VERMONT

AGENCY OF HUMAN SERVICES

DEPARTMENT OF DISABILITIES, AGING AND INDEPENDENT LIVING

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

March 6, 2019

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

Dear Ms. Walker:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **January 31, 2019**. 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 01/31/2019

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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F 000	INITIAL COMMENTS An unannounced on-site investigation of a facility self-report, an anonymous complaint, and a known complaint was conducted on 1/30/19 through 1/31/19 by the Division of Licensing and Protection. The following regulatory violations were identified as a result:	F 000	The filing of this plan of correction does not constitute an admission of the allegations set forth in the statement of deficiencies. The plan of correction is prepared and executed as evidence of the facility's continued compliance with applicable law.	
F 607 SS=D	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(3) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to ensure that their policies related to screening for abuse had been implemented for 1 of 6 employees reviewed (Employee #1). The detailed findings are as follows: Employee #1, who was a contracted Licensed Nurse Aide (LNA), was hired on 12/7/19. There was no evidence in the employee file that the Adult Registry review was conducted as required. The facility policy titled Abuse Prohibition dated revised on 8/1/16, identified that potential hires will be screened for a history of abuse, neglect,	F 607	**F-Tag 607**- There was no negative impact on residents. Resident who reside at the center have the potential to be effected. Current Policies and Procedures have been re-introduced to hiring manager (HR) and the Nurse Practice Educator (NPE) to ensure proof of abuse/neglect background checks are completed and available. Employee #1's contract ended and her last day worked was 1/25/19. An audit has been conducted on employee records and training has been provided to ensure new hires are processed appropriately.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Center Executive Director — (X6) DATE: 2/22/19

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 607	Continued From page 1 exploitation, or mistreating residents including checking with the appropriate licensing boards and registries. Confirmation was made by the Administrator on 1/31/19 at approximately 10:45 AM, that for Employee #1, (a contract employee), the registry check cannot be located.	F 607	Audits will continue to be conducted by Center Executive Director (CED) or designee weekly x 4weeks, then monthly x 3, results will be reviewed at QAPI for evaluation and further recommendations.	
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. (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	F 657	Date of Compliance 3/1/19 F607 POC accepted 3/4/19 DWdeawaker RN/PMC F-Tag 657- There was no negative impact to resident #7. Residents have the potential to be effected by a missed or undocumented care-plan meeting. In order to identify if other residents may have experienced a similar occurrence, the center's social services department have been re-educated on the Policy & Procedure and the CMS regulation in regards to person-centered care plans. Resident #7 was in continuous contact with Social Services and other Interdisciplinary Team members throughout his stay. Resident #7 is has been discharged. Audits will continue to be conducted by Center Executive Director (CED) or designee weekly x 4weeks, then monthly x 3, results will be reviewed at QAPI for evaluation and further recommendations.	

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F 657	Continued From page 2 assessments. This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to ensure that care plans were updated by the interdisciplinary team (physician, registered nurse, nurse aide, dietary staff member, resident and/or resident's representative, and any other professionals determined by the resident's needs and/or resident's request) for 1 of 6 applicable residents (Resident #7). Findings include: Per record review, an interdisciplinary care plan meeting was held on 6/26/18 at 1:30 PM for Resident #7. There was no indication in the record that there had been any other interdisciplinary care plan meetings for Resident #7 since that time. Per interview on 1/30/19 at 2:26 PM with the Director of Nursing (DNS), s/he stated that interdisciplinary care plan meetings were conducted quarterly and that Resident #7's was due in September 2018. S/he confirmed that there were no notes indicating that a care plan meeting had occurred with the interdisciplinary team and resident; and that there was no indication that Resident #7 was out of the facility and/or not available to participate in a care plan meeting. Per interview on 1/30/18 at 4:25 PM with the social worker, s/he confirmed that Resident #7 should have had a care plan meeting done with the interdisciplinary team in September 2018; and that it was not done.	F 657	Date of Compliance 3/1/19 F657 POC accepted 3/4/19 DWdeficiency/RN/pmc	
F 712 SS=E	Physician Visits-Frequency/Timeliness/Alt NPP CFR(s): 483.30(c)(1)-(4) §483.30(c) Frequency of physician visits §483.30(c)(1) The residents must be seen by a physician at least once every 30 days for the first	F 712		

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F 712	Continued From page 3 90 days after admission, and at least once every 60 thereafter. §483.30(c)(2) A physician visit is considered timely if it occurs not later than 10 days after the date the visit was required. §483.30(c)(3) Except as provided in paragraphs (c)(4) and (f) of this section, all required physician visits must be made by the physician personally. §483.30(c)(4) At the option of the physician, required visits in SNFs, after the initial visit, may alternate between personal visits by the physician and visits by a physician assistant, nurse practitioner or clinical nurse specialist in accordance with paragraph (e) of this section. This REQUIREMENT is not met as evidenced by: Based on interviews and record reviews the facility failed to ensure that physician visits were timely and alternated with nurse practitioner visits for 4 of 11 applicable residents on 2 of 3 nursing units (Resident #1, Resident #2, Resident #4 and Resident #5). The detailed findings include the following: 1. Resident #1 was seen by the physician on 8/21/18 and 1/22/19. The Advanced Practice Registered Nurse (APRN) saw the resident on 9/21/18, 10/23/18, 11/7/18, 12/4/18, and 12/11/18. The resident should have been seen by the physician in December 2018. 2. Resident #2 was seen by the physician on 8/21/18 and 1/22/19. The APRN saw the resident on 8/29/18, 9/28/18, 10/25/18, 11/6/18,	F 712	F-Tag 712- There was no negative impact on residents #1, 2, 4 or 5. Center physician, nurse practitioner and unit clerk were educated on CMS regulation §483.30 (c)(1-4). Unit Clerk and CED reviewed patient files to track previous doctor and nurse practitioner visit and created a chart detailing resident's 30, 60 and 90 day visits for new admissions/re-admissions, as well as, the 60 day visits for long-term residents. Weekly appointment lists are created for the center's physician and NP. Resident #1 & 5 were seen by physician 1/8/2019 Resident #2 was seen by physician on 1/22/19 Resident #4 was seen by physician 12/18/18, Nurse Practitioner (NP) on 2/7/19. Audits will continue to be conducted by Center Executive Director (CED) or designee weekly x 4weeks, then monthly x 3, results will be reviewed at QAPI for evaluation and further recommendations. Date of Compliance 3/1/19 F712 POC accepted 3/4/19 DWideawake RN/PMC	

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F 712	Continued From page 4 12/10/18, 1/11/19, 1/14/19, 1/16/19, 1/25/19 and 1/29/19. The resident should have been seen by the physician in December 2018. 3. Resident #4 was seen by the physician on 7/17/18 and 12/18/18. The APRN saw the resident on 9/10/18, 10/17/18, 11/8/18, 11/21/18, 11/28/18, 12/17/18, 12/27/18, and 1/18/19. The resident should have been seen by the physician in November 2018. 4. Resident #5 was seen by the physician on 7/10/18. The APRN saw the resident on 9/5/18, 10/1/18, 11/13/18, 11/15/18, 12/10/18, 12/19/18 and 1/18/19. The resident should have been seen by the physician in November 2018. Confirmation was made by the Unit Managers on each unit on 1/31/19 at approximately 10 AM that the physician visits were untimely and did not alternate between the Physician and the APRN.	F 712		
F 809 SS=D	Frequency of Meals/Snacks at Bedtime CFR(s): 483.60(f)(1)-(3) §483.60(f) Frequency of Meals §483.60(f)(1) Each resident must receive and the facility must provide at least three meals daily, at regular times comparable to normal mealtimes in the community or in accordance with resident needs, preferences, requests, and plan of care. §483.60(f)(2)There must be no more than 14 hours between a substantial evening meal and breakfast the following day, except when a nourishing snack is served at bedtime, up to 16 hours may elapse between a substantial evening meal and breakfast the following day if a resident group agrees to this meal span.	F 809	F-Tag 809 – There were no ill effects to resident #6. Residents that have off-sight appointments during meal times could be effected. Resident #6 returned from morning appointment on	

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F 809	Continued From page 5 §483.60(f)(3) Suitable, nourishing alternative meals and snacks must be provided to residents who want to eat at non-traditional times or outside of scheduled meal service times, consistent with the resident plan of care. This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to provide a breakfast meal, to an insulin dependent diabetic (Resident #6), prior to sending him/her out for an appointment. The detailed findings include the following: Per record review, Resident #6 has physician's orders to receive both sliding scale insulin as needed six (6) times a day according to blood sugar results and a daily scheduled insulin injection. Per record review, documentation evidenced that Resident #6, consumed 75% of his/her evening meal and snack on 1/6/19. On 1/7/19, the Resident received his/her daily dose of Glargine insulin prior to leaving for a physician's appointment. Upon return to the facility at 11:00 AM, the resident's blood sugar was checked and had registered 116. Per interview with the resident at that time, s/he stated that s/he "did not have any food today". Per interview on 1/30/19 at 3:00 PM with the Director of Nursing (DNS), s/he stated that all residents going out to an appointment can take a bagged meal. At no time was it the resident's responsibility to order either meal for him/her-self. The DNS also confirmed at that time that Resident #6's last meal was consumed	F 809	1/7/19 in time for lunch and snacks are available in the unit kitchenettes. To ensure residents that have off-site appointments during meal times receive food, the appointment scheduler (or designee) will fill out a food request form for the resident, in advance of appointment and give to dietary staff. On the form, there is an option for an early/late tray or bagged meal and the time and date needed by. Dietary will prepare meal, as requested and deliver. Audits will continue to be conducted by Center Executive Director (CED) or designee weekly x 4weeks, then monthly x 3, results will be reviewed at QAPI for evaluation and further recommendations. Date of Compliance 3/1/2019 F809 POC accepted 3/4/19 DWideawake RN/PMC	

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F 809	Continued From page 6 in the evening on 1/6/19.	F 809		