

Division of Licensing and Protection

HC 2 South, 280 State Drive

Waterbury, VT 05671-2060

<http://www.dail.vermont.gov>

Survey and Certification Voice/TTY (802) 241-0480

Survey and Certification Fax (802) 241-0343

Survey and Certification Reporting Line: (888) 700-5330

To Report Adult Abuse: (800) 564-1612

April 1, 2016

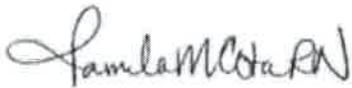
Ms. Kim Campbell,
Berlin Health & Rehab Ctr
98 Hospitality Drive
Barre, VT 05641-5360

Dear Ms. Campbell:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on March 9, 2016. 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: 03/15/2016
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 03/09/2016
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 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 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY 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. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility did not promote care for 3 of 17 applicable residents in a manner that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. (Resident #1, Resident #8, and Resident #9) Findings include: 1. Resident #1's privacy curtain and/or door was not closed during provision of care and services. Per observation on 03/08/16 at 6:00 PM, nursing staff came into the Resident's room, pulled up the resident's shirt, exposing the resident's abdomen and feeding tube in full view from the hallway. The nurse continued with the procedure of auscultation (listening with a stethoscope) and instilling fluids. The roommate entered the room at this time also. During interview on 03/09/16 at 10:43 AM the Unit Manager (UM) stated "I did see the nurse have the curtain/door open last night when I walked down the hall". The UM	F 241	F 241 Residents #1, #8, and #9 had no negative effects as a result of the alleged deficient practice Resident #1 privacy curtain is closed during provision of care and services Resident #8 is receiving oral care per plan of care Resident #9 is receiving oral care per plan of care Residents that require assist with care and services have the potential to be affected by the alleged deficient practice Nursing staff has been educated on completing oral care and risk factors associated with lack of oral care	

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

Kim Campbell

TITLE

Executive Director

(X6) DATE

3/25/16

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 241	<p>Continued From page 1</p> <p>confirmed that the curtain and or door should be closed to provide privacy during provision of care and services.</p> <p>2. Per record review, Resident #8 was admitted on 05/24/13 with diagnoses to include Bipolar Disease, Dysphagia and Chronic Obstructive Pulmonary Disease. Per review of the resident's plan of care, it states that the resident has an oral/dental health problem that is to be monitored. The resident is dependent on staff for activities of daily living care (ADL). Interventions include, but not limited to "needs mouth care and denture care two times a day". Per observation on 03/08/16 at 10 AM the resident is sitting in a wheel chair and is located at the entrance to her/his room. The resident presents with disheveled hair and teeth that do not appear to have been brushed. Tartar buildup and food residue was noted on review of the resident's teeth. Per interview with family of Resident #8 at approximately 10:45 AM, the family member stated that the only time s/he has her/his teeth brushed is when the family completes the task.</p> <p>Per interview with a Licensed Nurses Aide (LNA) on 03/08/16 at approximately 11:30 AM, confirms that s/he did not provide the resident with any oral care today, "we just don't have time. The only residents who receive oral care are those that make the request." Per interview with the Unit Manager (UM) on 03/08/16 at approximately 1:30 PM, and examination of Resident #8's mouth, confirmation was made that the resident has not had any oral care today.</p> <p>3. Resident #9 was admitted on 09/15/14 with</p>	F 241	<p>Nursing staff have been educated regarding requirement to provide for privacy and dignity during provision of care and services</p> <p>Audits will be completed five days a week for two weeks, weekly for two weeks then monthly x's 3 months to monitor effectiveness of the plan</p> <p>Results of the audits will be reviewed at QAPI for evaluation and further recommendations</p> <p>Oversight: will be done by DON or designee</p> <p>Corrective action will be completed by April 9, 2016</p> <p><i>F241 POC accepted 3/31/16 Simmons RN/mme</i></p>	

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F 241	Continued From page 2 diagnoses to include Parkinson's Disease, Major Depressive Disorder, Dysphagia and Atherosclerotic Heart Disease. Per review of the resident's plan of care, it states that the resident has a potential for oral health problem related to poor nutrition. This problem is to be monitored and s/he is dependent on staff for activities of daily living (ADL) care. Interventions include, but not limited to "provide mouth care as per ADL personal hygiene". Per observation on 03/08/16 at approximately 9:48 AM Resident #9 was reclined in a wheelchair at the nurses station with his/her mouth open and with teeth notably caked with tartar buildup and food residue (pink in color). Per interview with the Unit Manager (UM) on 03/08/16 at approximately 1:30 PM, and examination of Resident #9, confirmation was made that the resident has not had any oral care today.	F 241			
F 253 SS=E	(see also F282 and F312) 483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: The facility failed to provide housekeeping services necessary to maintain a sanitary and comfortable interior for three applicable residents. (Residents #4, #5, and #12) Findings include: 1. During interview, record review and	F 253			

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F 253	Continued From page 3 observation, three resident rooms were identified as not receiving effective housekeeping services as follows: a) Per interview on 03/08/16 at 1:45 PM the Director of Housekeeping Services (DHS) stated that twice a day, housekeeping staff will do a quick check/clean of each bathroom and rooms, such as emptying trash. Every other day, 13 of 26 rooms will receive a thorough cleaning that includes cleaning all residents' furniture, walls and floors. The DHS stated that when a resident leaves or is discharged, that room also gets a thorough cleaning. The DHS said "We usually wait until the family comes and gets their personal belongings and nursing will let us know, then we clean the room". This is made known during morning rounds and then relayed to the housekeeping staff. Resident #4 was identified as having being on 'precautions' and died on 01/25/16 around the Noon hour. The Housekeeping assignment record shows that housekeeping did not enter the room on the 25th, while the on 27th notes 'discharge'. Per interview on 03/09/16 at 9:56 AM, the staff nurse stated the family did not pick up Resident's personal items for several days, stating "We called them and told them no rush. Although we tried to keep the door closed, we do have about 11 people that wander and the residents were able to open the door, we do try to stop them when we see them". The nurse acknowledged that it was several days before that room got cleaned and residents did have access to the unclean room. b) An anonymous concern to the Division noted that a discharged resident's belonging were not removed nor the room cleaned prior to a new	F 253	F 253 No residents were negatively affected by this alleged deficient practice Residents residing in the facility have the potential to be affected by this alleged deficient practice All identified areas have been thoroughly cleaned Education will be provided to housekeeping staff regarding proper procedures for performing daily cleaning, complete cleaning, and discharge cleaning Weekly audits will be done by the Housekeeping Supervisor to monitor effectiveness of the plan Audits will be reviewed at QAPI for evaluation and further recommendations Corrective action will be complete by April 9, 2016 <i>F253 POC accepted 3/31/16 Semmons/RA/mae</i>		

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F 253	Continued From page 4 admission to the room. Per record review on 03/08/16 notes that Resident #5 was 'discharged' on 01/27/16, between 2:00 - 3:00 AM. A nursing note of 01/27/16 at 4:30 PM demonstrates there were two new admissions to this room. Per interview at 10:00 AM, the Director of Social Services stated, "I checked with [resident's] family and the said that they didn't pick up [his/her] belongings until later that night [of 27th]". Per the Housekeeping assignment sheet of 01/27/16, for Resident#5's room shows it not being checked off but states, 'Mattress'. Per interview on 03/09/16 at 12:28 PM the DHS stated "well perhaps that means only the mattress was not cleaned, or only the mattress was cleaned". The DHS was unable to state if the room was thoroughly cleaned.	F 253			
F 280 SS=D	c) Resident #13's bedside table was observed on 03/09/16 at 9:15 AM to be heavily soiled with dried food, dried liquid spills and a build up of other undistinguishable materials. This resident's room was identified by the housekeeper at that time, as having a thorough cleaning [two days ago], which included wiping/washing down all furniture as well as sweeping and mopping the floors. The DHS at 12:28 PM confirmed the bedside table was not thoroughly cleaned and had a build up of soiled food/liquid material. 483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.	F 280			

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F 280	<p>Continued From page 5</p> <p>A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview, the facility failed to review and revise the care plans for 3 of 17 residents (Resident #4, #6 and #7) with resident specific interventions to meet their care needs. Findings include:</p> <p>1. Per record review, the care plan for Resident #4 was not revised to reflect his/her refusals for care related to the treatment of his/her lower extremity wounds. Resident #4 was admitted with venous ulcers on his/her left lower extremity and a complicated medical history that included a history of sepsis (blood infection). A care plan for the venous ulcers was developed on 11/10/15 that included treatments and medications as ordered, update MD and family as indicated and monitor for [signs/symptoms] of infection; the care plan was revised on 01/25/16 to include wound nurse to follow as indicated.</p>	F 280	<p>F 280</p> <p>Resident #4 no longer resides in the facility</p> <p>Resident #6 has been re-evaluated for elopement risks and care plan has been updated</p> <p>Resident #7 care plan has been updated to include setting the resident up with a toothbrush to perform self-oral care</p> <p>Residents with refusal of care, risk for elopement, and require assist for oral care have the potential to be affected</p> <p>Nursing staff has been educated regarding revising care plans</p> <p>Audits of care plan revisions will be completed weekly x's 4 weeks then monthly x's 3 months to monitor effectiveness of the plan</p> <p>Results of the audits will be reviewed at QAPI for evaluation and further recommendations</p> <p>Oversight: DON or designee</p> <p>Corrective action will be complete by April 9, 2016</p>		

F280 POC accepted 3/21/16 Semmons R/L/ame

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F 280	<p>Continued From page 6</p> <p>Per review of the 01/06/16 physician orders and TAR (treatment administration record), nursing staff were to clean the wound with wound cleanser and apply tegaderm foam on Monday, Wednesday and Friday. Per review of the TAR, the dressing was not changed due to resident refusals on 01/11, 01/13, 01/14 and 01/18/16. Per review, the care plan was not revised to include resident education around the risks of non-treatment and benefits of consistent wound care; there was no evidence that strategies, approaches and interventions to address barriers to wound care were developed to assist staff to address the residents resistance to the dressing change and to help the resident attain or maintain his/her highest practicable level of well-being. On 03/09/16, the facility's Manager of Clinical Operations confirmed the above findings and that the care plan was not revised to address the resident's rejection of wound care. (Refer F309 and F329).</p> <p>2. Per record review, the care plan for Resident #6 was not revised to reflect his/her current elopement risk. Per review of the resident's nursing assessments, on 01/27/16 Resident #6 was assessed at high risk for elopement. On 01/28/16 a care plan was developed that included placing a secure care (a monitor that alarms if the resident attempts to exit the building) and re-evaluating the resident after s/he became oriented to the facility. Nursing progress notes on 02/13/16 documented that the "...resident currently does not have a secure care. Resident has managed to cut the band several times with a butter knife provided on tray when meals are served. Resident should be re-evaluated on whether [s/he] continues to need</p>	F 280			

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F 280	<p>Continued From page 7</p> <p>a secure care. Resident does exit seek in the evenings ...Will place one more time and ask that kitchen does not provide butter knife on tray." On 02/24/16 the nursing note states that "...Placed in care plan acknowledgement book that resident no longer has a secure care and to be cautious of their where abouts."</p> <p>Per interviews on 03/08/16 at 2:14 PM and 03/09/16 at 8:41 AM, the B wing Unit Manager (UM), confirmed the above information and that Resident #6 had not been reassessed for elopement risk since the original assessment on 01/27/16 and that his/her care plan had not been revised to reflect new measures to ensure resident safety from elopement following his/her removal of the secure care. The UM also reported that s/he was not aware of a "care plan acknowledgement book" and confirmed that no care plan revisions were made for the resident prior to the start of the survey.</p> <p>3. Per observations 03/08/16 and 03/09/16 , interviews and record review, the care plan for Resident # 7 was not revised to include his/her oral health needs. On 3/8/16 at 12:00 noon, per observation and interview with the resident and a family member, Resident # 7 reported that s/he is not getting his/her teeth brushed except for once per week. The resident's family member stated that this had been a problem in the past and that the resident can brush his/her own teeth if given a toothbrush. Per the 02/09/16 quarterly MDS (Minimum Data Set) review, the resident has a Cognitive score of 15 (cognitively intact), inattention that fluctuates, no rejection of care (behavior not exhibited) and requires extensive assistance for personal care, bed mobility,</p>	F 280			

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F 280	Continued From page 8 transfers and dressing. On 03/08/16 at 7:24 AM, Resident #7 was observed up and dressed and sitting in a chair in his/her room. The resident reported that AM care had been done, but that s/he was not offered mouth care; a thick white coating was observed on the resident's teeth and at the gum line. At 7:30 AM, the Unit Manger (UM) for the A wing, confirmed that Resident #7 has a care plan for ADL (Activities of Daily Living) Self Care performance deficit related to decreased mobility and parkinsonism but that the plan did not include mouth care. A review of the LNA care sheet for the resident was reviewed with the UM and s/he confirmed that mouth care (setting the resident up with a toothbrush for self-care) was not included. At 7:36 AM, the UM confirmed the resident's teeth were not brushed and that the teeth had a white coating and that the ADL care plan had not been revised to include mouth care. (see F 312)	F 280			
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET 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 observation, staff interview and record review, the facility failed to provide services that meet professional standards of quality by not following physician's order and clinical procedure for 1 applicable resident. (Resident #1) Findings include:	F 281	F281 Resident #1 had no negative effects as a result of the alleged deficient practice The physician orders for resident #1 have been reviewed and revised as needed Residents with gastric tubes have the potential to be affected Licensed staff has received education regarding following the MD order for appropriate nutritional supplementation and delivering H2O bolus via gravity.		

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F 281	Continued From page 9 1. Resident #1, who is receiving nutritional supplemental feedings via a tube directly into the gastrointestinal area [enteral feeding] did not receive services according to accepted standards of clinical practice. Nursing staff did not instill the correct nutritional supplement amount nor correctly instilled the water bolus. Per record review, the signed Physician's order directs staff to instill at 6:00 PM, Replete 750 ml [milliliters] at a rate of 187 ml over 4 hours and at 11:05 PM, Replete 500 ml at a rate of 166 ml for 3 hours. In addition, Staff are also to instill a water bolus of 220 ml five times a day at 6 AM, 9 AM, 2 PM, 6 PM and 11 PM. Per review of the amounts given via the history of the feeding pump, on 03/08/16 at 1:01 PM, with the Nurse Unit Manager (UM), demonstrated the amount given was greater than the amount ordered. The UM said the history readings should show approximately 1246 ml in a 24/hr period. The water bolus is not included in the history, as this is supplied via gravity flow, separate from the feedings. However, the last 24 hours totals demonstrated that 1394 ml were given [approximately 148 ml over], that 3042 ml were given over the last 48 hours [550 ml over the expected 2492 ml]; and the last 72 hours 3761 ml were given [slightly over at 23 ml of the expected 3738 ml.]. The UM confirmed at that the nutritional amounts were over the physician ordered amounts for the last 72 hours. In addition, during observation at 6:00 PM of the instillation of the water, the nurse filled a 60 cc syringe of water (three times with 60 cc and one with 40 cc) and pushed steadily each time. Per interview the nurse said that a bolus meant to give it quickly and "if you don't push it [s/he]	F 281	Gastric tube nutritional supplement and H2O bolus audits will be completed weekly x's4 then monthly x's 3 to monitor effectiveness of the plan Results of the audits will be reviewed at QAPI for evaluation and further recommendations Oversight: DON or designee Corrective action will be complete by April 9, 2016 <i>F281 POC accepted 3/31/16 scummspd/rme</i>		

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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 03/09/2016
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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F 281	Continued From page 10 could cough and it could go all over". The DNS that evening said that the procedure should be adhered to according to the Lippincott Nursing Manual and that a bolus should be given via gravity versus pushing the fluid. Per interview on 03/09/16 at 10:45 AM, the UM said that "from now on the pump will be checked each morning". The UM also stated the physician orders were re-written to clearly separate the evening and night dose. The UM said the problem was the order was written as one continually order and "if the nurse didn't use the down arrow in the electronic MAR [medication administration record], the nurse would only see the first part, which shows 750 instead of the 500". The UM confirmed the nurse did not follow professional standards for following physician's orders and nursing care according to accepted standards of clinical practice for administration of the water bolus. Reference: Lippincott Manual of Nursing Practice, 10th edition; page 745 - Procedure Guidelines 20-1; Performance Phase #2 "...allow fluid to flow in by gravity".	F 281			
F 282 SS=E	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, record review and confirmed by staff interview the facility failed to	F 282	F282 The identified residents had no negative effect as a result of the alleged deficient practice Resident #2 pain care plan has been reviewed and revised as needed and pain medication has been given as ordered Resident #3 has barrier cream applied after incontinent care Resident #8 is receiving oral care Resident #9 is receiving oral care Resident #10 is monitored per plan of care Resident #11 is monitored per plan of care		

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F 282	<p>Continued From page 11</p> <p>ensure that for 6 of 20 sampled residents (Residents #2, #3, #8, #9, #10 and #11), that services were provided according to each resident's written plan of care. The findings include the following:</p> <p>1. Resident #2's care plan was not implemented as written. Per record review, the Care Plan directs staff to conduct a weekly pain evaluation to be noted in PCC [point click care] every Friday evening and that it must be documented in PCC. Also, to administer analgesia [pain medications] as per orders. Per review of the PCC weekly pain evaluation from December 2015 until present 03/09/16, no evaluations were conducted January 8, 15, 22, 29, and February 5, 2016. Per review of the MAR [medication administration record] the scheduled analgesic medications were not administered as evident by lack of documentation as follows:</p> <p>*MS Contin Tablet Extended Release 15 MG (Morphine Sulfate ER) Give 1 tablet by mouth three times a day for Pain - Omitted Jan 7, 26, 29, 30 [AM shift], February 2, 11 [Afternoon shift], 26 [AM shift] 14/15 [Night shift] and March 4th [AM shift];</p> <p>*MS Contin Tablet Extended Release 60 MG (Morphine Sulfate ER) Give 1 tablet by mouth three times a day for Pain related to every 8 hours - Omitted Jan. 7, 26, 29 [afternoon shift], February 2 [AM], 11 [1400] 14/15 [2200] and 26 [AM], March 4th [AM shift];</p> <p>*Oxycodone HCl Tablet 10 MG Give 2 tablet by mouth four times a day for pain -omitted Feb 14 & 15 [night shift].</p> <p>The DNS [Director of Nursing Services] and the Manager of Clinical Operations on 03/09/16 at 1:36 PM confirmed the plan of care was not</p>	F 282	<p>Residents requiring barrier cream, assist with oral care, pain management, medications, and monitoring due to behaviors have the potential to be affected by the alleged deficient practice.</p> <p>Nursing staff has received education regarding the use of barrier cream, oral care, pain care plan, medication omission, and following the residents care plan that require monitoring for behaviors.</p> <p>Audits of residents requiring barrier cream, oral care, pain care plan revisions, medication administration, and following the residents care plan that require monitoring for behaviors will be completed weekly x's 4 then monthly x's 3 to monitor effectiveness of the plan</p> <p>Results of the audits will be reviewed at QAPI for evaluation and further recommendations</p> <p>Oversight: DON or designee</p> <p>Corrective action will be complete by April 9, 2016</p>	

FABA POC accepted 3/31/16 sammons/RAJ/pmc

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F 282	<p>Continued From page 12 followed.</p> <p>2. Resident #3 was identified by the facility on 03/08/16 at 9:30 AM as having a pressure ulcer. The Care plan for pressure ulcer development related to poor intake and immobility, directs staff to use barrier cream to be applied with incontinence care, LNA's to monitor skin daily with care and report to nursing any findings, monitor nutritional status, serve diet as ordered, monitor intake and record, pressure reducing cushion in wheelchair and mattress and to use disposable briefs and change every two hours and as needed. Per observation on 03/08/16 from 9:45 AM - 11:45 AM the resident was noted in bed, supine (on back). At 11:50 AM, two LNA staff were getting the resident out of bed and already dressed. LNAs said "we were going to check [his/her] brief after we got [him/her] up". At that time the nurse surveyor requested permission to look at the resident's skin. When the brief was pulled down, it was noted to be full of stool and a very red coccyx area was noted. During interview at that time, the LNAs stated "we don't put on the barrier cream unless the nurse tells us" and acknowledged that the coccyx area was red at 9:00 AM. The LNAs last checked/changed the brief at 9:00 AM and stated "I didn't put barrier cream on". The nurse was summoned and stated "I'm not sure if [s/he] is supposed to get cream" and said "check with the UM for an order". The UM confirmed at 12:20 PM on 03/08/16 that care was not provided per the care plan.</p> <p>3. Per record review, Resident #8 was admitted on 05/24/13 with diagnoses to include Bipolar Disease, Dysphagia and Chronic Obstructive</p>	F 282			

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F 282	<p>Continued From page 13</p> <p>Pulmonary Disease. Per review of the resident's plan of care, it states that the resident has an oral/dental health problem that is to be monitored. The resident is dependent on staff for activities of daily living care (ADL). Interventions include, but not limited to "needs mouth care and denture care two times a day". Per observation on 03/08/16 at 10 AM the resident is sitting in a wheel chair and is located at the entrance to her/his room. The resident presents with disheveled hair and teeth that do not appear to have been brushed. Tartar buildup and food residue was noted on review of the resident's teeth. Per interview with family of Resident #8 at approximately 10:45 AM, the family member stated that the only time s/he has her/his teeth brushed is when the family completes the task.</p> <p>Per interview with a Licensed Nurses Aide (LNA) on 03/08/16 at approximately 11:30 AM, confirms that s/he did not provide the resident with any oral care today, "we just don't have time. The only residents who receive oral care are those that make the request." Per interview with the Unit Manager (UM) on 03/08/16 at approximately 1:30 PM, and examination of Resident #8's mouth, confirmation was made that the resident has not had any oral care today.</p> <p>4. Per record review, Resident #9 was admitted on 09/15/14 with diagnoses to include Parkinson's Disease, Major Depressive Disorder, Dysphagia and Atherosclerotic Heart Disease. Per review of the resident's plan of care, it states that the resident has a potential for oral health problem related to poor nutrition. This problem is to be monitored and s/he is dependent on staff</p>	F 282			

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F 282	<p>Continued From page 14</p> <p>for activities of daily living (ADL) care. Interventions include, but not limited to "provide mouth care as per ADL personal hygiene". Per observation on 03/08/16 at approximately 9:48 AM Resident #9 was reclined in a wheelchair at the nurses station with his/her mouth open and with teeth notably caked with tartar buildup and food residue (pink in color). Per interview with the Unit Manager (UM) on 03/08/16 at approximately 1:30 PM, and examination of Resident #9, confirmation was made that the resident has not had any oral care today.</p> <p>5. Per record review, Resident #10 was admitted on 03/07/13, with diagnoses to include Alzheimer's Disease, Major Depressive Disorder and Dementia with Behavioral Disturbances. Per review of the resident's plan of care, it states that Resident #10 has potential to demonstrate verbal abusive behaviors, repetitive statements and inappropriate touching/groping with staff related to dementia. Interventions included, but not limited to, document observed behaviors. Care plan also identifies that Resident #10 is an elopement risk/wanderer exhibited by impaired safety awareness. Interventions include, but not limited to, monitor location.</p> <p>Per observation on 03/08/16 at 2:20 PM the surveyor was unable to locate Resident #10. Requested the assistance of Licensed Practical Nurse on the unit, who also was unable to locate the resident. On return to the unit the surveyor located the resident in another resident's room attempting to transfer self from bed to wheel chair. A Geriatric Aide removed the resident from the room in his/her wheel chair and relocated Resident #10 to the nurses station</p>	F 282			

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F 282	<p>Continued From page 15 (living room space). Surveyor sitting in the living room observed Resident #10, while sitting in the wheelchair relocate self in-front of Resident #3 who was also sitting in a wheelchair. Resident #3 had two large glasses of liquids in front of him/her. Resident #10 proceeded to pick up a (what appeared to be), chocolate milk and drink some of the remaining liquid, put the glass down and wheel her/his self away. Per interview with the Unit Manger at 2:50 PM confirmation was made that the resident was not monitored as per care plan indicates.</p> <p>6. Per record review, Resident #11 was admitted on 02/09/15 with diagnoses to include Dementia with Behavioral Disturbances, Enlarged Prostate, Major Depressive Disorder, Anxiety disorder and Alzheimer's Disease. Per review of Resident #11's written care plan, it identifies that the resident has a potential to demonstrate physical behaviors with a goal to not harm self or others. Interventions include, but not limited to, monitor/document/report to MD of danger to self and others. Per internal investigation dated 01/24/16, Resident #11 walked into another resident's room and was found to have the call light and telephone cord lightly wrapped around his/her arm. The nurse removed the cords, examined the resident and redirected the resident to a different location. Some thirty minutes after the intrusion, the victim made an accusation of being groped. The findings could not be substantiated. Per interview with the Unit Manger and review of Resident #11's care plan confirmation was made that the resident was not monitored as per care plan indicates.</p>	F 282			

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F 282	Continued From page 16 (See F-241, F- 312, & F-314)	F 282			
F 309 SS=D	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 medical record review and staff interviews, the facility failed to assure that services were provided to meet the highest practicable level of well-being for 1 of 20 (Resident #4) regarding provision of care. Findings Include: 1. Per 03/08/16 & 03/09/16 interviews and record review, the facility failed to ensure that wound care was provided in a manner so that Resident #4 met his/her highest practicable level of well-being. Resident #4 was admitted to the facility with venous ulcers on his/her left lower extremity and a complicated medical history that included sepsis (blood infection), peripheral vascular disease (poor circulation to the lower extremities) and chronic pain. A care plan for the venous ulcers was developed on 11/10/15 that included treatments and medications as ordered, update MD and family as indicated and monitor for [signs/symptoms] of infection; the care plan was revised on 01/25/16 to include wound nurse to follow as indicated.	F 309	F309 Resident #4 no longer resides in the facility Residents requiring wound care, narcotic pain medication, and body equipment have the potential to be affected by the alleged deficient practice Licensed staff has received education regarding wound care, infection control with soiled equipment, 5 rights of medication administration, and responsibility regarding medication errors Audits for wound care, equipment, and medication administration will be conducted weekly x4 weeks and		

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F 309	<p>Continued From page 17</p> <p>Per review of the 01/08/16 physician orders and TAR (treatment administration record), nursing staff were to clean the wound with wound cleanser and apply tegaderm foam on Monday, Wednesday and Friday. Per review of the TAR, the dressing care was performed on 01/08 and 01/08/16 and then was not changed due to resident refusals on 01/11, 01/13, 01/14 and 01/18/16.</p> <p>Per review of the nursing notes, on 01/11/16 "...resident complaining of to [sic] much pain refused to allow treatment to leg." On the 01/13/16 "...resident refused to allow treatment to his left lower leg stating that the pain would be unbearable and [s/he] would not be able to sleep tonight. [S/he] has not allowed treatment to [his/her] leg all week although we stress the importance of doing this treatment."</p> <p>Per 03/08/16 at 4:19 PM interview, the former Unit Manager (UM) for the B wing confirmed that on 01/14/16 Resident #4 went to the wound clinic. Once there, it was identified that the resident's ostomy bag had leaked onto the boot covering the wound dressing. The nursing home staff had wiped as "much of the feces off as they could" and put the soiled boot back on the resident's foot/lower extremity with a towel covering the soiled boot. After the dressing was removed at the wound clinic, clinic staff found that the dressing had been put on backwards by the nursing home staff, with the plastic film toward the wound side and the absorbent side of the dressing away from the wound. The nursing home staff were not aware that the dressing had been put on incorrectly and drainage from the</p>	F 309	<p>then monthly x3 to monitor effectiveness of the plan</p> <p>Audits for medication errors will be completed as needed to ensure corrective action is in place to prevent further errors.</p> <p>Results of the audits will be reviewed at QAPI for evaluation and further recommendations</p> <p>Oversight: DON or designee</p> <p>Corrective action will be complete by April 9, 2016</p> <p><i>F309 POC accepted 3/31/16 SEMmons/PMC</i></p>		

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F 309	<p>Continued From page 18</p> <p>wound was not being absorbed by the dressing and just collected under the dressing which probably added to the resident's pain. When the resident returned to the nursing home, the UM asked the resident why s/he left with feces on the boot, the resident stated that the other boot was not comfortable.</p> <p>Per record review, there was no evidence in the 01/14/16 nursing progress notes of education having been provided to the resident prior to leaving the nursing home (for the wound clinic appointment) to address the increased risks for wound infection (from leaving a feces stained boot over the lower extremity wound) or other benefits of having the dressing and boot changed or alternative measures that would have promoted comfort and infection control. There was also no revision to the care plan to address wound pain management prior to attempting dressing changes or evidence that the resident was re-approached after the initial refusals of dressing changes. The UM reported that the facility investigated the incident and staff were reeducated; however, on 03/09/16 at 1:59 PM, the Manager of Clinical Operations confirmed that the facility was not able to find the investigation file or re-education that was done.</p> <p>2. Per staff interview and record review, the facility failed to ensure that Resident #4 received the correct narcotic pain medication at the proper dose as ordered by the physician on two occasions and failed to take effective corrective action to ensure that the medication error did not recur after the first overdose was administered. Per record review on 03/08 and 03/09/16, Resident # 4 had diagnoses of chronic pain</p>	F 309			

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F 309	<p>Continued From page 19</p> <p>related to a history of an intraabdominal abscess, decreased mobility, venous ulcers and myelodysplastic syndrome (a bone marrow disorder). On 11/9/16, the resident's physician ordered Morphine Sulfate Extended Release 15 mg (MS ER), give 1 tablet orally every 12 hours for pain and Morphine Sulfate Extended Release 30 mg, give 1 tablet orally every 12 hours for pain (The two tablets were administered together for a total dose of 45 mg every 12 hours). Resident #4 also had orders for Morphine Sulfate 15 mg Immediate Release (MSIR) 1 tablet every 4 hours as needed for pain.</p> <p>Per review of the nursing progress note and incident report dated 11/10/15, during the change of shift narcotic count, it was determined that Resident #4 had been given MSIR 45 mg instead of the ordered dose of 15 mg at 11:00 AM. No further MSIR was given through the 1900 shift and no adverse effect was recorded. Per review of the nursing progress note and incident report dated 11/19/15, it was determined that Resident #4 was administered MSIR 45 mg instead of the scheduled MS ER 45 mg on 11/19/16. The resident's physician was notified and ordered that vital signs and oxygen saturation levels be monitored every 30 minutes for 4 hours and then every hour for 4 hours and if respirations were less than 10 and oxygen saturation less than 90 and the resident could not be awakened, to send to the Emergency Room. Vital signs were taken throughout the night and no adverse effect was recorded.</p> <p>Per review of the incident reports, nursing notes and staff interviews, there was no evidence provided that an effective corrective action was</p>	F 309			

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F 309	Continued From page 20 put in place to ensure that further mix up of the two similarly named but different types of Morphine did not occur following the first overdose. On 03/09/16 at 12:33 PM, the facility's Manager of Clinical Operations confirmed the above findings.	F 309			
F 312 SS=D	(Refer F280, F329). 483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interviews the facility failed to ensure that for 3 of 9 sampled residents (#7, #8 and #9) who were unable to carry out activities of daily living received necessary services to maintain grooming, personal and oral hygiene. The findings include the following: 1. Per observations 03/08/16 and 03/09/16 , interviews and record review, the care plan for Resident # 7 was not revised to include his/her oral health needs. On 3/8/16 at 12:00 noon, per observation and interview with the resident and a family member, Resident # 7 reported that s/he is not getting his/her teeth brushed except for once per week. The resident's family member stated that this had been a problem in the past and that the resident can brush his/her own teeth	F 312	F312 Resident #7 care plan has been updated to include setting the resident up with a toothbrush to perform self-oral care and set up is provided Resident #8 is receiving oral care Resident #9 is receiving oral care Residents that require assist with oral care have the potential to be affected Nursing staff has been education regarding completing oral care and risk factors associated with lack of oral care Oral care audits will be completed five days a week for two weeks, weekly for two weeks then monthly x's 3 months to monitor effectiveness of the plan		

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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 03/09/2016
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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F 312	<p>Continued From page 21</p> <p>if given a toothbrush. Per the 02/09/16 quarterly MDS (Minimum Data Set) review, the resident has a Cognitive score of 15 (cognitively intact), inattention that fluctuates, no rejection of care (behavior not exhibited) and requires extensive assistance for personal care, bed mobility, transfers and dressing.</p> <p>On 03/08/16 at 7:24 AM, Resident #7 was observed up and dressed and sitting in a chair in his/her room. The resident reported that AM care had been done, but that s/he was not offered mouth care; a thick white coating was observed on the resident's teeth and at the gum line. At 7:30 AM, the Unit Manger (UM) for the A wing, confirmed that Resident #7 has a care plan for ADL (Activities of Daily Living) Self Care performance deficit related to decreased mobility and parkinsonism but that the plan did not include mouth care. A review of the LNA care sheet for the resident was reviewed with the UM and s/he confirmed that mouth care (setting the resident up with a toothbrush for self-care) was not included. At 7:36 AM, the UM confirmed the resident's teeth were not brushed and that the teeth had a white coating and that the ADL care plan had not been revised to include mouth care.</p> <p>2. Per record review, Resident #8 was admitted on 05/24/13 with diagnoses to include Bipolar Disease, Dysphagia and Chronic Obstructive Pulmonary Disease. Per review of the resident's plan of care, it states that the resident has an oral/dental health problem that is to be monitored. The resident is dependent on staff for activities of dally living care (ADL). Interventions include, but not limited to "needs mouth care and denture care two times a day".</p>	F 312	<p>Results of the audits will be reviewed at QAPI for evaluation and further recommendations</p> <p>Oversight: DON or designee</p> <p>Corrective action will be complete by April 9, 2016</p> <p><i>F312 POC accepted 3/31/16 semmunska/ame</i></p>		

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F 312	<p>Continued From page 22</p> <p>Per observation on 03/08/16 at 10 AM the resident is sitting in a wheel chair and is located at the entrance to her/his room. The resident presents with disheveled hair and teeth that do not appear to have been brushed. Tartar buildup and food residue was noted on review of the resident's teeth. Per interview with family of Resident #8 at approximately 10:45 AM, the family member stated that the only time s/he has her/his teeth brushed is when the family completes the task.</p> <p>Per interview with a Licensed Nurses Aide (LNA) on 03/08/16 at approximately 11:30 AM, confirms that s/he did not provide the resident with any oral care today, "we just don't have time. The only residents who receive oral care are those that make the request." Per Interview with the Unit Manager (UM) on 03/08/16 at approximately 1:30 PM, and examination of Resident #8's mouth, confirmation was made that the resident has not had any oral care today.</p> <p>3. Per record review, Resident #9 was admitted on 09/15/14 with diagnoses to include Parkinson's Disease, Major Depressive Disorder, Dysphagia and Atherosclerotic Heart Disease. Per review of the resident's plan of care, it states that the resident has a potential for oral health problem related to poor nutrition. This problem is to be monitored and s/he is dependent on staff for activities of daily living (ADL) care. Interventions include, but not limited to "provide mouth care as per ADL personal hygiene". Per observation on 03/08/16 at approximately 9:48 AM Resident #9 was reclined in a wheelchair at the nurses station with his/her mouth open and with teeth notably caked with tartar buildup and</p>	F 312			

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F 312	Continued From page 23 food residue (pink in color). Per interview with the Unit Manager (UM) on 03/08/16 at approximately 1:30 PM, and examination of Resident #9, confirmation was made that the resident has not had any oral care today.	F 312			
F 314 SS=D	(See F280, F 282 and F 241) 483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to ensure that a resident with a pressure ulcer received all the necessary treatment and services to promote healing for 1 of 2 residents sampled (Resident #3). Findings include: Resident #3 was identified by the facility on 03/08/16 at 9:30 AM as having a pressure ulcer. The Care plan for pressure ulcer development related to poor intake and immobility, directs staff to use barrier cream to be applied with incontinence care, LNA's to monitor skin daily with care and report to nursing any findings, monitor nutritional status, serve diet as ordered,	F 314	F 314 Resident #3 does not have a pressure ulcer Resident #3 has barrier cream applied with incontinence care Residents requiring barrier cream have the potential to be affected Nursing staff has received education on the use of barrier cream with incontinence care Barrier cream audits for incontinent residents will be completed weekly x's 4 then monthly x's 3 to monitor effectiveness of the plan Results of the audits will be reviewed at QAPI for evaluation and further recommendations Oversight: DON or designee Corrective action will be complete by April 9, 2016		

F314 AOC accepted 3/31/16 Simmons RN/PMC

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F 314	Continued From page 24 monitor intake and record, pressure reducing cushion in wheelchair and mattress and to use disposable briefs and change every two hours and as needed. Per observation on 03/08/16 from 9:45 AM - 11:45 AM the resident was noted in bed, supine (on back). At 11:50 AM, two LNA staff were getting the resident out of bed and already dressed. LNAs said "we were going to check [his/her] brief after we got [him/her] up". At that time the nurse surveyor requested permission to look at the resident's skin. When the brief was pulled down, it was noted to be full of stool and a very red coccyx area was noted. During interview at that time, the LNAs stated "we don't put on the barrier cream unless the nurse tells us" and acknowledged that the coccyx area was red at 9:00 AM. The LNAs last checked/changed the brief at 9:00 AM [greater than 2 hours] and stated "I didn't put barrier cream on". The nurse was summoned and stated "I'm not sure if [s/he] is supposed to get cream" and said "check with the UM for an order". The UM confirmed at 12:20 PM on 03/08/16 that the resident didn't received all the necessary treatments to promote healing related to the pressure ulcer.	F 314			
F 323 SS=D	(also see F-282) 483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.	F 323	F323 Resident #10 is monitored per plan of care Resident #11 is monitored per plan of care Resident requiring supervision to prevent accidents have the potential		

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F 323	Continued From page 25 This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview the facility failed to ensure adequate supervision is provided to prevent accidents for 2 of 6 sampled residents (#10 and #11). The findings include the following: 1. Per record review, Resident #10 was admitted on 03/07/13, with diagnoses to include Alzheimer's Disease, Major Depressive Disorder and Dementia with Behavioral Disturbances. Per review of the resident's plan of care, it states that Resident #10 has potential to demonstrate verbal abusive behaviors, repetitive statements and inappropriate touching/groping with staff related to dementia. Interventions included, but not limited to, document observed behaviors. Care plan also identifies that Resident #10 is an elopement risk/wanderer exhibited by impaired safety awareness. Interventions include, but not limited to, monitor location. Per observation on 03/08/16 at 2:20 PM the surveyor was unable to locate Resident #10. Requested the assistance of Licensed Practical Nurse on the unit, who also was unable to locate the resident. On return to the unit the surveyor located the resident in another resident's room attempting to transfer self from bed to wheel chair. A Geriatric Aide removed the resident from the room in his/her wheel chair and relocated Resident #10 to the nurses station (living room space). Surveyor sitting in the living room observed Resident #10, while sitting in the wheelchair relocate self in-front of Resident #3	F 323	to be affected by the alleged deficient practice Nursing staff has received education on following the resident plan of care to ensure adequate supervision. Audits of residents that require monitoring for behaviors will be completed weekly x's 4 then monthly x's 3 to monitor effectiveness of the plan Results of the audits will be reviewed at QAPI for evaluation and further recommendations Oversight: DON or designee Corrective action will be complete by April 9, 2016 <i>F323 POC accepted 3/31/16 SEMINOWS R#1/pme</i>		

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F 323	Continued From page 26 who was also sitting in a wheelchair. Resident #3 had two large glasses of liquids in front of him/her. Resident #10 proceeded to pick up a (what appeared to be), chocolate milk and drink some of the remaining liquid, put the glass down and wheel her/his self away. Per interview with the Unit Manger at 2:50 PM confirmation was made that the resident was not monitored as per care plan indicates. 2. Per record review, Resident #11 was admitted on 02/09/15 with diagnoses to include Dementia with Behavioral Disturbances, Enlarged Prostate, Major Depressive Disorder, Anxiety disorder and Alzheimer's Disease. Per review of Resident #11's written care plan, it identifies that the resident has a potential to demonstrate physical behaviors with a goal to not harm self or others. Interventions include, but not limited to, monitor/document/report to MD of danger to self and others. Per internal investigation dated 01/24/16, Resident #11 walked into another resident's room and was found to have the call light and telephone cord lightly wrapped around his/her arm. The nurse removed the cords, examined the resident and redirected the resident to a different location. Some thirty minutes after the intrusion, the victim made an accusation of being groped. The findings could not be substantiated. Per interview with the Unit Manger and review of Resident #11's care plan confirmation was made that the resident was not monitored as per care plan indicates.	F 323			
F 329 SS=D	(See F 282) 483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS	F 329			

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F 329	<p>Continued From page 27</p> <p>Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.</p> <p>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility failed to ensure that 1 of 17 residents in the sample (Resident #4) was free from unnecessary drugs. Findings Include: Per staff interview and record review, the facility failed to ensure that Resident #4 received the correct narcotic pain medication at the proper dose as ordered by the physician on two occasions and failed to take effective corrective</p>	F 329	<p>F329</p> <p>Resident #4 no longer resides in the facility</p> <p>Resident receiving narcotic pain medication have the potential to be affected by the alleged deficient practice</p> <p>Education has been provided to licensed nurses regarding the 5 rights of medication administration and responsibility regarding medication errors</p> <p>Audits will be conducted as needed with medication errors to ensure corrective actions have been put into place to prevent further errors</p> <p>Results of the audits will be reviewed at QAPI for evaluation and further recommendations</p> <p>Oversight: DON or designee</p> <p>Corrective action will be complete by April 9, 2016</p> <p><i>F329 POC accepted 3/31/16 Stinson R/P/ma</i></p>		

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F 329	<p>Continued From page 28</p> <p>action to ensure that the medication error did not recur after the first overdose was administered. Per record review on 03/08 and 03/09/16, Resident # 4 had diagnoses of chronic pain related to a history of an intraabdominal abscess, decreased mobility, venous ulcers and myelodysplastic syndrome (a bone marrow disorder). On 11/09/16, the resident's physician ordered Morphine Sulfate Extended Release 15 mg (MS ER), give 1 tablet orally every 12 hours for pain and Morphine Sulfate Extended Release 30 mg, give 1 tablet orally every 12 hours for pain (The two tablets were administered together for a total dose of 45 mg every 12 hours). Resident #4 also had orders for Morphine Sulfate 15 mg Immediate Release (MSIR) 1 tablet every 4 hours as needed for pain.</p> <p>Per review of the nursing progress note and incident report dated 11/10/15, during the change of shift narcotic count, it was determined that Resident #4 had been given MSIR 45 mg at 11:00 AM instead of the ordered dose of 15 mg. No further MSIR was given through the 1900 shift and no adverse effect was recorded. Per review of the nursing progress note and incident report dated 11/19/15, it was determined that Resident #4 was administered MSIR 45 mg instead of the scheduled MS ER 45 mg on 11/19/16. The resident's physician was notified and ordered that vital signs and oxygen saturation levels be monitored every 30 minutes for 4 hours and then every hour for 4 hours and if respirations were less than 10 and oxygen saturation less than 90 and the resident could not be awakened, to send to the Emergency Room. Vital signs were taken throughout the night and no adverse effect was recorded.</p>	F 329			

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F 329	Continued From page 29 Per review of the incident reports, nursing notes and staff interviews, there was no evidence provided that an effective corrective action was put in place to ensure that further mix up of the two similarly named but different types of Morphine did not occur following the first medication overdose. On 03/09/16 at 12:33 PM, the facility's Manager of Clinical Operations confirmed the above findings.	F 329			
F 353 SS=E	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. This REQUIREMENT is not met as evidenced by:	F 353	F 353 No resident had a negative outcome as a result of the alleged deficient practice. The Executive Director and the Director of Nursing have reviewed the regulatory requirements for sufficient staffing and are aware of the requirements Facility administration will continue to monitor staffing levels to ensure there is sufficient staff to meet the needs of the residents Audits to include interviews and observation with residents, family, and staff will be conducted 3x weekly x1 month and then weekly x2 months to monitor effectiveness of the plan		

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F 353	<p>Continued From page 30</p> <p>Based on observation and interviews, the facility failed to provide sufficient staffing to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. (including residents #3, #8, #9, #10) Findings include:</p> <ol style="list-style-type: none"> 1. Refer to citation at F282, examples 2, 3, 4 & 5. 2. Per review of staffing records, the facility failed to meet the state-required minimum staffing levels. See F9999. 3. During the survey, on 03/08/16 a resident reported using his/her call light (after breakfast) to obtain assistance for toileting. A staff member responded but said that s/he would return after finishing [picking up breakfast] trays. The resident, who is care planned for fall risk, reported that when the LNA (licensed nursing assistant) did not return, s/he transferred him/herself to the commode and back to bed as s/he could not wait. 4. Per interviews throughout the two day survey, numerous anonymous residents, family members and staff report of facility staffing challenges, high turnover of staff and lack of care related to poor staffing levels. A family member who wished to remain anonymous complained to the survey agency that call lights go unanswered; sometimes it takes as long as 40 minutes to get care. S/he reported that his/her relative called [him/her] at home and s/he would need to call the nursing home to request care. S/he also reported that call light response is poor in the evenings. 	F 353	<p>Results of the audits will be reviewed at QAPI for evaluation and further recommendations</p> <p>Oversight will be done by the Executive Director or Designee</p> <p>Corrective action will be complete by April 9, 2016</p> <p><i>F353 POC accepted 3/31/16 S. Himmelskold/pna</i></p>	

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F 353	Continued From page 31	F 353			
F 356 SS=C	<p>Per interview on 03/09/16, with the Interim Executive Director, acknowledged there are several initiatives to correct the staffing problems such as LNA classes, sign-on bonuses, pay increases. S/he confirmed that the facility was aware of staffing problems.</p> <p>483.30(e) POSTED NURSE STAFFING INFORMATION</p> <p>The facility must post the following information on a daily basis:</p> <ul style="list-style-type: none"> o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: <ul style="list-style-type: none"> - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. <p>The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows:</p> <ul style="list-style-type: none"> o Clear and readable format. o In a prominent place readily accessible to residents and visitors. <p>The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard.</p> <p>The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as</p>	F 356	<p>F 356</p> <p>No residents were affected by this alleged deficient practice</p> <p>Residents residing in the facility have the potential to be affected by the alleged deficient practice</p> <p>Staff responsible to ensure nurse staff information is posted have received education regarding posting the Nurse Staffing Information to include facility name, date, total number and actual hours worked by each category of licensed and unlicensed nursing staff directly responsible for care per shift and census.</p>		

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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		
(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 356	Continued From page 32 required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation the facility failed to post the nurse staffing data as specified on a daily basis at the beginning of each shift. The findings include the following: Per observation by three (3) Registered Nurse (RN) Surveyors, on Tuesday 03/08/16 at 9:13 AM on entrance to the facility, the nurse staffing was posted in the living room adjacent to the administrative offices. The date on the posting was Friday 03/04/16 and did not include the census. Per interview with the Interim Executive Director (ED), at approximately 11:34 AM, informs to the surveyor that the posting is changed daily as required. Surveyor informed the ED that the 3 surveyors observed that the posting at 9:13 AM on entrance, evidence demonstrates that the information had not been updated since last Friday, three days ago.	F 356	Audits of nurse staffing data posting will be conducted daily Results of these audits will be reviewed at QAPI for further evaluation and further recommendation Oversight will be done by the Executive Director or designee Corrective action will be complete by March 9, 2016 <i>F356 POC accepted 3/31/16 SEMMANS 20/1/16</i>		
F9999	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 meet 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	F9999	9999 No residents had a negative outcome as a result of the alleged deficient practice The Executive Director and the Nurse Executive Director have reviewed the regulatory requirements for sufficient staffing and are aware of the requirements		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F9999	<p>Continued From page 33</p> <p>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.</p> <p>This REQUIREMENT is NOT MET as evidenced by:</p> <p>Based on interview and review of facility staffing schedules the facility failed to provide direct care staff (LNAs) to meet 2 hours per resident per day (PPD). Direct care staff provide personal care, assistance with ambulation and feeding etc., but do not assist with meal preparation, physical therapy or the activities program. The findings include the following:</p> <p>Per review of facility staffing schedules for the months of December 2015, January, February and March 2016 (to date), the following PPD's identified that the facility did not meet the LNA requirement.</p> <p>December 2015: Identified that 16 of the 31 days were below the 2.0 PPD for LNA staffing. January 2016: Identified that 4 of the 31 days were below the 2.0 PPD for LNA staffing. February 2016: Identified that 13 of the 29 days were below the 2.0 PPD for LNA staffing. March 2016: Identified that 1 of the 7 days for the month were below the 2.0 PPD for LNA staffing.</p>	F9999	<p>Audits will be conducted 3x weekly to monitor effectiveness of the plan</p> <p>Results of the audits will be reviewed at QAPI for further evaluation and recommendation</p> <p>Oversight will be done by the Executive Director or designee</p> <p>Corrective action will be complete by April 9, 2016</p> <p><i>F9999 POC accepted 3/31/16 SEM/MSD Rd/PRD</i></p>	

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F9999	<p>Continued From page 34</p> <p>Per interview on 03/08 and 03/09/16, with the Interim Executive Director, the Director of Nursing Service (DNS) and the Manger of Clinical Operations, confirmation is made that the above information is correct. Confirmation was also made that the facility developed numerous initiatives to correct the staffing problems to include, limiting admissions to those residents who required hospitalization.</p> <p>Per interview with the Admission Coordinator on 03/09/16 at approximately 11 AM, confirmation was made that residents who had been residing in the facility and hospitalized during the months of January and February 2016 were returned to the facility as requested by hospital discharge coordinators. Admission information also confirms that beginning January 15, 2016 through the month of February 2016, the facility admitted 11 residents who had never resided at the facility.</p> <p>Per interview through out the two day review numerous anonymous staff and family members report of facility staffing challenges, high turnover of good staff and lack of care related to poor staffing levels.</p> <p>See also F353.</p>	F9999			