

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

February 4, 2015

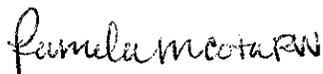
Mr. John O'Donnell, Administrator  
Berlin Health & Rehab Ctr  
98 Hospitality Drive  
Barre, VT 05641-5360

Dear Mr. O'Donnell:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **January 6, 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

PC:jl

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

PRINTED: 01/20/2015  
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 01/06/2015
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 000	INITIAL COMMENTS	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 281 SS=G	<p>483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS</p> <p>The services provided or arranged by the facility must meet professional standards of quality.</p> <p>This REQUIREMENT is not met as evidenced by: Based on staff interview and medical record review, the facility failed to ensure services provided met professional standards of quality for 2 of 3 residents in the sample. Resident #1 was not assessed by a Registered Nurse (RN) after numerous falls, nor was the resident's change in condition acted upon. For Resident #2, an RN assessment was not completed after a fall nor was the resident closely monitored for a possible head injury. The findings include the following:</p> <p>1. Per record review, Resident #1, who is 60 years of age, was admitted with diagnoses to include Prostate Cancer, Non-Hodgkin's Lymphoma, Seizure Disorder, Schizophrenia, Depressive Disorder, Anxiety, Anemia, Osteoporosis with Compression Fracture and Dizziness.</p> <p>Resident #1 has had documented falls as follows: 11/19/14 at 11:36 AM Resident witnessed falling backwards into the medication cart located in the</p>	F 281	<p>F281 483.20(k)(3)(i)</p> <ol style="list-style-type: none"> <li>1. Resident #1 and #2 no longer reside at the facility</li> <li>2. All residents that fall have potential to be effected by the alleged deficient practice.</li> <li>3. Education provided to nursing staff regarding fall aftercare policies, requirement of RN assessment.</li> <li>4. DNS or designee to conduct random weekly audits of all falls to monitor the effectiveness of the plan.</li> <li>5. Results of the audits will be reported to the QA committee by the Executive Director or designee for a minimum of 3 months at which time the QA committee will determine further frequency of the audits to be done.</li> <li>6. Corrective action to be completed by 2/6/15.</li> </ol>		

F281 POC accepted 2/3/15 mbestrand/pml

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *[Signature]* TITLE *Executive Director* (X6) DATE *1-3-2015*

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 281	Continued From page 1 hallway; 11/20/14 Resident sat on the floor after feeling dizzy; 11/23/14 at 7:30 PM Resident backing out of his/her room attempting to close the stop sign on the door, lost his/her balance and fell to the floor. This incident was not witnessed; 11/25/14 Resident was witnessed lowering self to the floor twice on the evening shift. Nurses notes identify that the resident was ambulating with an unsteady gait; 11/26/14 at 12 noon staff heard a large crash and found resident on the floor. Family was present during the fall; 11/29/14 at 10:45 AM Resident was found lying on his/her left side in front of the closet. Sustained a small laceration on right temple by the eyebrow. Resident was also witnessed placing him/her self on the floor and getting up independently on 4 different times during the shift; 11/30/14 at 8:30 AM Resident was witnessed standing up and sitting/falling in the dining room; 11/30/14 at 11:15 AM Resident found on his/her hands and knees at the foot of the bed; 12/1/14 staff witnessed resident crawl out of bed on to the floor next to the bed. Registered Nurse identifies that the resident will be monitored.  After each of the above falls, Resident #1 was assessed for injury by the Licensed Practical Nurse (LPN) on duty. Per the Vermont Board of Nursing Position Statement, "LPNs may not independently assess the health status of an individual or group and may not independently develop or modify the plan of care. LPNs may contribute to the assessment and nursing care planning processes; however, patient assessment and care plan development or	F 281			

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F 281	<p>Continued From page 2</p> <p>revision remain the responsibility of the RN, APRN, or other authorized health care practitioner." Only two of the 9 listed incidents were reported to the Director of Nurses (DNS).</p> <p>Progress notes dated 11/27/14 evidence that the resident requested, his/her back x-rayed. The nurse documented that the resident was difficult to follow. Family notified of rib complaint and family voiced that the ["resident was favoring that side yesterday. It is new."] Family told the nurse that it has been going on a couple of weeks.</p> <p>On 11/27/14, a Physician order at 12:20 states "May have X-ray of left rib cage if Berlin Health &amp; Rehab feels necessary." Nurses note 11/27/14 identifies that physician informed nurse he would not do the x-ray unless Resident #1 was having breathing issues. Progress notes from 11/27/14 to 12/1/14 do not evidence that any professional staff conducted a respiratory/lung assessment, nor is there any evidence identifying that the X-Ray was ever considered. An 11/28/14 LPN progress note identifies that Resident #1 was "moaning loudly, [s/he] could be heard all the way down the hallway."</p> <p>On 12/1/14 the Attending Physician was notified that the resident has been talking about wanting to kill himself, spit out medication and staff advised to transport to the Emergency Department (ED) for evaluation. There is no evidence in the medical record that the resident had any bruises or abrasions throughout his/her stay at the facility.</p> <p>On exam in the ED on 12/1/14, documentation evidences that Resident #1 had multiple bruises of his/her arms and diagnostic imaging showed a</p>	F 281			

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F 281	<p>Continued From page 3</p> <p>hip fracture. The Resident was then transferred to the VA Hospital for the management of pneumonia and a closed hip fracture. Resident #1 died on 12/15/14 after attempted Cardiac Pulmonary Resuscitation failed.</p> <p>Per interview with the DNS on 1/6/15 confirmation was made at 9:15 AM that a Registered Nurse (RN) assessment was not conducted for the above listed incidents.</p> <p>2. Per medical record review, Resident #2 fell on 9/22/14 at approximately 1145. Resident was found on the floor in the bathroom after attempting to transfer independently. Resident was assessed by the Registered Nurse (RN) and neurological vital signs were begun. Neurological Evaluation Flow Sheet identifies that neurological evaluation was not conducted on 9/23/14 for the 7-3 shift.</p> <p>On 10/17/14 Resident was found sitting on the floor next to his/her bed. Resident was assessed by the Licensed Practical Nurse (LPN) on duty and neurological signs were begun. Neurological Evaluation Flow Sheet identifies that neurological evaluation was not conducted as per policy for the first hour, nor was evaluation conducted on day 3 during the 7-3 shift.</p> <p>Per facility policy for Neurological Assessment dated October 2010 evidences that neurological assessments are to be completed on unwitnessed falls and completed every 15 minutes for 1 hour, every 30 minutes for 4 hours, every hour for 2 hours and every shift for 72 hours unless specified by MD.</p> <p>Per interview with the Director of Nurses on</p>	F 281			

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F 281	Continued From page 4 1/6/14 at 9:04 AM confirmation is made that the neurological assessments were not completed as per policy, nor was the resident assessed after the fall of 10/7/14 by an RN.  (See also F309)  References: 1. Lippincott Manual of Nursing Practice (9th ed.). Wolters Kluwer Health/Lippincott Williams & Wilkins.  2. Vermont State Board of Nursing - The Role of the Licensed Practical Nurse in Patient Assessment and Triage - Position Statement. <a href="https://www.sec.state.vt.us/media/369555/PS-Role-of-LPNs-in-Triage.pdf">https://www.sec.state.vt.us/media/369555/PS-Role-of-LPNs-in-Triage.pdf</a> (accessed 1/14/15).	F 281		
F 309 SS=G	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING  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.  This REQUIREMENT is not met as evidenced by: Based on staff interview and medical record review, the facility failed to ensure that each resident receives the necessary care and services to maintain the highest practicable physical well-being for 2 of 3 sampled residents (Resident #1 and #2) regarding proper assessment and monitoring after falls. The	F 309	F309 483.25  1. Resident #1 and #2 no longer reside at the facility 2. All residents that fall have the potential to be effected by the alleged deficient practice. 3. Education provided to nursing staff regarding fall aftercare policies, requirement of RN assessment. 4. DNS or designee to conduct random weekly audits of all falls to monitor the effectiveness of the plan.	

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F 309	<p>Continued From page 5 findings include the following:</p> <ol style="list-style-type: none"> <li>Per record review, Resident #1, who is 60 years of age, was admitted with diagnoses to include Prostate Cancer, Non-Hodgkin's Lymphoma, Seizure Disorder, Schizophrenia, Depressive Disorder, Anxiety, Anemia, Osteoporosis with Compression Fracture and Dizziness.</li> </ol> <p>Resident #1 has had documented falls as follows: 11/19/14 at 11:36 AM Resident witnessed falling backwards into the medication cart located in the hallway; 11/20/14 Resident sat on the floor after feeling dizzy; 11/23/14 at 7:30 PM Resident backing out of his/her room attempting to close the stop sign on the door, lost his/her balance and fell to the floor. This incident was not witnessed; 11/25/14 Resident was witnessed lowering self to the floor twice on the evening shift. Nurses notes identify that the resident was ambulating with an unsteady gait; 11/26/14 at 12 noon staff heard a large crash and found resident on the floor. Family was present during the fall; 11/29/14 at 10:45 AM Resident was found lying on his/her left side in front of the closet. Sustained a small laceration on right temple by the eyebrow. Resident was also witnessed placing him/her self on the floor and getting up independently on 4 different times during the shift; 11/30/14 at 8:30 AM Resident was witnessed standing up and sitting/falling in the dining room; 11/30/14 at 11:15 AM Resident found on his/her hands and knees at the foot of the bed; 12/1/14 staff witnessed resident crawl out of bed</p>	F 309	<ol style="list-style-type: none"> <li>The DNS or designee will report the results of the audits to the QA committee for a minimum of 3 months at which time the committee will determine further frequency of the audits.</li> <li>Corrective action will be completed by 2/6/15.</li> </ol> <p><i>F309 ROC accepted 2/3/15 M. Brennan RHP/ML</i></p>		

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F 309	<p>Continued From page 6</p> <p>on to the floor next to the bed. Registered Nurse identifies that the resident will be monitored.</p> <p>After each of the above falls, Resident #1 was assessed for injury by the Licensed Practical Nurse (LPN) on duty. Per the Vermont Board of Nursing Position Statement, "LPNs may not independently assess the health status of an individual or group and may not independently develop or modify the plan of care. LPNs may contribute to the assessment and nursing care planning processes; however, patient assessment and care plan development or revision remain the responsibility of the RN, APRN, or other authorized health care practitioner." Only two of the 9 listed incidents were reported to the Director of Nurses (DNS).</p> <p>Progress notes dated 11/27/14 evidence that the resident requested, his/her back x-rayed. The nurse documented that the resident was difficult to follow. Family notified of rib complaint and family voiced that the ["resident was favoring that side yesterday. It is new."] Family told the nurse that it has been going on a couple of weeks.</p> <p>On 11/27/14, a Physician order at 12:20 states "May have X-ray of left rib cage if Berlin Health &amp; Rehab feels necessary." Nurses note 11/27/14 identifies that physician informed nurse he would not do the x-ray unless Resident #1 was having breathing issues. Progress notes from 11/27/14 to 12/1/14 do not evidence that any professional staff conducted a respiratory/lung assessment, nor is there any evidence identifying that the X-Ray was ever considered. An 11/28/14 LPN progress note identifies that Resident #1 was "moaning loudly, [s/he] could be heard all the way down the hallway."</p>	F 309		

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F 309	<p>Continued From page 7</p> <p>On 12/1/14 the Attending Physician was notified that the resident has been talking about wanting to kill himself, spit out medication and staff advised to transport to the Emergency Department (ED) for evaluation. There is no evidence in the medical record that the resident had any bruises or abrasions throughout his/her stay at the facility.</p> <p>On exam in the ED on 12/1/14, documentation evidences that Resident #1 had multiple bruises of his/her arms and diagnostic imaging showed a hip fracture. The Resident was then transferred to the VA Hospital for the management of pneumonia and a closed hip fracture. Resident #1 died on 12/15/14 after attempted Cardiac Pulmonary Resuscitation failed.</p> <p>Per interview with the DNS on 1/6/15 confirmation was made at 9:15 AM that a Registered Nurse (RN) assessment was not conducted for the above listed incidents.</p> <p>2. Per medical record review, Resident #2 fell on 9/22/14 at approximately 1145. Resident was found on the floor in the bathroom after attempting to transfer independently. Resident was assessed by the Registered Nurse (RN) and neurological vital signs were begun. Neurological Evaluation Flow Sheet identifies that neurological evaluation was not conducted on 9/23/14 for the 7-3 shift.</p> <p>On 10/17/14 Resident was found sitting on the floor next to his/her bed. Resident was assessed by the Licensed Practical Nurse (LPN) on duty and neurological signs were begun. Neurological Evaluation Flow Sheet identifies that neurological</p>	F 309			

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F 309	<p>Continued From page 8</p> <p>evaluation was not conducted as per policy for the first hour, nor was evaluation conducted on day 3 during the 7-3 shift.</p> <p>Per facility policy for Neurological Assessment dated October 2010 evidences that neurological assessments are to be completed on unwitnessed falls and completed every 15 minutes for 1 hour, every 30 minutes for 4 hours, every hour for 2 hours and every shift for 72 hours unless specified by MD.</p> <p>Per interview with the Director of Nurses on 1/6/14 at 9:04 AM confirmation is made that the neurological assessments were not completed as per policy, nor was the resident assessed after the fall of 10/7/14 by an RN.</p> <p>(See also F281)</p> <p>References: 1. Lippincott Manual of Nursing Practice (9th ed.). Wolters Kluwer Health/Lippincott Williams &amp; Wilkins. 2. Vermont State Board of Nursing - The Role of the Licensed Practical Nurse in Patient Assessment and Triage - Position Statement. <a href="https://www.sec.state.vt.us/media/369555/PS-Role-of-LPNs-in-Triage.pdf">https://www.sec.state.vt.us/media/369555/PS-Role-of-LPNs-in-Triage.pdf</a> (accessed 1/14/15).</p>	F 309		