

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

June 1, 2016

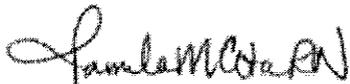
Ms. Ursula Margazano, Administrator
Berlin Health & Rehab Ctr
98 Hospitality Drive
Barre, VT 05641-5360

Dear Ms. Margazano:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **May 17, 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: 05/23/2016
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 05/17/2016
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)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS	F 000		
F 323 SS=D	<p>An unannounced onsite investigation of 5 facility self-reported incidents was conducted by the Division of Licensing and Protection on 5/16/16 - 5/17/16. The following regulatory violations were identified:</p> <p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interview, the facility failed to assure that adequate supervision was provided for one of two applicable residents (Resident #3) to prevent risk for altercation. Findings include:</p> <p>Per record review, Resident #3 has a diagnosis of dementia and has a history of confusion, agitation and physical behaviors. Per nursing progress notes, on 3/22/16 Resident #3 (who resides on B wing) entered Resident # 2's room (on A wing) and pinched Resident #2 on the arm while grabbing a bag of popcorn with the other hand. The two residents were separated and Resident #3 was brought back to the B wing common area.</p> <p>On 3/24/16, Resident #3 was on the A wing when</p>	F 323	<ol style="list-style-type: none"> 1. Resident #3 was assisted back to B wing per plan of care and went into a room that was empty at the time. There was no negative effects as a result of the alleged deficient practice. 2. Residents that do not want other residents in their room have the potential to be affected by the alleged deficient practice. 3. Re-education was done with staff regarding plan of care for resident # 3 and revisions were made. 4. Observation audits will be conducted weekly to monitor effectiveness of the plan 5. Results of the audits will be reported to the QAA committee x3 months for review and further recommendations. 6. Corrective action will be completed by June 3, 2016 7. The Center Nurse Executive or designee will be responsible to monitor the plan 	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *[Signature]* TITLE: Executive Director (X6) DATE: 5/24/16

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 323	<p>Continued From page 1</p> <p>a nurse heard yelling and saw Resident #3 arguing with Resident #4 as s/he tried to enter the Resident #4's room. Resident #3 allegedly grabbed Resident #4's right arm/wrist. The residents were separated and Resident #3 was returned to B wing. The note states "will continue to monitor."</p> <p>On 4/7/16 Resident #3 was on A wing in Resident #5's room, going through Resident #5's clothing. When Resident #5 returned to the room and asked Resident #3 to leave, Resident #3 slapped Resident #5 on the right upper arm. The residents were separated and Resident #3 was returned to B wing. Per 5/16/16 at 1:02 PM interview with the Resident #5, who has a history of mental health issues and paranoia, s/her reported not feeling safe when other residents come in his/her room as she might get hurt telling someone to leave [his/her] stuff alone.</p> <p>Per review of the facility investigation summary following the 4/7/16 resident to resident incident, the Director of Nursing (DNS) wrote that Resident #3 will be assisted after meals back to B-wing and staff will be more mindful of [his/her] location and the resident's care plan was updated.</p> <p>On 5/17/16 at 8:45 AM, Resident #3 was observed in the dining room (DR) eating breakfast. At 8:50 AM, the resident was observed foot paddling her wheelchair out of the DR (unsupervised) and turning in the hall towards B wing. The resident entered the first room s/he encountered (Room #17 which was not his/her room) and was observed rummaging through the other residents' possessions. At 8:55 AM, a staff</p>	F 323	F323 POC accepted 5/31/16 S.Dennis RN/AME	

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F 323	Continued From page 2 nurse was asked if s/he knew where Resident #3 was; the nurse looked in the resident's room (which was empty) and was going to check the DR, when the surveyor directed him/her to Room 17 where Resident #3 was observed about to climb into one of the other resident's beds. The staff nurse redirected Resident #3 to his/her room. At 9:10 AM, the staff nurse reported that another staff member had been assigned to accompany Resident #3 back to his/her room after breakfast and had left the DR to attend a meeting. The nurse confirmed that supervision was not provided to Resident #3 to prevent him/her from entering other resident's rooms and confirmed that when Resident #3 enters other resident rooms without permission, there is a risk for resident to resident altercations.	F 323		
F 514 SS=E	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced	F 514	1. Resident #'s 1, 5, and 6 had no negative effects as a result of the alleged deficient practice 2. Education to be provided to licensed nursing staff regarding the requirement to document medication and treatments administered and required documentation for refusal 3. Audits will be done 5x weekly x1 month and then weekly to	

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F 514	<p>Continued From page 3</p> <p>by: Based on observation, record review and staff interview, the facility failed to maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete and accurately documented for 3 of 7 residents (Resident #6, #1 and #5). Findings include:</p> <p>1. On 5/17/16 at 10:55 AM, the legal guardian of Resident #6 reported that s/he had been told that Resident #6 had refused his/her medication on the preceding Sunday night and was concerned whether the medications had been reoffered; s/he was also concerned that alternative approaches, such as contacting [him/her] to talk to the resident had not been utilized.</p> <p>Per review of the resident's MAR (Medication Administration Record), on 5/15/16 at 2100 (9:00 PM), there was no entry in the MAR or nursing progress notes documenting whether Depakote 500 mg was given as ordered or refused. At 11:15 AM, an A wing staff nurse confirmed the lack of documentation in the record. At 12:15 PM, the facility Director of Nursing (DNS) reported talking to the staff nurse who was on duty on 5/15/16, who stated that the medication was reoffered by another nurse (and again refused) but the refusals were not documented in the medical record. Also, on 5/4 and 5/6/16, there was no entry in the MAR whether Depakote had been administered. Per review of the resident's TAR (Treatment Administration Record), there was missing documentation as to whether the resident's secure care (safety alarm) had been checked on 5/10, 5/11, 5/12, 5/13, 5/14, 5/15 and 5/16/16; the lack of</p>	F 514	<p>monitor the effectiveness of the plan</p> <p>4. The results of the audits will be reported to the QAA committee x3 months for evaluation and further recommendations.</p> <p>5. The Center Nurse Executive or designee will be responsible to monitor the plan</p> <p>6. Corrective action will be completed by June 3, 2016</p> <p><i>F514 POC accepted 5/31/16 EDennis Rd pme</i></p>	

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F 514	<p>Continued From page 4</p> <p>documentation was confirmed by the DNS on 5/17/16 at 10:33 AM.</p> <p>2. The May 2016 MAR for Resident #1 also had missing documentation: there was no documentation that Levothyroxine (a thyroid replacement medication) had been administered on 8 of 17 days or that Pantoprazole (a medication for reflux) was administered on 7 of 17 days in the month. The above lack of documentation was confirmed by a staff nurse on the A wing on the morning of 5/17/16 who reported that the medications were given but not documented.</p> <p>3. Per review of Resident #5's April 2016 TAR, there was no documentation as to whether breast and abdominal fold skin care and Baza cream application had been completed on 7 evening shifts; there was no documentation that TED stockings had been taken off on 7 evening shifts; and no documentation that the resident's secure care was checked on 6 evening shifts and 7 night shifts during the month. The lack of documentation was confirmed by the facility DNS on 5/17/16 T 10:33 AM.</p> <p>Per review, the facility policy, NSG305 Medication Administration: General (revision date 3/15/16), under section Documentation 8.3, states "for medication refused by patient, circle your initials in the date and time space where that medication is ordered, and document patient's refusal of medication on the back of the MAR; under 8.3.1: For electronic Order Management (EOM), document refusal by entering the refusal code on the MAR.</p>	F 514			