

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

May 20, 2016

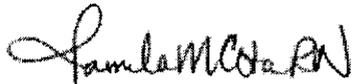
Ms. Ursula Margazano, Administrator
Berlin Health & Rehab Ctr
98 Hospitality Drive
Barre, VT 05641-5360

Dear Ms. Margazano:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **May 4, 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: 05/12/2016
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 R-C 05/04/2016
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}	<p>INITIAL COMMENTS</p> <p>An unannounced onsite revisit for the survey of 3/9/16 was conducted by the Division of Licensing and Protection on 5/4/16. The outstanding findings are as follows:</p> <p>{F 253} 483.15(h)(2) HOUSEKEEPING & SS=E MAINTENANCE SERVICES</p> <p>The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and confirmed by staff interview the facility failed to provide housekeeping services necessary to maintain a sanitary and comfortable interior for 2 of 3 Units, for A and B Wings. The findings include the following:</p> <p>Per facility tour on 5/4/16, in the presence of the Director of Nurses and Director of Health Care Services, multiple resident rooms were found on both units with dirty and soiled privacy curtains. Resident personal wheel chairs, walkers and intravenous poles were found to have accumulated dried food/liquids, dust/debris and soiled cushions. One resident commented "My chair needs cleaning.". A mechanical lift used for multiple residents was found to have accumulated dust and food on the base of the lift. Confirmation was made by both directors during the tour that the equipment needs cleaning.</p> <p>{F 280} 483.20(d)(3), 483.10(k)(2) RIGHT TO SS=D PARTICIPATE PLANNING CARE-REVISE CP</p>	{F 000}	<p>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.</p> <p>F253 483.15(h)(2)</p> <ol style="list-style-type: none"> 1. All identified privacy curtains, wheelchairs, walkers, intravenous poles and mechanical lifts have been cleaned 2. The facility has developed a schedule for routine cleaning the identified items. 3. Education has been provided to staff responsible for ensuring cleanliness of the identified items 4. Audits will be completed 3x weekly x1 month and then weekly x 2 months to monitor effectiveness of the plan 	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE Administrator - Executive Director (X6) DATE 5/18/16

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 listed 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.

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

PRINTED: 05/12/2016
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 R-C 05/04/2016
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 280}	<p>Continued From page 1</p> <p>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.</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 interviews the facility failed to revise a care plan for 1 of 4 applicable residents in the sample. (Resident #9) Findings include:</p> <p>Per record review, Resident #9's current care plan documents that staff are to transfer and complete bed positioning with one staff member to assist. During observation of care on 05/04/16, prior to the noon meal, Resident #9 demonstrated that one staff was unable to meet the needs for safe transfer and positioning in bed. The resident, while being assisted up in bed experienced severe dizziness and nausea. The LNA (licensed nursing assistant) who was holding</p>	{F 280}	<p>5. The results of the audits will be reported to the QAA committee x3 months for review and further recommendations.</p> <p>6. Corrective action will be complete May 24, 2016</p> <p>7. The Executive Director will be responsible for the plan</p> <p><i>F253 POC accepted 5/19/16 mBertrand RN/pmc</i> F280 483.20(d)(3), 483.10(k)(2)</p> <ol style="list-style-type: none"> 1. Resident #9 no longer resides in the facility 2. Residents with decline in transfers and positioning have the potential to be affected by the alleged deficient practice 3. Education has been provided to nursing staff regarding the requirement to revise the plan of care as needed to reflect current needs of the residents with transfers and positioning 4. Audits will be completed 3x weekly x1 month and then weekly x2 months to monitor effectiveness of the plan 	

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

PRINTED: 05/12/2016
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 R-C 05/04/2016	
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 280}	Continued From page 2 up the resident, asked the nurse surveyor to call for the nurse at once. In addition the LNA also requested assistance for bed positioning and to help with care items. The LNA acknowledged that the resident is requiring more assistance. Review of the MDS (minimum data set) of 04/20/16 shows a decline in functioning, especially for transferring, as noted by the need for extensive assistance with two staff. The previous MDS (01/12/16) shows at that time, assistance with one staff. The Unit Manager (UM) stated at 3:09 PM that two staff assistance would meet the need of the Resident #9, who has slowly declined. The UM confirmed the care plan was not revised.	{F 280}	5. The 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 May 24, 2016 7. The Center Nurse Executive will be responsible for the plan <i>FABO POC accepted 5/19/16 mbertrand RN/PMC</i>	
{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, staff interview and record review, the facility failed to implement the plan of care for 1 of 4 residents in the sample (Resident #9). Findings include: Per record review, Resident #9 relies on staff for extensive assist for activities of daily living (ADLs) as well for safety concerns. Per review of the Physical Therapy (PT) care plan as well as the Position Chart posted in the resident's room, they direct staff to keep the bed in the lowest position. Per interview at 1:03 PM, PT acknowledged that	{F 282}	F282 483.20(k)(3)(ii) 1. Resident #9 no longer resides in the facility 2. Residents requiring their bed in low position have the potential to be affected by the alleged deficient practice 3. Education has been provided to staff regarding the requirement to follow plan of care for bed in low position and location of information 4. Audits will be completed 3x weekly x1 month and then weekly x2 months to monitor effectiveness of the plan	

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

PRINTED: 05/12/2016
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 R-C 05/04/2016
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 282}	Continued From page 3 the bed should be in the lowest position at all times when the resident is in bed and not just at night. Per observation from 9:30 AM to 12:10 PM prior to provision of care the bed position was approximately two feet from the floor. At that time the nurse surveyor asked the Licensed Nurse Aide (LNA) to demonstrate the lowest position the bed could accommodate. The LNA was able to lower the bed further. The LNA confirmed the bed was not in the lowest position as care planned.	{F 282}	5. The 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 May 24, 2016 7. The Center Nurse Executive will be responsible for the plan. <i>FABA POC accepted 5/19/16 m Bertrand POC / pme</i>		

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

PRINTED: 05/12/2016
FORM APPROVED
OMB NO. 0938-0894

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 R 05/04/2016
NAME OF PROVIDER OR SUPPLIER BERLIN HEALTH & REHAB CTR			STREET ADDRESS, CITY, STATE, ZIP CODE 88 HOSPITALITY DRIVE BARRE, VT 05641	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
(F 000) (F 371) SS=E	<p>INITIAL COMMENTS</p> <p>An unannounced onsite visit to the survey of 3/30/16 was conducted by the Division of Licensing and Protection on 5/4/16. The outstanding findings are as follows: 483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY</p> <p>The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure that the dietary department prepares food under sanitary conditions. Findings include: Per observation in the presence of the Food Service Supervisor (FSS), the wall posterior to the stove has visible dried/caked on accumulated food. The ceiling fluorescent light covers are found to have dust and debris accumulation. Confirmation was made by the FSS that the wall is dirty, needs attention and is not sure how this was missed. Confirmation was also made that the light covers have been discussed with the administrator, regarding replacing. Per Plan of Correction dated 4/15/16, identifies staff have been educated on the cleaning schedules and</p>	(F 000) (F 371)	<p>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.</p> <p>This plan of correction is prepared and/or executed as required by State and Federal law.</p> <p>F371 483.35(i)</p> <ol style="list-style-type: none"> All identified areas have been addressed, cleaned, and items replaced as needed Re-education was done with dietary staff regarding identified items and cleaning schedules have been reviewed as revised Audits will be completed 3x weekly x1 month and then weekly x2 months to monitor effectiveness of the plan The results of the audits will be reported to the QAA committee x3 months for review and further recommendations. Corrective action will be complete by May 24, 2016 The Executive Director will be responsible for the plan 	

F371 POL accepted 5/19/16 mbertrand R/W Pmc
TITLE _____ (X5) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE
Margaret Administrator - Executive Director 5/18/16

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.

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

PRINTED: 05/11/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 476020	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 05/04/2016
--	--	--	---

NAME OF PROVIDER OR SUPPLIER BERLIN HEALTH & REHAB CTR	STREET ADDRESS, CITY, STATE, ZIP CODE 98 HOSPITALITY DRIVE BARRE, VT 05841
---	--

(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 371}	Continued From page 1 requirements".	{F 371}		
{F 441} 8S=E	<p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS</p> <p>The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p>	{F 441} F441.483.65	<ol style="list-style-type: none"> 1. Resident #1 and #13's nebulizer equipment was replaced 2. Resident #10 had no negative effect from the alleged deficient practice 3. Residents requiring nebulizers and wound care have the potential to be affected by the alleged deficient practice 4. Staff nurse #2 was re-educated and competency completed for correct procedure for wound care 5. A review of correct procedure for wound care has been reviewed with licensed nurses 6. A review of correct storage for nebulizer equipment has been reviewed with licensed nurses 7. Audits will be completed 2x weekly x1 month and then weekly x2 months 8. Results of the audits will be reported at the QAA committee x3 months for review and further recommendations 	

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

PRINTED: 05/11/2018
FORM APPROVED
OMB NO: 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 476020	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 05/04/2018
--	--	--	---

NAME OF PROVIDER OR SUPPLIER BERLIN HEALTH & REHAB CTR	STREET ADDRESS, CITY, STATE, ZIP CODE 88 HOSPITALITY DRIVE BARRE, VT 05841
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVICER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

(F 441)	Continued From page 2 This REQUIREMENT is not met as evidenced by: Based on observation and interview the facility failed to ensure that the Infection Control program was maintained to prevent the spread and transmission of disease on A and B Wings. For Residents # 1, #13 and #10. The findings include the following: 1. Per observation at 12:34 PM, Resident #1's bedside table was found to have nebulizer compressor resting on the surface. A mask connected to the medication dispenser was hanging unprotected from the compressor connection. Per Plan of Correction dated 4/16/16 identifies that staff have been educated on the storage of nebulizer equipment. Confirmation was made by the Licensed Practical Nurse that the resident received his/her treatment at 6 AM and the equipment should be stored in a plastic bag. 2. Per observation at 11:10 AM, Resident #13's bedside table was found to have a nebulizer compressor resting on the surface. A hand held medication dispenser connected to a T piece with a mouth piece, was resting unprotected on a cluttered bedside table. Per Plan of Correction dated 4/16/16 identifies that staff have been educated on the storage of nebulizer equipment. Confirmation was made by the Licensed Practical Nurse that the resident received his/her treatment at 8 AM and the equipment should be stored in a plastic bag. 3. Per observation on 5/4/16 at 2:20 PM, nursing	(F 441)	9. Corrective action will be completed by May 24, 2016 10. The Center Nurse Executive will be responsible for the plan <i>F441 POC accepted 5/19/16 MBE/mandi RN/PMU</i>	
---------	---	---------	--	--

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

PRINTED: 05/11/2016
FORM APPROVED
OMB NO. 0938-0381

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 R 05/04/2016
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 441}	<p>Continued From page 3</p> <p>staff failed to follow infection control practices during a wound dressing change. Resident #10 had an open skin tear on his/her left forearm. At the time of the observation, the old dressing had loosened and was stained with moist blood. Staff Nurse #1 gathered supplies and placed unwrapped 4x4 gauze and other supplies directly on the resident's bureau without cleaning the surface or setting up a clean barrier (there was no bedside table in the room). Staff Nurse #2 sanitized his/her hands, gloved and removed the blood soiled dressing. S/he removed the soiled gloves (but did not resanitize his/her hands), donned new gloves, and cleansed the open, moist wound with the 4x4 gauze that had been on the bureau and NS (normal saline). Nurse #1 brought a cup with additional gauze pads to the room; Nurse #2 pulled a 4x4 from the cup and pushed down on the extra 4x4s (so they would remain in the cup) with the soiled gloves. Nurse #2 continued to wear the soiled gloves to apply a clean dressing, wrap the wound with kling (rolled gauze) and tape it in place. After the wound care was completed, the leftover kling, 4x4 pads and roll of tape that had been touched by the contaminated gloves were placed in the resident's bureau drawer and not discarded.</p> <p>Following the procedure, Staff Nurse #2 confirmed the above observations and that infection control measures to avoid contamination of dressing materials had not been followed during the procedure. On 5/4/16 at 3:00 PM, the facility policy, Wound Dressing; Aseptic (revision 11/30/15) was reviewed with the Director of Nursing (DNS). Per the policy, Step #4 states to "Clean overbed table;" while #5 states "Place clean barrier on the over-bed table and place supplies on the barrier". Following the removal of</p>	{F 441}		

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

PRINTED: 05/11/2016
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 R 05/04/2016
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 441}	Continued From page 4 a soiled dressing and prior to cleansing a wound, Step #17 states to "Cleanse hands" and step #18 states to "Apply gloves." After cleansing the wound, Step #21.1 states "If gloves become contaminated, remove gloves, cleanse hands, and apply clean gloves." Step #28. states to "Discard supplies according to infection control procedure." The DNS confirmed that per review of the procedure, infection control practices had not been followed; s/he stated that the remaining contaminated supplies in the resident's room would be discarded.	{F 441}		
{F 465} SS=E	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview the facility failed to ensure that a safe environment was provided for residents, staff and the public. Findings include: Per observation on 5/4/16 of the storage room located on the central hallway that connects C Wing to the dining room, it was found unattended and the door was wide open. This hall is used by residents, visitors and staff. The room stores several gallon jugs of Lime Away, Bio cleaner and containers of ECOLAB Solitaire concentrated solid detergent as well as an electrical panel. A passing housekeeper voluntarily shared with the State Surveyor that the door has been open and	{F 465}	F465 483.70(h) 1. The storage room identified has had an auto-closure device installed and is auto-locking. 2. Re-education has been provided to dietary staff to ensure the door shuts when they leave the room. 3. Audits will be completed 3x weekly x1 month and then weekly x3 months to monitor effectiveness of the plan 4. Results of the audits will be reported to the QAA committee x3 months for review and further recommendations 5. Corrective action will be complete by May 24, 2016 6. The Executive Director will be responsible for the plan	

F465 POC accepted 5/19/16 mBertrand R/PME

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

PRINTED: 05/11/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 476020	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 05/04/2016
--	--	--	---

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 465}	Continued From page 5 unattended for the last 15 minutes. At 2:45 PM confirmation was made by the Food Service Director, Maintenance Staff and the Director of Nurses that the door was open and unattended placing wandering residents at risk. Plan of Correction dated 4/15/16 identifies that education was provided to the dietary staff (who utilize the storage room) regarding the requirements to ensure the safe storage of chemicals.	{F 465}		
---------	---	---------	--	--