

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 19, 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 30, 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: 04/07/2016  
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 03/30/2016
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  An unannounced on-site recertification survey was conducted by the Division of Licensing and Protection on 3/28/16-3/30/16. There were regulatory findings.	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 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY  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  This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure that food was prepared, distributed, and stored under sanitary conditions. Findings include:  1. Per observation on 3/28/16 at 9:40 AM, during the initial tour of the kitchen, the floors appeared to be soiled with spilled dried liquids, dirty footprints, food scraps, and a generally dirty appearance. Per interview with the cook on duty, the floors are supposed to be swept and mopped every night by the kitchen staff, and also receive a deep cleaning periodically by the housekeeping department. Also observed at this time was the hood panel behind the stove with a layer of dusty grease accumulated on it. Per interview on 3/28/16 at 10:25 AM, the District Supervisor of	F 371	F371 483.35(i)  1. No residents were negatively affected by this alleged deficient practice 2. Residents residing in the facility have the potential to be affected by this alleged deficient practice. 3. Identified areas in the kitchen were cleaned. 4. Education provided to dietary staff regarding cleaning schedule and requirements 5. Audits will be completed weekly x1 month then monthly by the dietary director or designee to monitor effectiveness of the plan. 6. Results of the audits will be reported to the QAA committee x3 months for further evaluation and recommendations 7. Corrective action to be completed by 4/15/2016	

*F371 POC accepted 4/14/16 DWD/awake/rlf/pme*

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  
*Kim Campbell* TITLE *Executive Director* DATE *4/12/16*

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 371	Continued From page 1 Food Services confirmed that the floors were excessively dirty, and that they did not appear to have been mopped over night. Also at this time he/she confirmed that the hood panel behind the stove had an accumulation of dust and grease, and that the schedule for cleaning this would be reviewed and adjusted to more frequent cleanings as necessary.  2. Per observation on 3/28/16 of the Main Dining room refrigerator, a multi-use plastic container with jelly was noted to have the dates, 3/7/16 good through 3/14/16. A non-labeled white liquid substance (with the likeness of tartar sauce) was noted to have a removal date of 3/19/16. Per interview on 3/28/16 at 11:50 AM, the Dietary Aide and Administrator in Training confirmed that the jelly and white liquid substance were outdated and should be removed. At 12:31 PM, the Food Service Supervisor confirmed the products were outdated and removed them after the surveyor had brought this information to his/her attention.	F 371		
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS  The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.  Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary	F 431	F431 483.60(b), (d), (e)  1. No residents were negatively affected by this alleged deficient practice. 2. Residents receiving TB testing and Influenza vaccine have the potential to be affected by the alleged deficient practice. 3. The identified medication was disposed of. 4. Education provided to licensed nurses regarding policy for drug storage.	

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F 431	<p>Continued From page 2</p> <p>instructions, and the expiration date when applicable.</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and staff interview the facility failed to ensure that controlled substances were accounted for on one unit and that medications were properly labeled on two units. Findings include:</p> <p>1. During observation of medication storage on 3/29/16 at 9:06 AM, the refrigerator on C Wing Unit contained an unlabeled black box with a padlock on it. The Registered Nurse (RN) Unit Manager (UM) was asked what was contained in the box and s/he replied that s/he thought that it was empty. The RN didn't think there was a key and s/he asked another RN, on the unit, who also stated that s/he didn't believe that there was anything in the box. The Manager of Clinical</p>	F 431	<p>5. Audits will be completed weekly by the Director of Nursing or designee to monitor effectiveness of the plan.</p> <p>6. Results of the audits will be reported to the QAA committee x 3 months for evaluation and further recommendations</p> <p>7. Corrective action to be complete 4/15/16</p> <p><i>F431 POC accepted 4/14/16 Dwidawaka RN/ptme</i></p>

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F 431	<p>Continued From page 3</p> <p>(MCO) Operations stated that there had to be a key. The UM located the key and unlocked the box. The box contained two (2) brown plastic bags that were labeled for two different residents. Per the MCO and the UM, neither of the residents reside at the facility and they were unsure how long ago they were discharged. One of the bags contained eight (8) multi-dose vials of Ativan (medication used for anxiety) 2mg [milligram]/ml [milliliter] and the other bag contained ten (10) multi-dose vials of Ativan 2mg/ml. At 9:10 AM per the DON the expectation was that the Ativan should have been counted every shift as all controlled medications. The UM reviewed the control substance count record and confirmed that there was no evidence that these vials were being accounted for.</p> <p>2. During observation of C Wing's medication storage room on 3/29/16, the refrigerator contained an opened multi-dose vial of Influenza vaccine. There was no evidence as to when it was opened or last used. The UM confirmed that the vial did not indicate when it was open and that it was not labeled according to expectations and it should be discarded.</p> <p>3. Per observation on 3/29/16, the Medication storage room refrigerator contained a vial of Tuberculin Protein Derivative used for testing staff and residents for Tuberculosis exposure. The vial was opened, and the contents partially gone, and there was no label to indicate when it had been opened. Per the Manufacturer's recommendation, an open vial is supposed to be discarded after 30 days in use. Per interview on 3/29/16 at 9:40 AM, the Unit Manager confirmed that the vial had been opened, and that there was no date of opening written on the bottle or the box</p>	F 431	

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F 431	Continued From page 4 it came in.	F 431		
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS  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.  (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.  (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.  (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.	F 441  F441 483.65	<ol style="list-style-type: none"> <li>No residents were negatively affected by this alleged deficient practice.</li> <li>Residents requiring the use of oxygen and nebulizer treatments have the potential to be affected.</li> <li>Education provided to licensed nurses regarding the policy for oxygen and nebulizer equipment cleaning and storage.</li> <li>The cleaning schedule for oxygen concentrators has been reviewed and revised and education provided to those responsible for cleaning.</li> <li>Audits will be completed weekly by the Director of Nursing or designee to monitor effectiveness of the plan.</li> <li>Results of the audits will be reported to the QAA committee x3 months for evaluation and further recommendations</li> <li>Corrective action will be completed by 4/15/16</li> </ol>	

*F441 PDC accepted 4/14/16 DvrbeawakeR/pme*

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F 441 Continued From page 5

F 441

This REQUIREMENT is not met as evidenced by:  
Based on observation and interview the facility failed to ensure that the Infection Control program is designed to provide a safe, sanitary and comfortable environment to prevent the transmission of disease and Infection. Findings include:

Per observation during the three days of survey 3/28, 3/29 and 3/30/2016, oxygen and nebulizer equipment, to include oxygen tubing, nasal cannulas and masks, were found on all three Units to be left uncovered and unprotected in resident rooms stored on bedside tables, resting on chairs and lying across a resident's bed. Oxygen concentrators were also found with an accumulation of dust and debris.  
Per facility tour on 3/30/16 at 9:41 AM in the presence of the Clinical Operation Manager, confirmation was made that the oxygen equipment was not stored properly to avoid cross contamination and protection; and the concentrators needed cleaning. Confirmation was also made that the facility does not have a policy on the management of oxygen equipment in-between use.

F 465 483.70(h)  
SS=E SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON

The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.

F 465 F465 483.70(h)

1. No residents were negatively affected by this alleged deficient practice.
2. Residents that walk in the hallway unattended have the potential to be affected by this alleged deficient practice.

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F 465 Continued From page 6

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 public. Findings include:

During the initial tour there was a storage room on the hallway that connects the C Wing Unit with activities, therapy, laundry, and dietary. The hallway was used by residents, visitors and staff; it also contained the Minimum Data Set (MDS) office and housekeeping. A storage door was found to be unlocked at 9:55 AM and it contained several gallon jugs of Lime Away, Ble cleaner and containers of ECOLAB Solitaire concentrated solid detergent. There was also an electrical panel. An employee that works in laundry confirmed at 9:55 AM that the door was not locked and that it was a closet used by dietary. The dietary assistant food manager confirmed on 3/28/16 at 10:09 AM that the storage closet was used for dietary and that the door was not locked and further confirmed that chemicals are stored there and the door should be locked. At 3:20 PM there was an unattended resident walking in the hallway that was touching doors and turning door handles. Per the Licensed Practical Nurse, (MDS) clinical reimbursement coordinator, there were often residents that walk unattended in the hall. Several staff members and visitors were also observed using the hall to get to C Wing.

F 485

3. The door knob was replaced on the identified closet door on day 1 of the survey. The new door knob consists of an automatic locking mechanism.
4. Education provided to dietary staff regarding the requirements to ensure safe storage of chemicals.
5. Audits will be conducted weekly x1 month then monthly by the Administrator or designee to monitor effectiveness of the plan.
6. The results of the audits will be reported to the QAA committee x3 months for evaluation and further recommendations.
7. Corrective action to be completed by 4/15/16.

*F465 POC accepted 4/14/16 DM [signature]*