E ROOMS/TOILET/BATH
The nurses' station must be equipped to receive resident calls through a communication system from resident rooms; and toilet and bathing

F 463 F463 483.70(f)
1. No residents were negatively affected by this alleged deficient practice

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

PRINTED: 04/02/2015
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 03/18/2015
--	--	--	---

NAME OF PROVIDER OR SUPPLIER BERLIN HEALTH & REHAB CTR	STREET ADDRESS, CITY, STATE, ZIP CODE 98 HOSPITALITY DRIVE BARRE, VT 05641
---	--

(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
F 463	<p>Continued From page 21 facilities.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and staff interviews, the facility failed to ensure that call lights were available and functioning for 2 of 28 residents on 1 of 3 nursing units. (# 52 and # 54). The specifics are as follows:</p> <p>1. Per observation of Resident # 54 on 03/16/2015 at approximately 2:00 pm in his/ her room, the resident had been trying to call the nurse to assist in changing garments after having spilled liquid on his/her clothes. The surveyor tried pushing the call light and observed that the end of the light was frayed at the junction of the cord and the button. What appeared to be a band-aid was applied at the site of the frayed cord. The surveyor also attempted to call the nurse by activating the bathroom call light. No one responded. The DNS (Director of Nursing) was walking by the room at 2:18 pm and asked if help was needed. When shown the cord it was taken out of the wall and replaced with the one for the other bed. (There is only 1 resident in this room)</p> <p>2. Per resident interview on the morning of 03/17/2015 at 10:05 am, Resident # 52 reported that his/her call light had not been working and the staff had replaced it with the call light from the area by the door. (Resident # 52 is also alone in his/her room.)</p> <p>3. Per interview on 03/16/14 at 3:00 PM the LNA stated "we have only one working beeper right now for us to share. I don't know why we can't</p>	F 463	<ol style="list-style-type: none"> 2. Residents residing on C wing in the facility have the potential to be affected by this alleged deficient practice 3. All call light cords on C wing were checked and replaced as necessary 4. The call light system was noted to be functioning properly 5. New pagers were ordered and nursing staff assigned to C wing have a functional pager 6. Education provided to staff regarding the requirement to meet resident needs timely and process reviewed for the call light system 7. Random audits/interviews will be conducted by the Director of Nursing and Maintenance Director or designees to monitor effectiveness of the plan 8. Results of the audits will be reported to the QAA committee monthly X3 months at which time the QAA committee will determine further frequency of the audits 9. Corrective action will be completed by 4/18/15 	

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

PRINTED: 04/02/2015
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 03/18/2015
--	--	--	---

NAME OF PROVIDER OR SUPPLIER BERLIN HEALTH & REHAB CTR	STREET ADDRESS, CITY, STATE, ZIP CODE 99 HOSPITALITY DRIVE BARRE, VT 05641
---	--

(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
--------------------	--	---------------	---	----------------------

F 463 Continued From page 22
use the nurses beepers but we can't". Per interview on 03/17/15 at 9:30 AM two LNAs acknowledged that the batteries are not always working on their beepers. On Unit C, the beepers carried by the LNAs are linked to the overhead stream of alerts from the resident rooms. The resident call lights are directly linked to the LNA beepers and if they are not working the resident would not be able to notify the LNAs. After 3 notifications of the beepers, the nurses' beepers are activated. This is conjunction with the notification that is evident on the wall near the nurses' station. The call light record provided by the facility indicates that as long as 60 minutes elapsed before call lights were answered.

F 463