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 3, 2018

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 **March 8, 2018**. 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	475020	A. BUILDING _____ B. WING _____	C 03/08/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BERLIN HEALTH & REHAB CTR	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 An unannounced, on-site investigation of 7 self reported events and 3 complaints was conducted by the Division of Licensing and Protection between 3/7-8/2018. The following regulatory issues were identified. The specifics are detailed below:	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. The plan of correction is prepared and/or executed as required by State and Federal law.**	
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.	F 609	1. Resident #1, 2, 3, 4, 5, and 8 had no negative effects as a result of the alleged deficient practice. 2. Residents involved in reported allegations of abuse have the potential to be affected by the alleged deficient practice. 3. Education will be provided to nursing staff re timely reporting of allegations of abuse. 4. Audits will be conducted weekly X 4 then monthly X 3 by the CED or designee to monitor effectiveness of the interventions.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

Executive Director 3/28/18

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 609	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to report allegations involving abuse to the State Survey Agency within the required time frame of 2 hours for 6 of 11 applicable residents (Resident #1, Resident #2, Resident#3, Resident #4, Resident #5, and Resident#8). Findings include: Per record review the facility reported an allegation of staff to resident abuse to the State Survey Agency on 12/17/17 at 10:41 AM for Resident#5 and Resident#8. Per review of the facility investigation, the incident occurred at 2345 on 12/16/17. Per interview on 3/7/18 at 3:19 PM with the Director of Nursing (DNS), s/he confirmed that the facility did not report the allegation of staff to resident abuse to the State Survey Agency timely. Per record review the facility reported an allegation of staff to resident abuse to the State Survey Agency on 11/30/17 for Resident#1, Resident#2, Resident#3, and Resident#4. Per review of the facility investigation, the incident occurred on 11/28/17. Per interview on 3/8/18 at 10:58 AM with the DNS, s/he confirmed that the incident was not reported to the State Survey Agency timely.	F 609	5. Results of the audits will be reported to the QAPI committee at which time the committee will evaluate and make recommendations as needed. 6. Corrective action to be completed by 4/9/18 F609 POC accepted 4/3/18 LLovell RN/Pmc	
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment.	F 657		

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F 657	Continued From page 2 (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on resident and staff interviews as well as medical record reviews, the facility failed to ensure that the plan of care for 1 of 18 residents (#12) was revised to reflect necessary care and services. Findings include: Per medical record review, Resident #12 was admitted to the facility 9/1/17, with diagnoses that include being legally blind. On 2 separate occasions, Resident #12 has been involved in resident to resident exchanges, including being the alleged victim. During a resident interview on 3/8/18 at 10:49AM, Resident #12 did express	F 657	1. Resident #12 had no negative effects as a result of the alleged deficient practice. Resident #12 care plan has been revised to reflect risk of becoming a victim. 2. Residents involved in resident to resident exchanges, including being the alleged victim have the potential to be affected by the alleged deficient practice. 3. Education will be provided to nursing and social service staff re revision of care plan to reflect the psychosocial needs of the resident related to the incident. 4. Audits will be conducted weekly X 4 then monthly X 3 by the CNE or designee to monitor effectiveness of the interventions.	

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F 657	Continued From page 3 concern for his/her safety, because s/he has limited vision. The care plan has not been revised to reflect the psychosocial needs of this resident related to these incidents. Per the nurse unit manager previously the Director of Nursing (DNS) was charged with updating care plans on resident to resident incidents, however, the new DNS has not taken over those duties. This was confirmed by the administrator, the unit manager and the social worker on 3/8/18.	F 657	5. Results of the audits will be reported to the QAPI committee at which time the committee will evaluate and make recommendations as needed. 6. Corrective action to be completed by 4/9/18	
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on medical record review, observations and staff interviews the facility failed to provide the necessary treatment and services to prevent new pressure ulcers from developing for 1 of 2 residents in the applicable sample (Resident # 16). The specifics are detailed below: Per medical record review, Resident # 16 was admitted to the facility in Nov. 2017 with no skin	F 686	F657 POC accepted 4/3/18 LLovell RN/PMC	

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F 686	Continued From page 4 issues. The documentation from the transferring facility indicated that Resident # 16 was at high risk for the development of pressure ulcers r/t decreased mobility and a previous history of ulcers. On 12/01/2017 the staff identified that the resident had reddened heels with unstageable areas on his/her heels. The care plan was revised to include "off-loading" his/ her feet while in bed. Non-individualized care planning had been in place prior to this to cue staff to care for a resident at risk for development of skin issues, but not until actual skin breakdown occurred, in early February 2018, did the staff institute different, more individualized approaches to manage skin breakdown. On 2/08/2018, a low pressure air mattress was ordered and placed on Resident # 16's bed. This is confirmed, during interview with the unit nurse, on 3/08/2018 at 3:00 PM. According to the DNS (Director of Nursing), during interview on 3/8/3018 at 4:11 PM, the 'off-loading' for Resident # 16's feet when in bed, created new areas on the coccyx and buttocks as his/her weight shifted. The DNS confirms during interview on 3/08/2018 that skin breakdown issues did develop in a resident who had been assessed as being a high risk for that problem.	F 686	1. Resident #16 treatment/service was reviewed and revised. 2. Residents at high risk for pressure ulcers have the potential to be affected by the alleged deficient practice. 3. Education will be provided to nursing staff re skin checks / assessments including interventions for high risk patients and new admissions. 4. Audits will be conducted weekly X 4 then monthly X 3 by the CNE or designee to monitor effectiveness of the interventions. 5. Results of the audits will be reported to the QAPI committee at which time the committee will evaluate and make recommendations as needed. 6. Corrective action to be completed by 4/9/18 F686 POC accepted 4/3/18 LLovell RN/PMC	
F 745 SS=E	Provision of Medically Related Social Service CFR(s): 483.40(d) §483.40(d) The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on staff interviews and record review the facility failed to ensure that residents receive	F 745		

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F 745	Continued From page 5 social services to attain or maintain the highest practicable physical, mental and psychosocial well-being for 7 of 18 applicable residents (Resident #1, Resident #2, Resident #3, Resident #4, Resident #5, Resident #6, and Resident #8). Findings include: Per review of the facility reported incidents, on 10/10/17 there was an allegation of a resident to resident altercation between Resident #6 and Resident #7. On 11/28/17, there was an incident of potential staff to resident abuse affecting Resident #1, Resident #2, Resident #3, and Resident #4. On 12/16/17, there was an incident of potential staff to resident abuse affecting Resident #5 and Resident #8. Per record review for Resident #1, Resident #2, Resident #3, Resident #4, Resident #5, Resident #6, and Resident #8 there was no evidence that each of these Residents were assessed and/or monitored by a social worker after the incidents of alleged abuse. Per interview on 3/8/18 at 4:37 PM with the Director of Social Work, s/he confirmed that there was no follow up from social work for each of the above Residents' after the alleged incidents of abuse.	F 745	1. Resident #1, 2, 3, 4, 5, 6, and 8 had no noted adverse effects related to the alleged deficient practice. Resident # 6 no longer at the center resident # 1, 2, 3, 4, 5, and 8 received a psychosocial well-being check by social work with results documented in record. 2. Residents involved in resident to resident exchanges, including being the alleged victim have the potential to be affected by the alleged deficient practice. 3. Education will be provided to social service staff regarding review/documentation of support to maintain the highest practicable psychosocial well-being of each resident related to residents in resident to resident exchanges, including being the alleged victim.	

See next page

F745 cont

4. Audits will be conducted weekly X 4 then monthly X 3 by the CED or designee to monitor effectiveness of the plan.
5. Results of the audits will be reported to the QAPI committee at which time the committee will evaluate and make recommendations as needed.
6. Corrective action to be completed by 4/9/18

F745 POC accepted 4/3/18 CLovell RN/PM