

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 29, 2019

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

Dear Ms. Haupt:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **May 1, 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

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 05/01/2019
--	--	--	--

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
--------------------	--	---------------	---	----------------------

E 000 Initial Comments

The Division of Licensing and Protection conducted an emergency preparedness survey on 5/1/19. There were no regulatory violations related to emergency preparedness as a result.

F 000 INITIAL COMMENTS

The Division of Licensing and Protection conducted an unannounced onsite recertification survey 4/29/19 - 5/1/19. The following regulatory deficiencies were identified as a result:

F 550 Resident Rights/Exercise of Rights
SS=D CFR(s): 483.10(a)(1)(2)(b)(1)(2).

§483.10(a) Resident Rights.
The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section.

§483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident.

§483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source.

§483.10(b) Exercise of Rights.

E 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 000

F 550

F 550
Resident #47 and resident #74 suffered no negative impact.
Residents who reside at the center have the potential to be effected.
A letter dated 5/14/19 was sent to providers regarding dignity and privacy.
Staff education will occur regarding acceptable location of provider visits
audits by CNE or designee for provider visit locations will occur weekly times 4, then monthly times 2 or until substantial compliance has been achieved. Results will be reported to QAPI.

Date of compliance: May 31, 2019

F550 POC accepted 5/28/19 RTremblay RA/PMC

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Melissa Haupt</i>	TITLE <i>Admission Director</i>	(X6) DATE 5/21/19
---	--	--------------------------

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.

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

PRINTED: 05/10/2019
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 05/01/2019
--	--	--	--

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 550	<p>Continued From page 1</p> <p>The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States.</p> <p>§483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility.</p> <p>§483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation and staff interview, the facility failed to treat 2 applicable residents (Residents #47, #74) with respect and dignity. Findings include:</p> <p>On 04/29/19 at 12:58 PM, surveyors observed a physician and medical student examine Residents #47 and #74 in the main dining room during the noon meal in the presence of surveyors, staff and other residents. The physician and the medical student were observed using a stethoscope to examine Resident #47's chest and abdomen. The physician could be heard by the surveyors discussing the Resident's personal health information (PHI) with the Resident and the medical student. There were 9 other residents seated at tables within approximately 10-12 feet away. The physician then proceeded to interview Resident #74 at a nearby table. Again, PHI could be overheard by surveyors. The Center Nurse Executive and the facility Executive Director both observed the</p>
-------	---

F 550

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

PRINTED: 05/10/2019
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 05/01/2019
--	--	--	--

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 550 Continued From page 2
physician discussing Resident #74's PHI observed and both stated that "that is not ok".

F 583 Personal Privacy/Confidentiality of Records
SS=D CFR(s): 483.10(h)(1)-(3)(i)(ii)

§483.10(h) Privacy and Confidentiality.
The resident has a right to personal privacy and confidentiality of his or her personal and medical records.

§483.10(h)(1) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident.

§483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service.

§483.10(h)(3) The resident has a right to secure and confidential personal and medical records.
(i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(i)(2) or other applicable federal or state laws.
(ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law.

F 550

F 583 F 583
Resident #47 and resident #74 suffered no negative impact.
Residents who reside at the center have the potential to be effected.
A letter dated 5/14/19 was sent to providers regarding dignity and privacy.
Staff education will occur regarding acceptable location of provider visits, dignity, and privacy.
audits by CNE or designee for provider visit locations will occur weekly times 4, then monthly times 2 or until substantial compliance has been achieved. Results will be reported to QAPI.
Date of compliance: May 31, 2019
F583 POC accepted 5/28/19 RTremkley RN/PMU

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

PRINTED: 05/10/2019
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 05/01/2019
--	--	--	--

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 583 Continued From page 3
This REQUIREMENT is not met as evidenced by:
Based on observation and staff interview, the facility failed to ensure 2 applicable residents (Residents #47, #74) had the right to personal privacy. Findings include:

On 04/29/19 at 12:58 PM, surveyors observed a physician and medical student examine Residents #47 and #74 in the main dining room during the noon meal in the presence of staff and other residents. The physician and the medical student were observed using a stethoscope to examine Resident #47's chest and abdomen. The physician could be heard by the surveyors discussing the Resident's personal health information (PHI) with the Resident and the medical student. There were 9 other residents seated at tables within approximately 10-12 feet away. The physician then proceeded to interview Resident # 74 at a nearby table. Again, PHI could be overheard by surveyors. The Center Nurse Executive and the facility Executive Director both observed the physician discussing Resident #74's PHI observed and both stated that "that is not ok" and that it was an invasion of the Residents' personal privacy.

F 584 Safe/Clean/Comfortable/Homelike Environment
SS=E CFR(s): 483.10(i)(1)-(7)

§483.10(i) Safe Environment.
The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.

The facility must provide-
§483.10(i)(1) A safe, clean, comfortable, and

F 583 F584
No residents had a negative outcome

All residents that reside in the center can be effected

The needed repairs have been entered into the TELS system and have been corrected.

A cleaning schedule for the vents and lights has been initiated

Environmental rounds have been initiated weekly to identify and address concerns-information gleaned from rounds will be entered into the TELS system.

Housekeeping staff will be educated on vents cleaning, complete room cleans, and promotion of home like environment.

F 584 Audits will occur by account manager or designee-weekly times 4, then monthly times two, or until substantial compliance is achieved. Results will be reported to QAPI committee.

Date of compliance: May 31, 2019

F584 POC accepted 5/28/19 RRembley Ral/PMC

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

PRINTED: 05/10/2019
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 05/01/2019
--	--	---	--

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 584 Continued From page 4
 homelike environment, allowing the resident to use his or her personal belongings to the extent possible.
 (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk.
 (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft.
 §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior;
 §483.10(i)(3) Clean bed and bath linens that are in good condition;
 §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv);
 §483.10(i)(5) Adequate and comfortable lighting levels in all areas;
 §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and
 §483.10(i)(7) For the maintenance of comfortable sound levels.
 This REQUIREMENT is not met as evidenced by:
 Based on observation and staff interview the facility failed to ensure that housekeeping and maintenance services were utilized to uphold a safe, clean, comfortable and homelike environment for 2 of 3 units (A and B Units). The findings include the following:

F 584

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

PRINTED: 05/10/2019
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 05/01/2019
--	--	--	--

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-584 Continued From page 5

F 584

Per facility tour in the presence of the Center Executive Director (CED), Maintenance Director, the Regional Executive Director and the Regional Healthcare Services Supervisor for Housekeeping/Nutritional Services on 4/30/19 at 2:06 PM, the following was identified and confirmed as present:

A Wing:

- Room #A5c-door frame to the entrance of the resident's bathroom has a wooden frame that is splintered, rough, and in need of paint;
- Room #A5d - Room appeared cluttered and in need of cleaning. Multiple wash-basins were stored on Resident #12's bureau that were splattered with dried brown liquid and contained multiple toiletry supplies. Stored on the floor to the right of the resident, was a toiletry bag that was wet and stained. Also on the floor were scattered used medication cups, crumbs that have been dropped and a shoe with an attached splint that the resident is not wearing. These were observed during the three days of survey (4/29/19-5/1/19). The bathroom floor was dirty with visible dried dirt and grime and the base of the toilet was found with discolored stained caulking;
- Room #A3 bathroom exhaust vent found to be heavily caked with dust. Thermostat identified without a cover, leaving the working mechanism exposed;
- Room #A2 - The elevated toilet seat was found with dried feces on day one and three of survey (4/29/19 at approximately 10:15 AM and again on 5/1/19 during the tour);
- Room #19 - The bathroom exhaust vent was found to be heavily caked with dust;
- Room # A21 - The bathroom ceiling light was

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

PRINTED: 05/10/2019
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 05/01/2019
--	--	--	--

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 584 Continued From page 6
found with expired insects present;
-Room # A23 was found with a trash basket without a liner and very dirty and stained of various dried materials;

B Wing:
-Room # B3- The bathroom exhaust vent found to be heavily caked with dust;
Per observation on 4/29/2019 at 11:08 AM the baseboard heat radiator in the A- wing Solarium was found with the cover bent forward exposing a large area of sharp fins. Two large pieces of crown molding (where the wall meets the ceiling), were missing. A television was placed on the floor next to a wheelchair scale. There were also two unidentified wheelchairs being stored in the area.

Per interview on 4/29/19 at 11:30 AM, the Unit Manager confirmed that the sharp fins inside the baseboard heater were exposed. S/he confirmed that the crown molding was missing, and that the television and wheelchairs should not be stored in a resident common area. S/he also confirmed that the Solarium is used by residents and it is also used for resident yoga. Per interview with the CED on 4/30/19, s/he was not aware that the room was in that condition.

F 584

F689
No residents suffered a negative impact.
Residents who reside at the center have the potential to be effected.
More oxygen securement devices were obtained and placed in oxygen rooms.
Staff education will occur regarding requirement to secure oxygen tanks.

F 689

audits by CNE or designee of oxygen rooms will occur weekly times 4, then monthly times 2 or until substantial compliance has been achieved. Results will be reported to QAPI.

Date of compliance: May 31, 2019

F 689 Free of Accident Hazards/Supervision/Devices
SS=D CER(s): 483.25(d)(1)(2)

§483.25(d) Accidents.
The facility must ensure that -
§483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and
§483.25(d)(2) Each resident receives adequate supervision and assistance devices to prevent accidents.

F689 POC accepted 5/20/19 RTremblay/RW/PMC

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

PRINTED: 05/10/2019
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 05/01/2019
--	--	--	--

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 689 Continued From page 7
This REQUIREMENT is not met as evidenced by:
Based on observation and staff interview, the facility failed to ensure that the resident environment remains as free of accident hazards as is possible. Findings include:

F 689

Per observations on 4/30/19 at 11:20 AM, portable oxygen tanks were found unsecured, creating a potential accident hazard. On 04/29/19 at 10:12 AM, in an unlocked closet on B wing used for oxygen storage, there are 3, 24 cubic feet oxygen bottles unsecured standing on the floor. On 4/30/19 at 11:20 AM, 1 oxygen was tank found unsecured in an A wing storage room. Both observations were confirmed by the respective unit nurses at time of observations.

F800

No residents had a negative outcome
All residents can be effected

F 800 Provided Diet Meets Needs of Each Resident
SS=E CFR(s): 483.60

F 800

Dietary staff will be educated on tray card system and resident preferences located on tray cards

§483.60 Food and nutrition services.
The facility must provide each resident with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs, taking into consideration the preferences of each resident.

Tray distribution will be shorted by use of single serve condiments and individual drinks.

This REQUIREMENT is not met as evidenced by:
Based on observation, interview and record review, the facility failed to provide each resident with a nourishing, palatable, well-balanced diet that meets his/her daily nutritional dietary needs, taking into consideration the preferences of each resident. The findings include the following:

Audits will occur by account manager or designee weekly times 4, then monthly times two, or until substantial compliance is achieved. Results will be reported to QAPI committee.

1. Per observation during the breakfast and noon meals on the three days of survey (4/23/19-5/1/19) on A Wing, the meal services

Date of compliance: May 31, 2019

See attached addendum.

F800 POC accepted with addendum 5/20/19 Rtrvablgpd/Pna

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

PRINTED: 05/10/2019
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 05/01/2019
--	--	--	--

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 800 Continued From page 8

were disorganized, untimely and did not meet some of the resident preferences. The following was observed by the two surveyors on the unit:

- Tray service on A Wing, for breakfast is posted from 7:30 AM-8 AM, Lunch 11:30 AM- 12 PM. Breakfast cart was delivered to the unit at 8 AM and lunch at 12:20 PM (4/29/19). Licensed Nurse Aides (LNA) are expected to deliver the prepared tray to each resident on the unit along with preparing/pouring hot and cold beverages and placing dessert if appropriate on the tray. There are approximately 30 residents from this unit who eat their meals in their rooms. The last breakfast tray was delivered at 9 AM and the last lunch tray at 1 PM. The meal service for some of the 30 residents served is untimely;
- Staff are observed to begin tray passing some 5-10 minutes after delivery of the jitney (food cart) on A wing. Staff are observed answering call lights and providing personal care to resident in preparation for the meal and/or the day;
- Per observation over 2 survey days during the morning and noon meals, the jitney doors are not consistently closed by staff, therefore the hot food temperature can not be maintained;
- Staff observed passing trays on the unit were the Unit Manager and 2-3 LNA's consistently. Throughout the three days of survey, various additional staff were assisting with meal delivery (Center Nurse Executive (CNE), LNA's from B wing, the Registered Dietician and the Admission Coordinator). The meal service was disorganized due to the additional staff not have knowledge of residents needs or desires;
- LNA staff confirm on 4/29/19 at approximately 9 AM, that many trays delivered from the dietary department have something wrong with it, therefore they have to run to the dietary department to obtain the needed items;

F 800

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

PRINTED: 05/10/2019
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: 05/01/2019
--	--	---	---

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 800 Continued From page 9

-Resident/family comments during the initial tour and through interviews during the survey identified that the trays delivered do not have items as requested, the food has no taste, the hot foods are cold, the oatmeal is never hot, one resident voices s/he has waited as long as 2 hours for breakfast, another resident voices the food is "muck and poorly made, dietary staff don't stay and the food is of poor quality";

-Nurse surveyor observes on during the morning meals on 4/29 and 4/30/19 that prepared trays do not have condiments, soggy toast has to be replaced by freshly made toast by the LNA's and missing items or replacements must be retrieved by the LNA staff from the facility main kitchen;

Confirmation was made on 5/1/19 at 10:20 AM by the District Manager of Health Care Services and the Regional Manager of the Vermont Division of Health Care Services of the Dietary Department, that the food service is slow and disorganized.

2. Per interview on 5/1/2019 at 09:10 AM, Residents #44 and 35 reported to surveyors that the morning meal included food items not requested and did not include the resident's preferred foods. Per observation, Resident # 44 had eggs on his/her meal tray and the resident stated h/she is brought eggs every day and does not request them. Per observation, Resident # 35 did not have requested meal of omelet with bacon and, "has never seen it". A soiled spoon with dried, visible food was given to surveyor by Resident # 35. The Resident reported it came on his morning meal tray and that he had not used it. Resident # 35's meal ticket was observed by the surveyor and read "wants bacon and cheese omelet everyday for breakfast". Resident # 44's meal ticket states "raisin toast x 2, coffee with

F 800

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

PRINTED: 05/10/2019
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 05/01/2019
--	--	--	--

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 800 Continued From page 10
sugar, white bread only". None of the preferred items were observed on the meal tray.

3. Per interview on 04/29/19 at 01:08 PM, Resident #2 reported that s/he does not like scrambled eggs and is served them every morning. The dietary meal slip on the breakfast tray indicated that the resident dislikes scrambled eggs. Per observation on 4/29, 4/30 and 5/1/19 during breakfast service, Resident #2 was served scrambled eggs on his/her breakfast tray. Per interview with the Registered Dietician, it was confirmed that Resident #2's meal slip indicated that s/he dislikes scrambled eggs.

(See additional Citations F 802, F 804 and F 812.)

F 802 Sufficient Dietary Support Personnel
SS=F CFR(s): 483.60(a)(3)(b)

§483.60(a) Staffing
The facility must employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, taking into consideration resident assessments, individual plans of care and the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e).

§483.60(a)(3) Support staff.
The facility must provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service.

§483.60(b) A member of the Food and Nutrition Services staff must participate on the interdisciplinary team as required in § 483.21(b)

F 800

F802
No residents had a negative outcome
All residents can be effected
Job flows have been created to ensure efficient use of dietary personnel
Additional staff has been hired for the dietary department
Dietary staff have been educated on call-out procedures, job flows, and kitchen efficiency.
Audits will occur by account manager or designee weekly times 4, then monthly times two, or until substantial compliance is achieved. Results will be reported to QAPI committee.

F 802

Date of compliance: May 31, 2019
F802 POC accepted 5/28/19 RTremblay Ral/Pm

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

PRINTED: 05/10/2019
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 05/01/2019
--	--	--	--

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 802 Continued From page 11
(2)(ii).
This REQUIREMENT is not met as evidenced by:
Based on observation and confirmed by staff interview, the facility failed to ensure that there is sufficient support personnel to safely and effectively carry out the functions of the food and nutrition services. The findings include the following:

Per observation during the morning and noon meals on the three days of survey (4/29/19-5/1/19) on A Wing, the meal services were disorganized, untimely and did not meet some of the resident preferences. The following was observed by the two surveyors on the unit:
-Tray service on A Wing, for breakfast is posted from 7:30 AM-8 AM, Lunch 11:30 AM- 12 PM. Breakfast cart was delivered to the unit at 8 AM and lunch at 12:20 PM (4/29/19). Licensed Nurse Aides (LNA) are expected to deliver the prepared tray to each resident on the unit along with preparing/pouring hot and cold beverages and placing dessert if appropriate on the tray. There are approximately 30 residents from this unit who eat their meals in their rooms. The last breakfast tray was delivered at 9 AM and the last lunch tray at 1 PM. The meal service for some of the 30 residents served is untimely;
-Staff are observed to begin tray passing some 5-10 minutes after delivery of the jitney (food cart) on A wing. Nursing staff are observed answering call lights and providing personal care to resident in preparation for the meal and/or the day;
-Staff observed passing trays on the unit were the Unit Manager and 2-3 LNA's consistently;
-LNA staff confirm that many trays delivered from the dietary department have something wrong with it, therefore they have to run to the dietary

F 802

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

PRINTED: 05/10/2019
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 05/01/2019
--	--	--	--

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 802	<p>Continued From page 12</p> <p>department to obtain the needed items;</p> <p>-Resident/family comments during the initial tour and through interviews during the survey identified that the trays delivered do not have items as requested;</p> <p>-Nurse surveyor observes during the morning meals on 4/29 and 4/30/19, that prepared trays do not have condiments, soggy toast is replaced by freshly made toast by the LNA's and missing items or replacements must be retrieved by the LNA staff from the facility main kitchen.</p> <p>Confirmation was made on 5/1/19 at approximately 10:00 AM by the Regional Manager of the Vermont Division of Health Care Services for the Dietary Department, that an added point of service was initiated to serve residents on C-Wing. A steam table is delivered to the unit and food is made to order. However, staffing was not increased to accommodate the added service, leaving other units and the main dining room short handed. The dietary staffing includes 1 cook and 2 dietary aides and a part-time preparation cook from 2 PM-6 PM seven days a week. During breakfast and lunch meals one dietary aide is in the dining room and one dietary aide on C Wing serving food and meeting resident requests. The cook is in the diet kitchen, answering the phone and making accommodations to resident diet needs. Therefore, the additional duties for the tray service delivery has become the responsibility of the nursing staff on the units. The service is observed to be disorganized and untimely.</p> <p>(See additional Citations F 800, F 804 and F 812.)</p>	F 802		
F 804	Nutritive Value/Appear, Palatable/Prefer Temp	F 804		

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

PRINTED: 05/01/2019
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 05/01/2019
--	--	--	--

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
--------------------	--	---------------	---	----------------------

F804 SS=F
Continued From page 13
CFR(s): 483.60(d)(1)(2)

§483.60(d) Food and drink
Each resident receives and the facility provides-

§483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance;

§483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature.
This REQUIREMENT is not met as evidenced by:
Based on observation and confirmed by staff interview, the facility failed to ensure that food and drink is palatable, attractive, and at a safe and appetizing temperature. The findings include the following:

1. State Surveyor requested a test tray to be served at the end of service for the noon meal on 4/25/19. The jitney (food cart) was delivered to the unit at 12:20 PM. The test tray meal was evaluated at 12:55 PM. Two State Surveyors and the Registered Dietician (RD) checked the food temperatures with a calibrated thermometer. The findings were as follows:
 - BBQ Chicken registered a temperature of 119 degrees F (not acceptable temperature);
 - Creamy Cole Slaw registered a temperature of 68 degrees F (not acceptable, a mayonnaise-based product);
 - Whole Milk registered a temperature of 40 degrees F;
 - Fresh Fruit Cup registered a temperature of 46 degrees F (not acceptable temperature);
 - Apple Juice registered a temperature of 42 degrees F;

F 804 F804

No residents had a negative outcome

All residents can be effected

Dietary staff have been educated on acceptable food temperature storage and the procedure for temperature logging.

Audits will occur by account manager or designee weekly times 4, then monthly times two, or until substantial compliance is achieved. Results will be reported to QAPI committee.

Date of compliance: May 31, 2019

See attached addendum.

Food POC accepted with addendum 5/20/19 R Tremblay RN/PMC

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

PRINTED: 05/01/2019
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 05/01/2019
--	--	--	--

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 804 Continued From page 14

A second test tray was requested on 4/30/19 at the morning meal on A Wing. The jitney was delivered at 8:01 AM and the Licensed Nursing Assistant (LNA) staff began preparing and passing trays at 8:10 AM. The test tray was evaluated at 8:45 AM. Two State Surveyors and the Unit Manger (UM) checked the food temperatures with a calibrated thermometer. The findings were as follows:

- Blueberry Pancakes, without syrup, registered a temperature of 120 degrees F (not acceptable);
- Link Sausage registered a temperature of 118 degrees F (not acceptable);

["According to food safety, cold foods must remain at 41 degrees Fahrenheit (F) or below and hot or reheated foods must remain at a minimum of 135 degrees F. Bacteria grow most rapidly in the range of temperatures between 40 degrees F to 140 degrees F. This range of temperatures is often called the "Danger Zone".]

Confirmation was made by the RD and the UM at the time the test trays were evaluated that items listed above as unacceptable were served at the "Danger Zone" temperatures. The above test results were reported to the Vermont Regional Dietary Manager and the Health Care Service representative by the State Surveyor.

2. Per review of the daily temperature logs documented by the dietary staff, dated 2/3/19 through 4/27/19, there is inconsistency in logged temperatures of liquids and for both food and liquid for the week of 4/21/19. Policy requires documentation of temperatures of all foods and liquids prior to serving of all meals. Confirmation

F 804

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

PRINTED: 05/10/2019
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: 05/01/2019
--	--	--	---

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 804 Continued From page 15
was made by the Vermont Regional Manager on 5/1/19 at approximately 1:00 PM, that the temperatures have not been checked/logged as required.

3. Per observation of the morning meal on 04/30/19, a plate of pancakes and eggs sat uncovered from 9:45 - 10:16 AM on a counter after being plated by dietary staff. After being served, Resident # 16 stated that the food was cold and always is. This observation and resident statement was witnessed by two surveyors.

4. Per interview on 5/1/2019 at 09:10 AM, Residents #44 and 35 reported to surveyors that the morning meal included food items not requested and did not include the resident's preferred foods. Per observation, Resident # 44 had eggs on his/her meal tray and the resident stated h/she is brought eggs every day and does not request them. Per observation Resident # 35 did not have requested meal of omelet with bacon and, "has never seen it". A soiled spoon with dried, visible food was given to surveyor by Resident # 35. The Resident reported it came on his morning meal tray and that he had not used it. Resident # 35's meal ticket was observed by the Surveyor and read "wants bacon and cheese omelet everyday for breakfast". Resident # 44's meal ticket states "raisin toast x2, coffee with sugar, white bread only". None of the preferred items were observed on the meal tray.

F 804

(See citations F 800, F 802 and F 812.)
F 812 Food Procurement, Store/Prepare/Serve-Sanitary
SS=F CFR(s) 483.60(i)(1)(2)

§483.60(i) Food safety requirements.

F 812

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

PRINTED: 05/10/2019
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 05/01/2019
--	--	--	--

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 812 Continued From page 16
The facility must -

§483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities.
(i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations.
(ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices.
(iii) This provision does not preclude residents from consuming foods not procured by the facility.

§483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by:
Based on observation, staff interviews, and record review the facility failed to assure that food was stored, prepared, distributed, and served in accordance with professional standards for food service safety. Findings include:

1. Per observation, on 4/29/2019, at the noon meal service at 12:28 PM, the steam table was observed to hold pans heavily soiled and discolored. There were food particles from other meals scattered around the serving pans. Additionally a plate warmer, holding clean plates for serving food, had food particles around the rim and had a soiled cover.
Food for lunch service was brought to the serving area from the main kitchen in covered containers placed in the steam table. The ungloved food server opened and closed the containers multiple times. S/he placed the food service utensils for

F 812 F812

No residents had a negative outcome
All residents can be effected
Dietary staff will be educated on the sanitization of the kitchen and the use of test strips, and the reporting policy for maintenance issues.
Audits will occur by account manager or designee weekly times 4, then monthly times two, or until substantial compliance is achieved. Results will be reported to QAPI committee.
Date of compliance: May 31, 2019
FBI2 POC accepted 5/20/19 RTrembley rd/pm

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

PRINTED: 05/10/2019
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 05/01/2019
--	--	--	--

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 812	<p>Continued From page 17</p> <p>each food on the protective cover for that food. In interview at 12:45 PM s/he immediately stated I'm waiting for them to bring me gloves (service had begun). S/he confirmed that it was standard practice to place the utensils on the protective covers and dip back into the food for service. In the area where clean eating utensils are stored for each meal, the silverware containers were placed on a soiled tray. Adaptive eating utensils were observed lying on the soiled tray.</p> <p>2. Per the initial tour of the Dietary Department on 4/29/19 at approximately 9:07 AM in the presence of the Regional Dietary Supervisor and the District Manager of Health Care Services (Housekeeping), the following conditions were identified and confirmed:</p> <ul style="list-style-type: none"> -The slats of the hood above the kitchen stove were last inspected on 2/25/19, however much accumulated dust and grime is visible; -The convection oven has visible dust and grime and the knobs are caked with grease; -The shelves below the production table used to store various pots and pans have visible crumbs and dried splatter; -The three-pot sink used for sanitation of various pots/pans/utensils (Manual Sanitization), which is tested three times a day, utilizing a test tape that expired 1/15/16; -A cart used to store clean lids and bottom plate holders is heavily caked with dust and grime; -An unsealed 25 pound partially used bag of bread-crumbs is stored on a top shelf close to the ceiling; -The wall near the exit door has missing sheet rock, missing and broken tiles that are dirty in appearance. The area is used to store clean food carts; 	F 812		

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

PRINTED: 05/10/2019
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 05/01/2019
--	--	--	--

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 812 Continued From page 18

- The kitchen floor has accumulated dust, grout with grime that is stained and is found to have accumulated dried splatter that is also noticeable on the feet of various tables and carts;
- A paper towel dispenser has dried matter (brown in color), at the handle used to retrieve a new paper towel;
- There is a gap between the window and the screen above the three-pot sink that would enable insects to enter the diet kitchen;
- The wood framed door at the entrance to the dry storage room has multiple gouges and chips in the wood, leaving a splintered exposure door frame visibly dirty and in need of cleaning and cosmetic repair;
- A 25 pound bag of flour partially used, is unsealed and stored under the air-handler;
- The air handler itself is visibly dirty, stained, splattered with various dried material along with grease and grime;
- Various carts for delivery of food and supplies have visible dried splatter;
- The toaster is severely discolored and heavily caked with crumbs;
- A step stool located by the steam table and cereal bins has accumulated crumbs, dirt, grime and debris present;
- Three cereal bins with noted residual crumbs at the bases of the containers are identified as being cleaned on 1/27/19 and are found with dried material at the exit spout. The area between the bins has an accumulation of crumbs and cereal present;
- Various carts used to deliver, snacks, trays and ice have dried brown matter, spills and stains visible.

Per review of the Food/Nutrition Master Cleaning Schedules documentation for the months of

F-812

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

PRINTED: 05/10/2019
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 05/01/2019
--	--	--	--

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 812 Continued From page 19
March and April 2019 identify that the daily and weekly assigned cleaning duties were completed. The Vermont Regional Manager confirms that the logs have been signed demonstrating that the cleaning was completed, however the appearance of the kitchen does not evidence that facility policy was followed.

Per review of the Registered Dietician's Food and Safety Audits, for the months of February and March 2019, there are multiple areas that needed improvement. (Examples are produce left on the counter after delivery, outdated products located, dirty fan and other various equipment need clearing, (are few to mention). Confirmation was made on 5/1/19 at approximately 10:00 AM by the Dietician that the audit reports were sent to his/her supervisor along with the Regional Executive Director, none of which responded.

F 812

F883
No residents had a negative impact.
All residents have the potential to be affected.
Nursing staff educated on the process for vaccinations.
Literature and consent forms were sent to all families for the 2019 flu season.
Audits will occur by CNE or designee to ensure consent forms are returned weekly times 4, monthly times 2 or until 100% complaint. Results will be reported to QAPI.
Date of compliance: May 31, 2019

F 883 SS=E
Influenza and Pneumococcal Immunizations
CFR(s): 463.80(d)(1)(2)

§483.80(d) Influenza and pneumococcal immunizations
§483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that-
(i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization;
(ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period;
(iii) The resident or the resident's representative

F 883

F803 POC accepted 5/20/19 RTremblay/RK/PME

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

PRINTED: 05/10/2019
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 05/01/2019
--	--	--	--

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 883 Continued From page 20

has the opportunity to refuse immunization; and

(iv) The resident's medical record includes documentation that indicates, at a minimum, the following:

(A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and

(B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal.

§485.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that-

(i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization;

(ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized;

(iii) The resident or the resident's representative has the opportunity to refuse immunization; and

(iv) The resident's medical record includes documentation that indicates, at a minimum, the following:

(A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and

(B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal.

F 883

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

PRINTED: 05/10/2019
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 05/01/2019
--	--	--	--

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 883

Continued From page 21
This REQUIREMENT is not met as evidenced by:
Based on staff interview and record review, the facility failed to ensure that the resident or resident representative were provided education regarding the benefits and potential side effects of the influenza vaccine and that an informed consent was obtained before administration of the influenza vaccine for 5 of 5 sampled residents (Residents #45, #49, #57, #75 and #86).

Confirmation was made by the Licensed Practical Nurse on 5/1/19 at 2:23 PM, that there was no evidence in resident medical records that the facility obtained a signed informed consent form prior to administration of the influenza vaccine, that the resident or resident representative were provided updated educational information regarding the influenza vaccine used during the 2018/2019 influenza season.

F 883

F 921

Safe/Functional/Sanitary/Comfortable Environ CFR(s): 483.90(i)

§483.90(i) Other Environmental Conditions
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 confirmed by staff interview, the facility failed to provide a safe, functional, sanitary and comfortable environment. Findings include:

1. Per facility tour in the presence of the Center Executive Director (CED), Maintenance Director, the Regional Executive Director and the Regional Healthcare Services Supervisor for

F 921

F921
No residents had a negative impact.
All residents have the potential to be impacted.
Construction for the removal of the pipes began 5/13.
Thermostat covers have been ordered and will be replaced as needed throughout the building.
The heater has been fixed. The television has been removed. The Crown moulding has been replaced. The wheelchairs have been stored elsewhere.
Environmental rounds initiated weekly with IPP, UM, CNE, maintenance, housekeeping, and CED.

audits by CED or designee will occur weekly times 4, then monthly times 2 or until 100% compliant. Results will be reported to QAPI.

Date of compliance: May 31, 2019

FTAI POL accepted 5/20/19 R.Trembley/Rd/Amu

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

PRINTED: 05/10/2019
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 05/01/2019
--	--	--	--

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 921	<p>Continued From page 22</p> <p>Housekeeping/Nutritional Services on 4/30/19 at 2:06 PM, a resident bathroom (B-20) was identified with an exposed pipe protruding from the wall. No protective covering was provided in place of the faucet handle that have been removed, leaving the butt end of the pipe exposed. The exposed pipe could potentially lead to an injury if someone fell against it. A Licensed Nurse Aide confirms on 5/1/19 at approximately 4 PM that the resident is capable of using the bathroom with or without assistance.</p> <p>Confirmation was made by the Maintenance Director at the time of the tour that the above bathroom has an exposed pipe with an unprotected end.</p> <p>2. Per facility tour in the presence of the CED, Maintenance Director, the Regional Executive Director and the Regional Healthcare Services Supervisor for Housekeeping/Nutritional Services on 4/30/19 at 2:06 PM, Room B 3 was found to have the thermostat without a cover, leaving the working mechanism exposed. This was confirmed during the tour.</p> <p>3. On 4/29/2019 at 11:03 AM the baseboard heat radiator in the A- wing Solarium was found with the cover bent forward exposing a large area of sharp fins. Two large pieces of crown molding (where the wall meets the ceiling), were missing. A television was placed on the floor next to a wheelchair scale. There were also two unidentified wheelchairs being stored in the area.</p> <p>Per interview on 4/29/19 at 11:30AM, the Unit Manager confirmed that the sharp fins inside the baseboard heater were exposed. S/he confirmed that the crown molding was missing, and that the television and wheelchairs should not be stored in</p>	F 921		

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

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 05/01/2019
--	--	--	--

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-921 Continued From page 23
a resident common area. S/he also confirmed that the Solarium is used by residents and it is also used for resident yoga. Per interview with the CED on 4/30/19, s/he was not aware that the room was in that condition.

F 921

May 22, 2019

Addendum to POC submitted 5/21/19-see changes to original POC in bold.

F800

No residents had a negative outcome

All residents can be effected

Dietary staff will be educated on tray card system and resident preferences located on tray cards

Dietary manager will review resident preferences and update tickets accordingly.

Tray distribution will be shorted by use of single serve condiments and individual drinks.

Audits will occur by account manager or designee weekly times 4, then monthly times two, or until substantial compliance is achieved. Results will be reported to QAPI committee.

Date of compliance: May 31, 2019

F804

No residents had a negative outcome

All residents can be effected

Dietary staff have been educated on acceptable food temperature storage and the procedure for temperature logging.

Dietary manager will review resident preferences and update tickets accordingly

Audits will occur by account manager or designee weekly times 4, then monthly times two, or until substantial compliance is achieved. Results will be reported to QAPI committee.

Date of compliance: May 31, 2019

Respectfully submitted,

Melissa Haupt, CED