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 11, 2021

Mr. Brian Labelle, Administrator
Berlin Health & Rehab Ctr
98 Hospitality Drive
Barre, VT 05641-5360

Dear Mr. Labelle:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **May 19, 2021.** 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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	475020	A. BUILDING ______ B. WING ______	05/19/2021

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

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E 000	Initial Comments The Division of Licensing and Protection conducted an emergency preparedness survey on 5/19/21. There were no regulatory violations related to emergency preparedness.	E 000	The filing of this plan of correction does not constitute an admission of the allegations set forth in the statements of deficiencies. Berlin Health and Rehab doing business as Berlin Meadows has prepared and executed a plan of correction as evidence of the facilities' continued compliance with applicable federal and state laws.	
F 000	INITIAL COMMENTS An unannounced onsite recertification survey was conducted by the Division of Licensing and Protection from 5/17/21 to 5/19/21. The following regulatory deficiencies were identified as a result.	F 000		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to	F 690	Residents #75 and 60 have had their catheters adjusted to be off the floor. Both resident's continue to reside in the center and are having their needs met. Residents who have indwelling catheters have a potential to be affected by this alleged deficient practice. All residents with indwelling catheters were audited on 5/19/21 to ensure drainage collection bags are off the floor. Nursing staff were re-educated on the policy/procedure for placing drainage bags in a manner that keeps them off the floor to prevent the possibility of infection. Director of Nursing/designee will conduct random audits on residents who have indwelling drainage collection bags. These audits will be done weekly X 4 then monthly X 3 or until such time substantial compliance has been achieved.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [illegible signature] LNHA
TITLE: ADMINISTRATOR
(X6) DATE: 06/9/2021

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.

F690 - F804 POC's accepted 6/10/21 KCampos RN/pmc

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F 690	Continued From page 1 prevent urinary tract infections and to restore continence to the extent possible, §483 25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible, This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure that all residents who are incontinent of bladder receive appropriate treatment and services to prevent urinary tract infections for two of 6 residents (Resident #75 and Resident #60). Findings include: 1. Per record review, Resident #60 has a diagnosis of neuromuscular dysfunction of the bladder, unspecified (a bladder dysfunction that can make normal urination difficult) as well as a diagnosis of urinary retention. As a result, Resident #60 has a suprapubic catheter (a tube inserted into the bladder through a hole made below the belly button that drains urine into a bag). On 5/17/2021 at approximately 9:30am, Resident #60 was observed in his/her wheelchair in the hallway with an opaque urine collection bag hooked onto the wheelchair below the wheelchair seat, partially resting on the floor. Later that day at approximately 12:30pm, Resident #60 was observed in the main dining room in his/her wheelchair. The urine collection bag was hooked onto the wheelchair below the	F 690	The results of these audits will be reviewed by the QAPI committee for further recommendations. Date of Compliance 6/17/2021	

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F 690	Continued From page 2 wheelchair seat, partially resting on the floor At approximately 2:30pm that same day, Resident #60 was observed being wheeled back to his/her room by a staff member. The urine collection bag was hooked onto the wheelchair below the wheelchair seat, partially dragging along the floor as s/he went down the hallway 2. Per record review, Resident #75 has a diagnosis of neuromuscular dysfunction of the bladder, unspecified as well as cauda equina syndrome (a syndrome that effects function of the bladder). As a result, Resident #60 has an indwelling catheter (a tube inserted into the bladder through the urethra that drains urine into a bag) On 5/17/2021 at approximately 2:50 pm, Resident #75 was observed in his/her bed with an opaque urine collection bag hooked onto the side of the bed, partially resting on the floor Per interview on 5/19/2021 at approximately 11:20 am, the Unit Manager confirmed that nursing staff are expected to ensure that the foley bag is secured off of the floor to prevent possible contamination of the foley bag and subsequent urinary infection. A short time later, the Nurse Practice Educator provided the facility's procedure guide for care of indwelling catheters and examples of clinical competency validations for staff who have received urinary catheter training. Both the procedure guide and competency validation sheets include information regarding the need to secure the foley bag off of the floor	F 690		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning	F 695		

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F 695	Continued From page 3 CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation and confirmed by staff interview and record review, the facility failed to ensure that a resident who needs respiratory care is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals, and preferences for two of 6 residents who use portable oxygen tanks when out of their rooms (Resident #47 and Resident #74). Findings include: 1. During observation of the 5/17/2021 lunch service at 12:20pm in the main dining room, Resident #47 was observed to be experiencing shortness of breath as evidenced by gasping and clutching his/her chest. Resident #47 was wearing a nasal cannula (a device that delivers oxygen via tube through the nose) connected to an oxygen tank on the back of his/her wheelchair. Resident #47 stated that s/he was experiencing shortness of breath, was out of oxygen and was waiting for a facility staff member to come back and help him/her obtain more oxygen. Resident #47 stated that s/he had mentioned the issue to a facility staff member approximately 10 minutes prior to our interaction. Observation of the oxygen	F 695	Residents #47 and 74 were immediately provided with full oxygen tanks. Both residents continue to reside in the center and are having their needs met. Residents who require portable oxygen use, have a potential to be affected by this alleged deficient practice. All residents with portable oxygen tanks were audited on 5/19/21 for adequate oxygen supply while on portable tanks. Nursing staff were re-educated on the policy/procedure for converting a resident to a portable tank from the concentrator, frequency of monitoring for appropriate levels of compressed air, and signing off when completed in the TAR. Director of Nursing/designee will conduct random audits on residents who utilize portable oxygen tanks. These audits will be done weekly X 4 then monthly X 3 or until such time substantial compliance has been achieved. The results of these audits will be reviewed by the QAPI committee for further recommendations. Date of Compliance 6/17/2021	

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F 695	Continued From page 4 level of Resident #47's tank showed an oxygen level of 0 pounds per square inch (a unit of measurement for oxygen). We alerted the unit manager who obtained a new oxygen tank for the Resident. Per record review, Resident #47 had the following active order in his/her chart at the time of observation "Oxygen @ 3L/min (liters per minute) via NC (nasal cannula) continuous (all the time). every shift for SOB (shortness of breath)." Resident #47's care plan had the following care plan focus: "The resident has Oxygen Therapy related to COPD (Chronic Obstructive Pulmonary Disease - a respiratory disease that causes difficulty breathing)" and an intervention for that care plan focus that read, "OXYGEN SETTINGS as ordered by MD (Doctor of Medicine)." 2 During observation of the 5/17/2021 lunch service at 12:30pm in the main dining room, Resident #74 had an oxygen tank on the back of his/her wheelchair that showed an oxygen level of 0 pounds per square inch. Resident #74 was not receiving oxygen at this time. Per record review, Resident #74 had the following active order in his/her chart at the time of observation: "Oxygen @ 1 L/min via nc continuous every shift related to CHRONIC OBSTRUCTIVE PULMONARY DISEASE, UNSPECIFIED." Resident #74's care plan had the following care plan focus: "The resident has Oxygen Therapy related to COPD, CHF (Congestive Heart Failure - a heart condition that can cause difficulty breathing)" and an intervention for that care plan focus that read, "O2 (oxygen) as ordered via NC."	F 695		

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F 695	Continued From page 5 Per interview on 5/18/2021 at approximately 3:40pm, the Nurse Practice Educator stated that there are no formal expectations for nursing staff regarding the frequency or indications for checking the oxygen levels in portable oxygen tanks and/or replacing portable oxygen tanks. S/he also confirmed that there is no education provided to facility staff on such topics. Shortly after our interview, the Educator provided a copy of the facility's procedure guide for high pressure oxygen cylinders (portable oxygen tanks). Per review of the guide, it instructs facility staff to "replace [the tank] if pressure is 500 pounds per square inch or less."	F 695		
F 804 SS=E	Nutritive Value/Appear, Palatable/Prefer Temp 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, resident interview, and staff interview, the facility failed to ensure that each resident receives, and the facility provides, food and drink that is palatable, attractive, and at a safe and appetizing temperature for 6 of 19 interviewed Residents (Resident #51, Resident #42, Resident #55, Resident #47, Resident #29, and Resident #66). Findings include:	F 804	Residents #51, 42, 55, 47, 29, and 66 are being interviewed regularly about the satisfaction of their meals. All residents noted above continue to reside in the center and are having their needs met. Residents who reside on the long term care unit have the potential to be affected by this alleged deficient practice. The meal delivery system is being changed from tray line service to point of service/steam table in the dining room for the long term care units and the portion of C wing that is not the AOU unit. Nursing, dietary and management staff have been reeducated on the change in meal delivery system.	

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F 804	Continued From page 6 1 During resident interviews, Residents #51, #42, #55, #47, #29, and #66 voiced concerns about hot foods frequently being cold by the time their meals are delivered to them. 2 State surveyors requested that a test tray be served at the end of 5/18/21 lunch service on the unit with the smallest census. Surveyors received the 10th and final tray from the jitney (food service cart) at 12:43pm. Food temperatures were checked with a calibrated food thermometer The temperatures were as follows: - Roasted Ham registered a temperature of 125.7 degrees Fahrenheit (below safe temperature for hot foods), - Cooked spinach registered a temperature of 131.7 degrees Fahrenheit (below safe temperature for hot foods); - Baked Potato registered a temperature of 145.5 degrees Fahrenheit; - Fruit Salad registered a temperature of 58.1 degrees Fahrenheit (above safe temperature for cold foods) According to food safety, the "danger zone" is a temperature range above 41 degrees Fahrenheit (F) and below 135 degrees F that allow the rapid growth of harmful pathogens (germs) that can cause foodborne illness. The longer food remains in the danger zone, the greater the risks for growth of harmful pathogens. Bacteria multiply rapidly in a moist environment in the danger zone. To ensure 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 During an interview on 5/18/2021 at	F 804	Dietary Director/designee will conduct random audits of food temperatures daily at point of service to ensure food is being served at desirable temperatures. These audits will be conducted weekly x 4 and monthly x 3 or until such time substantial compliance has been achieved. The results of these audits will be reviewed by the QAPI committee for further recommendations Date of Compliance 6/17/2021	

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F 804	Continued From page 7 approximately 2:30pm, the Administrator and Dietary Services Manager confirmed that the temperatures of the ham, spinach, and fruit were not safe temperatures for food served to Residents.	F 804		