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 30, 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 **April 11, 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

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 _____	04/11/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BERLIN HEALTH & REHAB CTR	98 HOSPITALITY DRIVE BARRE, VT 05641

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E 000	Initial Comments An unannounced onsite Emergency Preparedness survey was completed by the Division of Licensing and Protection on 4/11/18. The facility was found in substantial compliance with the regulations.	E 000		
F 000	INITIAL COMMENTS An unannounced, onsite Recertification survey was completed by the Division of Licensing and Protection from 4/9/18-4/11/18. The following regulatory violations were identified.	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 636 SS=D	Comprehensive Assessments & Timing CFR(s): 483.20(b)(1)(2)(i)(iii) §483.20 Resident Assessment The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. §483.20(b) Comprehensive Assessments §483.20(b)(1) Resident Assessment Instrument. A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following: (i) Identification and demographic information (ii) Customary routine. (iii) Cognitive patterns. (iv) Communication. (v) Vision. (vi) Mood and behavior patterns. (vii) Psychological well-being. (viii) Physical functioning and structural problems. (ix) Continence.	F 636	F636 1. Resident #52 MDS modified and #55 MDS modified and dental CAA created. Corrected / modified MDSs were submitted. 2. No residents were harmed by this alleged deficient practice. Residents exhibiting behaviors and residents with dental complication have the potential to be affected by the alleged deficient practice.	

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

Center Executive Director 4/25/18

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 636	Continued From page 1 (x) Disease diagnosis and health conditions. (xi) Dental and nutritional status. (xii) Skin Conditions. (xiii) Activity pursuit. (xiv) Medications. (xv) Special treatments and procedures. (xvi) Discharge planning. (xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS). (xviii) Documentation of participation in assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and nonlicensed direct care staff members on all shifts. §483.20(b)(2) When required. Subject to the timeframes prescribed in §413.343(b) of this chapter, a facility must conduct a comprehensive assessment of a resident in accordance with the timeframes specified in paragraphs (b)(2)(i) through (iii) of this section. The timeframes prescribed in §413.343(b) of this chapter do not apply to CAHs. (i) Within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. (For purposes of this section, "readmission" means a return to the facility following a temporary absence for hospitalization or therapeutic leave.) (iii)Not less than once every 12 months. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to assure the accuracy of the comprehensive assessments for two of 21	F 636	3. CNE, NPE and/or designee will provide education to nurses regarding accurate and complete dental assessment. Education will also be given to nurses & LNAs regarding the importance of capturing resistance to planned care and verbal resistance including hollering at staff in their documentations. 4. Audits will be conducted weekly X 4 then monthly X 3 by the CNE 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 May 9, 2018. F636 POC accepted 4/27/18 JHemerkN/PMC	

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F 636	Continued From page 2 residents in the sample (Resident #52 and Resident #55). Findings include: 1). Per record review Resident #52 has exhibited the behavior of resistance to care. Per staff interview the resident has refused a shower for approximately the past two months and also refuses a clothing change. The MDS (Minimum Data Set) assessments for this resident dated 3/9/18 and 12/8/17 code the resident as "behavior not exhibited" for Verbal behavioral symptoms directed toward others (eg. threatening others, screaming at others, cursing at others) and Resistance to evaluation and care. In an interview on 4/11/18 at 1:45 PM the Social Worker confirmed that s/he had completed the Behavior section of the MDS assessment and is aware of the resident's increasing resistance to care and history of hollering at staff. 2). Per interview on 4/9/18 Resident #55 states that s/he has 5 remaining teeth and would like to have dentures. Upon observation, discolored teeth and many missing teeth are noted. The Admission MDS codes the Dental section of the assessment as having none of the listed dental issues present. In interview on 4/11/18, the MDS Coordinator stated that the MDS was coded based on the automatic carry over from the nursing admission assessment.	F 636		
F 645 SS=D	PASARR Screening for MD & ID CFR(s): 483.20(k)(1)-(3) §483.20(k) Preadmission Screening for individuals with a mental disorder and individuals with intellectual disability. §483.20(k)(1) A nursing facility must not admit, on	F 645		

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F 645	Continued From page 3 or after January 1, 1989, any new residents with: (i) Mental disorder as defined in paragraph (k)(3)(i) of this section, unless the State mental health authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission, (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services; or (ii) Intellectual disability, as defined in paragraph (k)(3)(ii) of this section, unless the State intellectual disability or developmental disability authority has determined prior to admission- (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services for intellectual disability. §483.20(k)(2) Exceptions. For purposes of this section- (i)The preadmission screening program under paragraph(k)(1) of this section need not provide for determinations in the case of the readmission to a nursing facility of an individual who, after being admitted to the nursing facility, was transferred for care in a hospital. (ii) The State may choose not to apply the preadmission screening program under paragraph (k)(1) of this section to the admission to a nursing facility of an individual-	F 645	F645 1. Resident #47 and #72 PASRRs reviewed, updated and resubmitted. 2. No residents were harmed by this alleged deficient practice. Residents that are newly admitted and re-admitted have the potential to be affected by the alleged deficient practice. 3. CED and/or designee will provide education to Social Svcs and Admissions related to requirements for PASRR. 4. Audits will be conducted weekly X 4 then monthly X 3 by the CNE or designee to monitor effectiveness of the plan.	

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F 645	Continued From page 4 (A) Who is admitted to the facility directly from a hospital after receiving acute inpatient care at the hospital, (B) Who requires nursing facility services for the condition for which the individual received care in the hospital, and (C) Whose attending physician has certified, before admission to the facility that the individual is likely to require less than 30 days of nursing facility services. §483.20(k)(3) Definition. For purposes of this section- (i) An individual is considered to have a mental disorder if the individual has a serious mental disorder defined in 483.102(b)(1). (ii) An individual is considered to have an intellectual disability if the individual has an intellectual disability as defined in §483.102(b)(3) or is a person with a related condition as described in 435.1010 of this chapter. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interviews, the facility failed to complete a Pre Admission Screening (PASARR) for 2 of 21 residents (# 47 and # 72), who may have been eligible for additional services based on their diagnosis. The specifics are detailed below: 1. Per record review, Resident # 47 was discharged from the facility on 1/19/2017 and re-admitted on 2/08/2017. Despite having qualifying mental health diagnoses, a PASARR was not completed for Resident #47; the screening would have determined whether the state should review the case for potential service determination. The social worker confirmed during interview on 4/11/2018 in the early	F 645	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 May 9, 2018. F645 POC accepted 4/27/18 JHosmer RN/PMC	

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F 656	Continued From page 6 (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility failed to assure the development of a comprehensive person-centered care plan for 1 of 21 residents sampled (Resident #55) regarding dental services. Findings include: 1). Per resident interview on 4/9/18, Resident #55 states that s/he has only 5 teeth and that s/he would like to have dentures. Per observation at that time, the resident exhibits discolored teeth and many missing teeth. There is no dental care plan found in the record. In an interview on 4/10/18 the Unit Manager confirmed that s/he was unaware of the resident's desire for dentures and that a dental care plan was not present.	F 656	F656 1. Resident # 55 CP was developed re dental care. Resident #55 was seen by dentist on 4/18/18. 2. No residents were harmed by this alleged deficient practice. Residents with dental care concerns have the potential to be affected by the alleged deficient practice. 3. CNE, NPE and/or designee will be provided education related to Care Plans re dental concerns. 4. Audits will be conducted weekly X 4 then monthly X 3 by the CNE 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 May 9, 2018	
F 657	Care Plan Timing and Revision	F 657	F656 POC accepted 4/27/18 JHosmer RN/PMC	

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F 645	Continued From page 5 afternoon, that screening was not completed for a resident with qualifying mental health issues who would be receiving long term care at the facility. 2. Per medical record review, Resident #72 had a 30-day exemption PASARR, dated 4/12/17. When it was determined that Resident #72 would remain in long term care, and after the 30 days had lapsed, the facility failed to complete a Level 1 PASARR screening for the change to long term care status. The Director of Social Services confirmed during an interview on 4/11/18 at 2:00 PM, that no PASARR screening was completed after the 30-day exemption document lapsed.	F 645		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6).	F 656		

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F 657 SS=E	Continued From page 7 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. (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 interviews with residents and/or their representative and with staff, and record review, the facility failed to provide evidence of interdisciplinary team input to the periodic care plan meeting, to include at least the physician, a registered nurse (RN) and a nurse aid (LNA) who have responsibility for care of the resident, and a member of food and nutrition services. This	F 657	1. Resident #44, 46, 47, 54, 58, 65, 72, and 87 had no negative impact. 2. Residents with scheduled Care Plan meetings have the potential to be affected by the alleged deficient practice. 3. The center has developed a process to better include the interdisciplinary team in preparing the comprehensive plan of care. Education regarding person centered care planning provided to the interdisciplinary care plan team. 4. Audits will be conducted weekly X 4 then monthly X 3 by the CNE 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 May 9, 2018. F657 POC accepted 4/27/18 JHorman RN/QMC	

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F 657	Continued From page 8 deficiency applied to 7 of 21 residents in the sample (Residents #44, 46, 47, 54, 58, 65, 87). Findings include: 1. Per record review, Resident #44 had an annual care plan review in September 2017. Per documentation of the quarterly care plan review meetings on 12/7/17 and 3/6/18, the only participating team members were the Social Worker and a nurse from the unit, as well as a family member. Per interview on 4/10/18 at 3:40 PM, the Social Worker confirmed that there was no evidence that the entire IDT had participated in the care planning process. 2. The representative of Resident #46 expressed concern at having only a telephone conversation with one social worker during a care plan meeting. Per record review, there was a telephone care plan meeting with one social worker on 3/13/18; this was also confirmed by interview with the social worker at approximately 10:00 AM on 4/11/18. The facility failed to provide evidence that required members of the interdisciplinary team (physician, RN, LNA, and nutrition services) had given input to the quarterly care plan process for Resident #46 prior to the meeting on 3/13/18. 3. Per medical record review, Resident #47 has neither a care plan including input from LNAs, nor any evidence to support that LNAs attend care plan meetings. Two (2) LNAs report during interviews on 4/11/2018 that they do not attend care plan meetings. 4. Per record review, Resident #54 had quarterly care plan review meetings on 12/28/17 and again on 3/29/18. Per review of the progress notes ,	F 657		

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F 657	Continued From page 9	F 657		

there was no documentation in the medical record of the care plan meeting on 3/29/18. The meeting attendance for the quarterly review in December 2017 did not include all members of the IDT, only a nurse and the Social Worker. Per interview on 4/11/18 at 4:34 PM, the Social Worker confirmed that they had not written a note in the record to document the care plan meeting on 3/29/18, and still had the notes in a word document in their computer. The SW also confirmed at this time that besides a family member, the only attendees of these two quarterly care plan reviews were nursing and social services.

5. Per medical record review, Resident #58 had a note dated 3/16/18 indicating that the resident and his/her sister were invited to a care plan meeting scheduled for 4/3/18 at 11 AM. However, there was no documentation to reflect that the meeting had actually been held and who was in attendance. On 4/11/18 at 4:08 PM in an interview with the Social Worker (SW) s/he reported that s/he failed to document the meeting in the record; s/he further reported that the only attendees were the resident's brother and sister and the SW. There were no other members of the Interdisciplinary Team (IDT) present and no evidence that they provided any input into the quarterly care plan process.

6. Per medical record review, Resident #65 had a quarterly care plan meeting on 1/23/18. The meeting attendance record identified that the resident, the Social Worker (SW) and the Unit Manager [who is a Licensed Practical Nurse (LPN)] were present. The facility failed to provide evidence that required members of the interdisciplinary team (IDT) (physician, RN, LNA,

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F 657	Continued From page 10 and nutrition services) had given input to the quarterly care plan process for Resident #65 prior to the meeting. The SW confirmed on 4/11/18 at 10:53 AM that there were no other members of the IDT present, and that input from them was not documented. 7. Per record review, Resident #87 had a quarterly care plan meeting held on 2/14/18. The staff listed as attending the meeting were a nurse and the Social Worker. Per interview on 4/11/18 at 4:25 PM, the SW confirmed that there was no documented input by the entire IDT members to evaluate the care plan.	F 657		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) 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 interviews and record review, the facility failed to assure the provision of Activities of Daily Living (ADL) assistance to maintain personal hygiene to one of 21 sampled residents (Resident #76) who depend on staff for the task. Findings include: Per interview on 4/9/18 at 2:52 PM, Resident #76 stated "I should have a shower every week and I've only had 2 since I got here." Per record review the resident had 2 showers in the period between 3/22/18 and 4/1/18. The showers are scheduled to be done on the evening shift. The 3/27/18 MDS assessment (Minimum Data Set)	F 677		

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BERLIN HEALTH & REHAB CTR	98 HOSPITALITY DRIVE BARRE, VT 05641

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F 677	Continued From page 11 codes the resident as a 2 person assist with total dependence on staff for bathing. The abilities have been stable at his/her baseline. The admission assessment states that bathing did not occur during the first week. In an interview with the Unit Manager, s/he was unaware that the resident had not received weekly showers. There is no LNA (Licensed Nursing Assistant) documentation of shower or bath refusals other than one coded on April 7th. The resident received showers on March 22, April 1, and April 11, 2018 and sponge/bed baths were provided on 5 occasions. There was no bathing documented for 13 of 29 days since admission. Resident #76 was showered with a new shower chair on 4/11/18 after the Unit Manager was made aware of the issue.	F 677	F677 1. Resident #76 was provided a shower on 4/11/18. 2. No residents were harmed by this alleged deficient practice. Residents who are totally dependent for their shower and/or tub have the potential to be affected by the alleged deficient practice. 3. CNE, NPE and/or designee will provided education to nursing to ensure that weekly shower and/or tub is offered to totally dependent residents and is documented. 4. Audits will be conducted weekly X 4 then monthly X 3 by the CNE 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 May 9, 2018.	

F677 POC accepted 4/27/18 JHosmerRN/PMC