

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

June 14, 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 21, 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

amlaMCtaPN

Licensing Chief

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		OMB NO. 0938-03 (X3) DATE SURVEY COMPLETED	
		**************************************				C
NAME OF I	PROVIDER OR SUPPLIE	475020	B. WING		05	/21/2019
	HEALTH & REHAB		1 3	STREET ADDRESS, CITY, STATE, ZIP COD 98 HOSPITALITY DRIVE BARRE, VT 05641	<u>.</u>	
(X4) ID	SUMMARYS	TATEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF CORRE	ATTION .	-
PREFIX TAG	(EACH DEFICIENC	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	COMPLETION DATE
F 000	INITIAL COMMEN	ITS .	France	The filing of this plan of correct		
9.		T. F. C.	F 000	not constitute an admission of		
	An unannounced	complaint investigation was	4	allegations set forth in the stat		
	conducted by the	Division of Licensing and	į. Į	deficiencies. The plan of correc		
	Protection of 5/20	and 5/21/19. The following		prepared and executed as evid		Total Section of the
	regulatory violation	ns were identified:		the facility's continued complia	nce with	#
F 623	Notice Requireme	nts Before Transfer/Discharge	F 623	applicable law.		
SS=B	CFR(s): 483.15(c)	(3)-(6)(8)		F 623	4)	1. 2. 1.
r	§483.15(c)(3) Not	ice before transfer.		The transfer notice for resider		
100	Before a facility tra	ansfers or discharges a		resident #2 was delivered to	nt #1 and	
E 9	resident, the facility	ry must- ent and the resident's	in .	resident #2 was delivered to r		
	representative(s)	of the transfer or discharge and		and were uploaded on 5/20/1	.9.	
1	the reasons for the	e move in writing and in a		An audit for the completion o	ftha	1 80
	language and mar	nner they understand. The		transfer notice for residents to	ancforred	Še.
	facility must send	a copy of the notice to a	÷	in the last 60 days was comple	tod	ž.
4	Long-Term Care (he Office of the State				
-	(ii) Record the rea	sons for the transfer or		Residents that are transferred	have the	
	discharge in the re	esident's medical record in		potential to be affected by this	s alleged	1
i i	accordance with p	aragraph (c)(2) of this section;		deficient practice.		
		notice the items described in		Education was provided		ŀ
1	paragraph (c)(5) o	f this section		Education was provided to nur	ses,	
			0	department managers, and m	anagers	
ě	§483.15(c)(4) Tim	ing of the notice.		on duty regarding the transfer	process.	
*	(i) Except as spec	ified in paragraphs (c)(4)(ii) and on, the notice of transfer or		Audits of transfers will occur w	e o kly	Đ.
***	discharge required	I under this section must be		times 4, then monthly times 2	or until	
44	made by the facilit	y at least 30 days before the	1.	substantial compliance has bee	or until	23 25
	resident is transfei	red or discharged.	•	achieved. Results will be repor	(1) ************************************	i i
	(II) Notice must be	made as soon as practicable		reviewed for further recomme	ted and	
	(A) The safety of it	discharge when- ndividuals in the facility would	7	at QAPI.	ndations	
4 * 6	be endangered un	der paragraph (c)(1)(i)(C) of		we som i.		F 16
* E	this section;			Date of compliance: June 21, 2	019	
	(B) The health of in	ndividuals in the facility would		F623 POC accepted with attached ad	dendiem	
	be endangered, ur	nder paragraph (c)(1)(i)(D) of		6/13/19 MBertranen		
ORATORY	DIRACTOR'S OR PROVI	DER/SUPPLIER REPRESENTATIVE'S SIGN	NATURE ,	, TITLE	THE SHIP IS	(X6) DATE
·	Mitteu	A Roman	ustra	AM	6/11	5/19
deficiency	statement ending with	Van asterisk (*) denotes a deficiency who	ob the most of	ion may be excused from correcting prov	iding it is deta	rmined tha
saregua wing the c	ras provide sufficient of	otection to the patients. (See instruction	s.) Except for	r nursing homes, the findings stated above	e are disclos	able 90 day
s following ram partic	the date these docume	ents are made available to the facility it	or nursing hor	r flursing nomes, the findings stated above mes, the above findings and plans of corr are cited, an approved plan of correction	rection are di	sclosable 1

ORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: N4YJ11

Facility ID: 475020

If continuation sheet Page 1 of 10

AN EIVIE	NT OF DEFICIENCIES: I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUI A. BUILC	FORM APPROV OMB NO. 0938-03 MULTIPLE CONSTRUCTION (X3) DATE SURVEY COMPLETED
AME OF	PROVIDER OR SUPPLIER	475020	B. WING	NGC
ERLIN	I HEALTH & REHAB (OTR .	Open to the over the control of	STREET ADDRESS, CITY, STATE, ZIP CODE 98 HOSPITALITY DRIVE BARRE, VT 05641
(X4) ID PREFIX TAG		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CORRECTION (X5) FIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETIC G. CROSS-REFERENCED TO THE APPROPRIATE DATE
F 623	this section; (C) The resident's allow a more imme under paragraph (c) (D) An immediate to required by the resunder paragraph (c)	health improves sufficiently to diate transfer or discharge, (1)(i)(B) of this section; ransfer or discharge is ident's urgent medical needs,	F-6	623
	days. §483.15(c)(5) Continuotice specified in produce include the following the reason for transferred or discharge in the continuous forms of the co	ents of the notice. The written paragraph (c)(3) of this section lowing ransfer or discharge; te of transfer or discharge; which the resident is arged; he resident's appeal rights, address (mailing and email); per of the entity which		
1 () 3 o ft to 0 a c ()	completing the form hearing request; (v) The name, addrest elephone number of cong-Term Care Om vi) For nursing facilities, the mailir elephone number of the protection and adlevelopmental disabilities, the mailir elephone number of the protection and adlevelopmental disabilities of the Developmental disabilities at 42 U.S.C. (vii) For nursing facilities and the protection and Bill of Rights Act.	orm and assistance in and submitting the appeal ass (mailing and email) and the Office of the State budsman; by residents with intellectual isabilities or related and email address and the agency responsible for vocacy of individuals with littles established under Part tal Disabilities Assistance of 2000 (Pub. L. 106-402, 15001 et seg.); and		
	Sorder or related dis	papilities, the mailing and		

CENTER	RS FOR MEDICAR	E & MEDICAID SERVICES	1							0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/GLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILC	Sept.	E CONSTRUCT	ION	2			SURVEY PLETED
		475020	B. WING		-	7				21/2019
NAME OF F	PROVIDER OR SUPPLIE	R	·	ST	TREET ADDRES	SS, CITY,	STATE, ZII	PCODE	1 001	4.172013
BERLIN	BERLIN HEALTH & REHAB CTR			98	HÖSPITALIT ARRE, VT 0	Y DRIVE		5.00		2
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG	ış	(EACH	CORREC	TIVE ACT	CORRECTI ON SHOU! HE APPRO Y)	D BE	(X5) COMPLETION DATE
F 623	Continued From	page 2		323	99	· "	- 2	181871		3 Company of the Comp
	email address an	d telephone number of the		JZJ		275	ŝ			*
	advocacy of indiv	ole for the protection and iduals with a mental disorder or the Protection and Advocacy	2	λ			\$ 	*	18.3	
	for Mentally III Inc	lividuals Act.								
	If the information	anges to the notice: in the notice changes prior to	مسترد (۹) به وجوزت	П	*	ä	· & :			
T.	must update the	sfer or discharge, the facility recipients of the notice as soon ce the updated information le.	A Company and the Company and			78		8 4	9 2	
	In the case of facting the administrator written notification	tice in advance of facility closure ility closure, the individual who is of the facility must provide n prior to the impending closure	4	o .	¥	3 * 0	ě	10 M M	ž	2
	State Long-Term the facility, and the well as the plan f	ey Agency, the Office of the Care Ombudsman, residents of the resident representatives, as or the transfer and adequate residents, as required at \$	en james versten og med de james til men skyllet for en skyllet for en skyllet for en skyllet for en skyllet f	e de la companya de l					2 F	
() () () ()	483.70(I). This REQUIREM	ENT is not met as evidenced								Al constraint of the state of t
	failed to notify the	ew and record review the facility resident and/or the resident's writing, of a transfer/discharge		and the second second second second second						24
	and the reasons residents, (Residents, also failed to noti	for the transfer, for 2 applicable ents #1 and #2). The facility fy a representative of the Office 1-Term Care Ombudsman as	Water State of the	there the below, it is a second			195			of particular to the second se
	required. The fin	idings include the following:	•	State of the State of		4.6				
iv.	had been transfe due to an elevate and respiratory re	medical records, Resident #1, rred to the hospital on 5/5/19 ed temperature, and low heart ate. There is no evidence		The state of the s				2		
Sec. 25.	located in the me	edical record identifying that the	13	×			9			3

Charles and the second of the second	The second secon	& MEDICAID SERVICES				0938-0391
ATEMENT (OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING _	CONSTRUCTION	(X3) DATE	SURVEY
3.	8.	475020	B; WING.	<u> </u>	05/2	21/2019
IAME OF PI	ROVIDER OR SUPPLIER	7	ŠŤ	REET ADDRESS, CITY, STATE, ZIP COD		
BERLIN H	IEALTH & REHAB C	TR.	K2 12501A	HOSPITALITY DRIVE ARRE, VT 05641	manythe fieldiges	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS REFERENCED TO THE API DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE
		5	ř			
F 623	Continued From pa family and for repre the required notific	esentative was provided with	F 623		\$77	And the state of t
	5/20/19 at approxing was made that s/h documents related Resident #1 that of confirms that the of Ombudsman was required. The Admis her/his responsing notice. The facility on 5/20/19 at approximently there is not the resident and/of transfer/discharge holidays and/or at Coordinator is not	the Admission Coordinator on mately 2:33 PM, confirmation e is unable to locate any to transfer/discharge for courred on 5/5/19. S/he also office of the Long-Term Care not notified of the transfer as mission Coordinator confirms it bility to provide the required y Executive Director confirms oximately 3:10 PM that to process in place to provide representative the notice of during off hours, weekends, any time the Admission scheduled to work.				
F 606	to the hospital for Per interview with (AC) at 2:30 PM, to completed. The Alabout this transfer surveyors had ask and that they had resident had been	ew, Resident #2 was transferred an acute condition on 5/20/19 the Admissions Goordinator he transfer notice had just been C stated that they only knew to the hospital because the sed to see the documentation, not been notified that the transferred prior to this.				
F 625 SS=B	CFR(s): 483.15(d)		F 625		z.	
i K	§483.15(d) Notice	of bed-hold policy and return-	**************************************	9.	4 . *	
	nursing facility tra the resident goes	ice before transfer. Before a nsfers a resident to a hospital or on therapeutic leave, the ist provide written information to	Pea.			

DIMITMEN	T OF DEFICIENCIES	E & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	Tayay Marin Tin	C	FORM APPROVEI MB NO. 0938-039
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A, BUILDIN	PLE CONSTRUCTION S	(X3) DATE SURVEY COMPLETED
NAME OF	PROVIDER OR SUPPLIE	475020	B: WING_	SI .	C
	2000	*		STREET ADDRESS, CITY, STATE, ZIP CODE	05/21/2019
·	HEALTH & REHAB			98 HOSPITALITY DRIVE BARRE, VT 05641	
(X4) ID PREFIX	SUMMARY ST	TATEMENT OF DEFICIENCIES	io i	The second secon	E come demonstrate was as
TAG	(CAO) OEFICIENT	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	OF CONTRACT
F 625	Continued From p	age 4	5.00	F 625	
	the resident or res	ident representative that	F 625		45
7	Specifies-			The bed hold notice for resident #1	
	(i) The duration of	the state bed-hold policy, if		resident #2 were delivered to resid	ent
· ·	return and resume	the resident is permitted to residence in the nursing		and uploaded on 5/20/19.	STAKE.
o shearpay.	100mty.		2	An audit for the completion of the I	hed
	(II) The reserve be	d payment policy in the state		hold notice for residents transferre	d in
7	(iii) The nursing fac	ility's policios sa sad		the last 60 days was completed.	U III
i	ped-fiold bellods I	Which must be consistent in		Residents that transfer have the	The state of the s
	resident to return:	INIS Section permitting a	N .	potential to be affected by this alleg	
	(iv) The information of this section.	and i specified in paragraph (e)(1)	¥	deficient practice.	gea
ļ			1 to 1	Education will be provided to nurse	c
	§483.15(d)(2) Bed-	hold notice upon transfer, At		department managers, and manage	re !
	hospitalization or th	Oha resident for		on duty regarding the bed hold prod	ess.
· · · · · · · · · · · · · · · · · · ·	Gomes mast provide	of the recident and the			
§ +1	Coldent lepresents	TIVE Written notice was a	=	Audits of bed holds will occur weekl	У
	specifies file fill still	on of the hod kald well	4	times 4, then monthly times 2 or un	til 🕴 -
	ACOCHOCU III IIAI AAN	ann (d)(1) aftha	15500	substantial compliance has been	i ji k
		NT is not met as evidenced		achieved. Results will be reported ar	nd
ž	Based on interview	and record review the facility	2	reviewed at QAPI	* -
3 5%	anca to hours the re	Sident and/or the		Date of compliance: June 21, 2019	Y
10000	Shicoculative III MI	IIIIO Of a hed hold and L			
	one applicati	le residents, (Residents #1 gs include the following:		FGDS PDC accepted with attached addendu	um.
1	. Per review of me	idical records. Daniers us	di I		
	an Accid Hallelle	I In the bornital on First			
- 5	ac to all clevated t	emperature and law basis		**	- 8
G	THE MODIFICION PAIR	here is no ouidance			ž
10	rearen in the wedic	al record identifying the take			Add a
W	ritten notice of a be	sentative was provided with hold and return policy at			181
th	e time of the trans	fer.	4		i
		e i		51 2-	- H 2
CMS-2567	02-99) Previous Vossi	The second secon	<u> </u>	7 The second of	

HAILME	NT OF DEFICIENCIES I OF CORRECTION	E & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BÜILD	TIPLE CONSTRUCTION	FORM APPROVE OMB NO. 0938-039 (X3) DATE SURVEY COMPLETED
NAME	PROMOPO AS ALTON	475020	B. WING		C
BERLIN	F PROVIDER OR SUPPLIER N HEALTH & REHAB (CTR		STREET ADDRESS, CITY, STATE, ZIP CODE 98 HOSPITALITY DRIVE BARRE, VT 05641	05/21/2019
(X4) ID PREFIX TAG	TEACH DEFICIEN	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID. PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRODEFICIENCY)	DOE COMPLETION
F 625	was made that s/h documents related policy for Resident The Admission Co responsibility to pre facility Executive E approximately 3-10 process in place to representative the policy during off he	the Admission Coordinator on mately 02:33 AM, confirmation e is unable to locate any to a bed hold notice and return #1 that occurred on 5/5/19 ordinator confirms it is her/his poide the required notice. The hirector confirms on 5/20/19 at 0 PM that currently there is no provide the resident and/or notice of bed hold and return urs, weekends, holidays the Admission Coordinator in	F 6	25	
F 726 SS=C	2. Per record reviet to the hospital for a Per interview with t (AC) at 2:30 PM, the and return policy had ac stated that they to the hospital becato see the document.	w. Resident #2 was transferred in acute condition on 5/20/19, he Admissions Coordinator e written notice of bed hold ad just been completed. The only knew about this transfer use the surveyors had asked hation, and that they had not he resident had been this.	F 726		
	provide nursing and resident safety and practicable physical well-being of each resident assessment and considering the	ve sufficient nursing staff with ipetencies and skills sets to related services to assure attain or maintain the highest mental, and psychosocial esident, as determined by			

DEPARTI	MENT OF HEALTH	AND HUMAN SERVICES		C	MB NO.	938-0391
TATEMENT	S FOR MEDICANE OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING	LE CONSTRUCTION	(X3) DATE COMP	LETED
		475020	B. WING	*	lue:	1/2019
NAME OF P	ROVIDER OR SUPPLIER	7,3043		STREET ADDRESS, CITY, STATE, ZIP CODE	-0.0V	
		, , , , , , , , , , , , , , , , , , ,	5	98 HOSPITALITY DRIVE	198	
BERLIN I	IEALTH & REHAB C	TR:		BARRE, VT 05641	1 1 1 1 1 1 1 1 -	<u> </u>
(X4) ID PREFIX TAG	JEACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAĞ	PROVIDER'S PLAN OF CORRECTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) GOMPLETION DATE
		2 °				
F 726			F 72	6 F 726	200	4
Æ	accordance with that §483.70(e).	ne facility assessment required		Employee #1 no longer works in	the	ę.
e e	CA02-25(5)/2) The	facility must ensure that	11/1	center.	3	
	licensed nurses h	ave the specific competencies		Employee #2 has received comp	etency	1
	and skill sets nece	essary to care for residents!		training.		
	needs, as identifie	ed through resident			a for	
	assessments, and	d described in the plan of care.		Competency training is occurring		
	6483.35(a)(4) Pro	viding care includes but is not	Cilia Cita	licensed staff with a focus on Re	esidenc	
	limited to assessi	ng, evaluating, planning and		rights, person centered care,	kille	
		ident care plans and responding		communication, basic nursing s		
	to resident's need	15.	i i	basic restorative nursing skills,	anu	
	§483.35(c) Profic	iency of nurse aides.	aluji ka	infection control.		
	The facility must	ensure that nurse aides are able		Employee files will be audited f	or	
e 2	to demonstrate o	ompetency in skills and		competency training and upda		
540	needs as identifi	ssary to care for residents" ed through resident	1	needed.		
	assessments, an	d described in the plan of care.	Printer and the second	100	***	
	This REQUIREM	ENT is not met as evidenced		Audits of competency training	will occur	
	by:	vation and confirmed by staff		weekly times 4, then monthly	times 2 01	
	interview, the fac	ility failed to ensure that 2 of 2	i s	until substantial compliance ha		
	Licensed Nurse	Aides (LNA's) have specific		achieved. Results will be repo	rted and	
	competencies ar	nd skill sets to provided nursing	a.	reviewed at QAPI.		
	attain or maintair	ices to assure resident safety and the highest practicable physical chosocial well-being of each	ii,	Date of compliance: June 21,	2019	į.
	resident, (Emplo include the follow	yee #1 and #2). The findings	200 \$ 50 mm	F726 PDC accepted with attached a	ddendum	
	C. M. 100			6/13/19 MBortrand RAIPML.		i i
an a	1. Per review of	Employee #1's file on 5/20/19,	400	9		3
	s/he is a contrac	cted (agency) employee; hired or) til		*	
37f. +	5/25/19 There	heduled to work at the facility un is no evidence that s/he has	91			1 11
	completed the 8	mandatory education programs	į			
5	required by the	Genesis organization. On 3/4/1	9 1	44		
	Code of Conduc	ct for new employees a			and the second	Contract of the second

ATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	The second of th	PLE CONSTRUCTIO	N		(X3) DATE	SURVEY	
D PLAN O	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING.			4.			
			35 35 WHATE	200			051	21/2019	
		475020	B. WING_	0 × 5 × 5 × 5 × 5 × 5 × 5 × 5 × 5 × 5 ×	Situ etate	אום פסטב	1 03/2	21/2013	
NAME OF F	ROVIDER OR SUPPLIE	R %	4	STREET ADDRESS		ZIP CODE			
BERLIN I	HEALTH & REHAB	GTR		98 HOSPITALITY BARRE, VT 05	5641	S made and a			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES NCY MUST BE PREGEDED BY FULL	ID PREFIX	/EACH (VIDER'S PLAN O	CTION SHOUL	D.BE	(X5) COMPLETION DATE	
PREFIX	REGULATORY O	R LSC IDENTIFYING INFORMATION)	TAG	CROSS-R	EFERENCED TO DEFICIEN	THE APPRO	PRIATE	, Danie	
1/40		91	1	4	DEI/IOIE			32 × 1-1 × 1	
F 726	Continued From	page 7	F7	26				# # -	
, ,,,,,		am was completed. On 3/14/19	1		845				
	an Ahuse Prohit	oition Case Scenarios Handout							
	au actionnaire w	as answered. The employee file	j			***		1	
	does not contait	any information from the	Ì	1				i	
	contracted com	pany that evidences that	THE STATE OF THE S	j.	NE CONTRACTOR OF THE CONTRACTO		3	1	
	Employee #1 ha	is had competency audits prior to	2			8		i	
	his/her Genesis	employment. Nor is there	1	\$ F:	0				
	evidence that th	e facility has evaluated	Ì			ď.			
	competencies f	or Employee #1.	1						
		# · · · · · · · · · · · · · · · · · · ·	į.	133					
	Confirmation w	as made by the Executive Director	or i —	75		F4.		1	
	and the Directo	r of Nurses (DNS) on 5/20/19 the	it .	k.	8		9	i.	
	Genesis Health	care requires that all agency stat	f				349)	
	working directly	with patient care receive the	Ì	g.		N.	Ý	. 1	
	following training	ig's prior to working with patients			A. 8.				
	on the units:		1	i.	2				
	-Genesis Com	oliance and Ethics Program/Code	9 .	į.	2 5				
	of Conduct;	± 4-					ě.	1	
	-Discrimination	and Harassment in the	, Land of the land			13			
	Workplace;	0.000	4		2		4		
	-Safety Trainin		* 4	1		*	6	Į.	
¥	-Resident Righ							•	
(6)	-Abuse Prohib	ition;							
		r in Long Term Care,				125			
	-Emergency P	reparedness;	. 2	K	4				
		ia 1-3 Hand-in-Hand Education)	B v					4	
	Training _*	ą.	4	^ {				1	
	0 6	was made by the DNS on 5/21/19	i at	i			8	ž.	
	Confirmation	1.40 PM, that Employee #1 has	not						
	approximately	raining requirements, nor is there	ž.						
	any evidence	that the contracted company	ř.					5**-	
•	provided infor	mation related to competencies	ž.				*	1	
	completed pri	or to his/her hire date of 3/4/19.	Nor .	*	£16			-	
	is there evide	nce that the facility has evaluated		50000000000000000000000000000000000000				2	
	competencies	o for Employee #1 in skills and	6 6						
	techniques ne	ecessary to care for residents nee	eds	į.				4	
	including but	not limited to such areas as:	**************************************	Service of the servic					
	Resident Ria	nts, Person Centered Care,	¥	i. k				sheet Page	

CENTE	RS FOR MEDICARE	& MEDICAID SERVICES				APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A, BUILDIN	IPLE CONSTRUCTION NG	COM	E SURVEY PLETED
		475020	B. WING_			3 21/2019
NAME OF	PROVIDER OR SUPPLIER	4		STREET ADDRESS, CITY, STATE, ZIP CODE	1	20
BERLIN	HEALTH & REHAB C	TR	*	98 HOSPITALITY DRIVE BARRE, VT 05641		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE.	(X5) COMPLETION DATE
F 726	Continued From pa Communication, Ba Restorative Nursing Control.	ige 8 asic Nursing Skills, Basic g services, and Infection	F 72	6	é	
	with a hire date on any documents der	nployee #2's file on 5/20/19, 12/1/15, does not evidence monstrating that the facility has notes for Employee #2.		A THE PARTY OF THE		- Constitution of the cons
e e	on 5/21/19 at appro are unable to locate that Employee #2 r evaluated in skills a	nade by the Director of Nurses eximately 1:40 PM that they are any documents that identify has had competencies and techniques necessary to needs including but not limited	7	Note that the state of the stat		
F 730	to such areas as: J Centered Care, Co Skills, Basic Restor Infection Control	Resident Rights, Person mmunication, Basic Nursing rative Nursing services, and Review-12 hr/yr In-Service	E 7 0	76.		A CONTRACTOR CONTRACTO
SS=B	CFR(s): 483.35(d)(7)	F 73			
	The facility must co of every nurse aide months, and must i	ular in-service education, implete a performance review at least once every 12 provide regular in-service			Pa ⁴	2
	education based or reviews. In-service requirements of §4. This REQUIREMEN	n the outcome of these training must comply with the				
	2 Licensed Nurse A received at least 12	e file review and confirmed by facility failed to ensure that 1 of sides (LNA's) reviewed, hours of regular in-service see #2). The findings include		A STATE OF THE PROPERTY OF THE	4	age and the same of the same and the same an

CENTE	RS FOR MEDICARE OF DEFICIENCIES	AND HUMAN SERVICES & MEDICAID SERVICES		OM.	NTED; 06/03/2019 FORM APPROVED B NO. 0938-039
ND PLAN C	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING	LE CONSTRUCTION (c)	(3) DATE SURVEY COMPLETED
NAME OF I	DEOMBER OF CO.	475020	B. WING.	Section 1. Company of the Company of	Č 05/24/2040
	PROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP CODE	05/21/2019
	HEALTH & REHAB C	W		8 HOSPITALITY DRIVE BARRE, VT 05641	# *E
(X4) ID PREFIX TAG	(EACH DEFICIENCY	STEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ÍD PRÉFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE GROSS REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) E COMPLETION TE DATE
F 730	Continued From pa	ge 9.	F 730	F 730	
The second secon	educational program date: -2/6/18 Sensitivity T -2/23/18 Whirlpool	oyee #2's file on 5/20/19, with 15, evidences the following ms completed in 2018-2019 to raining 15 minutes; Tub 30 minutes;	1 100	Employee #2 is receiving ongoing education towards 12 hour mandate minimum education for 2019. LNA files have been audited for	d
Section species are sense, and section species are sense.	(refusals and show)	aten to minutes; cument in Pont of Care ers not on shower day) 20 are education 30 minutes.	a a	education hours for 2019. Ongoing training is occurring for LNA staff.	
	Confirmation was mon 5/21/19 at approare unable to locate	ear totals 1 hour and 50 hade by the Director of Nurses ximately 1:40 PM that they any documents that identify as completed the 12 hours of as required.	221	Audits of education will occur weekly times 4, then monthly times 2 or unti substantial compliance has been achieved. Results will be reviewed ar reported at QAPI. Date of compliance: June 21, 2019	The same
iliye addin da addin		The state of the s	The state of the s	F730 POC accepted with attached addendum 6/13/19 meertrand PN/PML	
			* * * * * * * * * * * * * * * * * * *		
	· · · · · · · · · · · · · · · · · · ·	22 A A A A A A A A A A A A A A A A A A	BIOLOGICA CA		
			25 (g		
out the second		W T WENT TO THE	The state of the s		
M CMS are	7(02-99) Previous Versions C		Globa:	*	

Addendum to 5/21 POC for Berlin Health and Rehab

June 13, 2019

F 623

Department managers and staff nurses are responsible for ensuring notice of transfer is given outside normal business hours. Center executive director will monitor.

F 625

Department managers and staff nurses are responsible for ensuring that notice of bedhold is given outside of normal business hours. Center executive director will monitor.

F 726

Nurse practice educator will administer competencies for LNAs with a focus on resident rights, person centered care, communication, basic nursing skills, basic restorative nursing skills, and infection control. Center Nurse Executive will monitor progress.

F 730

Nurse practice educator is responsible for ensuring the 12 hour mandatory minimum education requirements are completed for LNAs. Center nurse executive will monitor progress.