

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

November 24, 2015

Mr. Casey Keefe, Administrator
Berlin Health & Rehab Ctr
98 Hospitality Drive
Barre, VT 05641-5360

Dear Mr. Keefe:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **October 21, 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

NOV 17 2015

PRINTED: 11/03/2015
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 10/21/2015
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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
F 000	INITIAL COMMENTS	F 000		
F 225 SS=D	<p>483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS</p> <p>The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.</p> <p>The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.</p> <p>The results of all investigations must be reported to the administrator or his designated</p>	F 225	<p>F225 483.13(c)(1)(ii)-(iii), (c)(2) - (4)</p> <ol style="list-style-type: none"> 1. Resident #1 had no negative effect as a result of the alleged deficient practice 2. Residents residing in the facility have the potential to be affected by the alleged deficient practice. 3. Education to be provided to staff regarding requirements for reporting allegations of abuse and the process to report. 4. Random weekly interviews will be conducted for staff and residents by the Executive Director or designee to monitor effectiveness of the plan. 	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *[Signature]* TITLE *Executive Director* (X6) DATE *11/9/15*

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.

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F 323	Continued From page 2 This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to sufficiently supervise Resident #1 [who was known to have behaviors such as to wander, intrude and grasp others by the wrist] and failed to prevent unwanted interaction with three of five residents reviewed (Residents #2 #3 & #5) . Findings include: 1. Review of an incident reported by the facility and the medical records, revealed that on 7/19/15, Resident #1 wandered into the room of Resident #2, initially reclined on the bed, then rummaged on the bureau of Resident #2. Staff witnessed that Resident #1 grasped the wrist of Resident #2. Record review also established that both residents have dementia with behaviors, and that they resided on Unit B. Care plans reflected this interaction on 7/19/15 and staff had access to the information through their care plan acknowledgement system. Subsequently on 7/27/15, per an incident reported and investigated by the facility, Resident #1 wandered to the doorway of the room of Resident #2, and Resident #2 grasped Resident #1 by both wrists. The care plan and medical record of Resident #1, as confirmed by the Director of Nursing 10/21/15 at approximately 9:30 AM, directed staff to supervise Resident #1 and redirect him/her from others. Regarding Resident #1, there was an established pattern of wandering, intruding, and grasping behaviors which might precipitate a negative response from	F 323	<ol style="list-style-type: none"> Resident #1 has been placed on 1:1 supervision while awake. Residents that require an increased level of supervision have the potential to be affected by the alleged deficient practice. Education will be provided to staff regarding adequate supervision to prevent unwanted behaviors. Random observations will be conducted weekly by the DNS or designee to monitor effectiveness of the plan Results of the observations will be reported by the DNS monthly x3 months to the QAA committee at which time the QAA committee will determine further frequency of the observations. Corrective action will be completed by 11/21/15 <p>F323 POC accepted 11/24/15 Semmons RN/PML</p>	

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F 323	<p>Continued From page 3</p> <p>others, particularly Resident #2, going back to 7/19/15. A physician's progress note on 8/31/15 suggested that Resident #2 be moved to another unit in order to reduce resident to resident altercations. Record review, confirmed by interview of the A Unit Manager on 10/20/15 at approximately 9:30 AM, showed that Resident #2 was moved to a room on Unit A subsequent to family agreement.</p> <p>2. Per review of a self report resident to resident incident dated 08/17/15, Resident #1 wandered into Resident #3' room and proceeded to nap in the empty bed by the door, causing distress for Resident #3 and a subsequent altercation. The report states that a staff member was walking down the hall of B wing and heard Resident #1 yelling for help. The resident had gone into the resident room where Resident #3 resides in the window bed. Resident #3 got up and grabbed the hair of Resident #1 and began slapping the resident. The staff member was able to get the hands out of the hair and deflect further slapping and escorted Resident #1 from the room to the nurse working at the nearest medication cart.</p> <p>Resident #1, has a pattern of wandering and known behaviors for at least the previous month. According to the LNAs assignment sheet, Resident #1 is to have 'distant supervision in room and halls, assist to bed when looking tired'. Resident #3's medical record shows that the resident can become agitated when having an UTI (urinary tract infection). The resident, on the previous of day of this incident, was noted as having an UTI and on antibiotics. Per interview on 10/20/15 at 10:30 PM the Unit Manger stated that since that incident, there has been a 'stop' sign on Resident #3's door way to prevent further</p>	F 323		

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F 323	<p>Continued From page 4 intrusions or interactions with Resident #1.</p> <p>3. Per review of an incident reported by the facility and medical records, on 9/16/15 Resident #2 came over to Unit B from his/her new room location on Unit A to visit a friend. Resident #1 wandered into the room of this friend and Resident #2 grabbed the wrist of Resident #1, pulled him/her and then pushed him/her toward the door. The care plan and medical record of Resident #1, as confirmed by the Director of Nursing 10/21/15 at approximately 9:30 AM, directed staff to supervise Resident #1 and redirect him/her from others. There was an established pattern of wandering, intruding, and grasping behaviors by Resident #1 which might precipitate a negative response from others, particularly Resident #2, going back to 7/19/15. The care plan for Resident #2, and confirmed by surveyor observation and Unit A Manager interview 10/20/15 at 9:30 AM, indicated that a velcro stop sign had been placed across the door of Resident #2 on the A unit in order to prevent Resident #1 from intruding. It was further confirmed by the B Unit manager on 10/21/15 at 9:30 AM that staff were aware of the risk of negative response between Resident #1 and Resident #2.</p> <p>4. Per review of an incident reported by the facility and medical records, on 9/16/15 during a fire drill exercise, an unlicensed staff member ushered Resident #1 into the single room of Resident #5 and closed the door. Though securing residents in rooms is an established emergency drill procedure, Resident #5 has a care plan which acknowledges that s/he does not mix well with others and exhibits aggressive behaviors. Resident #1 had an established history and care</p>	F 323		

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F 323	Continued From page 5 plan regarding wandering, intruding, and grasping at others. While in the room together, Resident #1 grabbed the wrist of Resident #5 and Resident #5 slapped Resident #1. Per training records and care plan review system, as confirmed by the Director of Nursing on 10/21/15 at approximately 9:30 AM, this staff person and others had access to the care plan information and were expected to review it. The care plans outlined risk of aggressive behaviors for both Resident #1 and Resident #5.	F 323		
F 353 SS=E	Also see F-353 and F-9999 483.30(a) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS 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 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.	F 353	F353 483.30(a) 1. No residents had a negative outcome as a result of the alleged deficient practice. 2. Residents residing in the facility have the potential to be affected by the alleged deficient practice. 3. The facility Executive Director, Director of Nursing, and Staffing Coordinator have reviewed the regulatory requirements for sufficient staff and are aware of what those requirements are. 4. Audits will be completed 3x weekly by the DNS or designee x3 months to	

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F 353	<p>Continued From page 6</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interviews, the facility failed to assure sufficient staff to provide nursing and supervision to maintain the highest practicable well-being of each resident according to residents' assessments and individual plans of care, to meet the needs of the residents who would be able to use the dining room. Findings include:</p> <p>1. Per an anonymous complainant, a concern was brought forth to the Division of Licensing and Protection regarding the lack of adequate staffing. The concern stated that on at least one unit, residents were not being groomed, fed or supervised due to lack of staffing. Per review of the actual staffing pattern and the hours of direct care per resident per day, known as PPD (State regulatory requirements is 2.0 PPD of LNA [Licensed Nursing Assistant] care), shows an average for August as 1.55 PPD hours of LNA care and September 2015 as 1.63 PPD hours.</p> <p>A statement written by a staff person stated that the dining room was not used due to lack of adequate staffing. On the evening of 08/23/15 the dining room was closed to residents and the PPD for that day 1.31 hours. Review of the LNA assignment sheet for Unit B, which notes the resident's preferences for meals, demonstrates that 20 out of the 37 residents eat their meals in the dining room. Four residents are encouraged to eat in the dining room but may eat in their room if they wish and all others eat in their rooms or on the unit.</p> <p>Per interview on 10/20/15 at 1:20 PM, the DNS</p>	F 353	<p>monitor effectiveness of the plan.</p> <p>5. Results of the audits will be reported monthly to the QAA committee by the DNS x3 months at which time the QAA committee will determine further frequency of the audits.</p> <p>6. Corrective action will be completed by 11/21/15</p> <p><i>F353 POC accepted 11/24/15 Semmon R/W/PML</i></p>	

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F 353	Continued From page 7 acknowledged the dining experience is important to residents for interaction and socialization. The DNS stated "I found out at morning meeting about the dining room being closed as staff felt they were short staffed to feed everyone in the dining room. I told them that they are not allowed to do that". The DNS confirmed the dining needs of the residents were not met and staffing pattern did not met the basic requirement for standard LNA care such as assistance with ambulation or feeding.	F 353		
F9999	Also see F-323 and F-9999 FINAL OBSERVATIONS Per Vermont Licensing and Operating Rules for Nursing Homes regulation 7.13(d)(1)(i): (d) Staffing Levels. The facility shall maintain staffing levels adequate to met resident needs. (1) At a minimum, nursing facilities must provide: (i) no fewer than 3 hours of direct care per resident per day, on a weekly average, including nursing care, personal care and restorative nursing care, but not including administration or supervision of staff; and of the three hours of direct care, no fewer than 2 hours per resident per day (PPD) must be assigned to provide standard LNA care (such as personal care, assistance with ambulation, feeding, etc.) performed by LNAs or equivalent staff and not including meal preparation, physical therapy or the activities program. This REQUIREMENT is NOT MET as evidenced	F9999	F9999 1. No residents had a negative outcome as a result of the alleged deficient practice. 2. Residents residing in the facility have the potential to be affected by the alleged deficient practice. 3. The facility Executive Director, Director of Nursing, and Staffing Coordinator have reviewed the regulatory requirements for sufficient staff and are aware of what those requirements are.	

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F9999	<p>Continued From page 8</p> <p>by:</p> <p>Based on record review and staff interview, the facility failed to assure that no fewer than 2 hours per resident per day are assigned to provide standard LNA (Licensed Nursing Assistant) care. Findings include:</p> <p>A review of the hours of direct care per resident per day (state regulatory requirements) was conducted for August and September 2015. The month of August 1st through the 31st does reveal that there were 16 days (Aug 1, 2, 9, 15, 16, 17, 19, 20, 22, 23, 24, 27, 29, 30, and 31) with fewer than the required number of LNA hours per day per resident and the average for the month was noted as 1.55 LNA hours per resident per day.</p> <p>In the month of September there were 11 days with fewer than 2 hours per day of assigned LNA direct care per resident (Sept. 1, 3, 5, 6, 7, 12, 16, 19, 20, 26 & 27). The average for the month of September was noted to be 1.63 LNA hours per resident per day.</p> <p>In an interview on 10/20/15 at 2:45 PM the DNS confirmed that the provided documentation reflected assigned direct care by LNAs as reflected above which did not meet the 2 hours per resident per day to provide standard LNA care.</p>	F9999	<p>4. Audits will be completed 3x weekly by the DNS or designee x3 months to monitor effectiveness of the plan.</p> <p>5. Results of the audits will be reported monthly to the QAA committee by the DNS x3 months at which time the QAA committee will determine further frequency of the audits.</p> <p>6. Corrective action will be completed by 11/21/15</p> <p><i>F9999 POC accepted 11/21/15 Jennifer R. J. PMLC</i></p>	

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NPs	PROVIDER # 475020	MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	DATE SURVEY COMPLETE: 10/21/2015
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ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 431	<p>483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS</p> <p>The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.</p> <p>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>This REQUIREMENT is not met as evidenced by: The facility failed to maintain and/or have an account of the disposition of a controlled drug in accordance with currently accepted professional principles for one of five residents in the sample. (Resident #4) Findings include:</p> <p>1. Per record review on 10/21/15 of the MAR for Resident #4, the narcotic Oxycodone 10 mg, was not disposed of in accordance with current practices. Per facility policy: Controlled Drugs, states "all controlled drugs will be logged in and monitored to insure that they can be accurately accounted for. Strict control of narcotics is always maintained; #6) if the medication is removed and the resident refuses it, it is not given or only partial dose is used the medication is to be destroyed in the presence of two licensed nurses. Both nurses must sign the Individual Narcotic Record".</p> <p>During review of the Narcotic Record, the order is for the resident to receive 15 mg as needed for pain. On two occasions, 08/23/15 and 08/26/15, two 10 mg tablets were signed as being used, with one tablet being split to equal a total of 15 mg. Half of the split tablet (5 mg) was documented as being "wasted" (wasted = disposed of due to not being used); however, there is no documentation that a second nurse witnessed or co-signed the disposal of the narcotic. During interview the DNS on 10/21/15 at 11:49 AM stated the expectations and practice is to have two nurses witness and sign for the disposal of narcotics. S/he confirmed the narcotic was not disposed of in accordance with current practices</p>

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

The above isolated deficiencies pose no actual harm to the residents

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DEFICIT PREFIX SUFFIX	SUMMARY STATEMENT OF DEFICIENCIES
431	Continued From Page 1 *This is an "A" level citation.*