VERMONT

AGENCY OF HUMAN SERVICES
DEPARTMENT OF DISABILITIES, AGING AND INDEPENDENT LIVING

Division of Licensing and Protection
HC 2 South, 280 State Drive
Waterbury, VT 05671-2060
http://www.dail.vermont.gov
Survey and Certification Voice/TTY (802) 241-0480
Survey and Certification Fax (802) 241-0343
Survey and Certification Reporting Line: (888) 700-5330
To Report Adult Abuse: (800) 564-1612

August 31, 2022

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

Dear Ms. Moxley:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **August 10, 2022.** 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

Pamela M. Cota, RN
Licensing Chief

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	475020	A. BUILDING _____ B. WING _____	C 08/10/2022

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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 review during the annual recertification survey on 8/10/22. There were no regulatory violations identified.	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 has prepared and executed a plan of correction as evidence of the facilities' continued compliance with applicable federal and state laws.	09/09/2022
F 000	INITIAL COMMENTS The Division of Licensing and Protection conducted an unannounced, on-site re-certification survey, staff vaccination requirement review and 1 compliant investigation 8/8/22 - 8/10/22. The following regulatory violations were identified as a result:	F 000		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6).	F 656	F 656 Resident #24 continues to reside at the facility and has their needs met. Residents who have care plans and orders for wound care are potentially at risk due to this alleged deficient practice. A house-wide audit was conducted for residents with wound care orders for proper compliance. All nurses were re-educated on the NSG 241 Treatments Policy and NSG 246 Wound Dressing Policy. This is also part of the orientation process for all newly hired nurses.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Amanda Quagliano	Administrator	8/30/2022

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 656	Continued From page 1 (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility failed to develop a comprehensive care plan for 1 applicable resident in the sample of 29. (Resident #24) Findings include: There was no care plan to address Resident # 24's needs related to a wound. Resident # 24 was admitted to the facility on 5/6/20 and was being treated for a wound on his/her foot. On 08/09/22 at 12:30 PM, the A wing Unit Manager stated that there should be a care plan to address needs related to an actual wound and confirmed that there was no care plan in place to address these needs.	F 656	Audits will be conducted weekly X4 and monthly X2 by DON or designee to monitor effectiveness of the plan. The audit results will be reviewed at QAPI for further interventions if needed. Tag F656 PoC accepted ON 8/31/2022 by R. Tremblay/PMC	
F 657	Care Plan Timing and Revision	F 657		

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F 657 SS=D	Continued From page 2 CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on Observation, Interview and record review, the facility failed to ensure that a care plan was revised to reflect the most current representation regarding 1 resident (#52) in a sample of 29.	F 657	F 657 Resident #52 had no negative effects as a result of the alleged deficient practice. Resident #52 care plan has been revised to reflect risk from suicidal ideation. Residents with history of suicidal ideation have the potential to be affected by the alleged deficient practice. Education will be provided to all nurses and social services on revision of care plans to reflect psychosocial needs of the resident related to the incidents. DON or designee will conduct random audits weekly X4 and monthly X2 to monitor effectiveness of interventions. The audit results will be reviewed at QAPI for further interventions if needed.	

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F 657	Continued From page 3 Findings include: During observation on 08/08/22 of resident #52's room, there was no call light cord connected to the wall for the resident to use if s/he needed to alert staff for help. The medication nurse and an LNA stated that the resident did have a hand-held "Dinger Bell" at bedside, but the resident may have misplaced or lost it. The nurse stated it would be replaced. Review of a care plan for resident # 52, indicates "The resident has incidents of verbalization of suicidal ideations (Date Initiated: 12/27/2021)." Removing the call light and replacing it with a hand- held bell is not listed as a safety measure to prevent strangulation in the intervention column of the care plan. The call light cord was removed due to threats of suicide per the Unit B nurse manager per interview on 08/09/22 at 02:24 PM. S/he confirmed that the resident's care plan had not been updated to reflect removing of the call light and replacing it with a hand bell as a safety intervention prior to surveyor observation.	F 657	Tag F657 Poc accepted on 8/31/2022 by R.Trembley/PMC	
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices.	F 684	F 684 Resident #24 continues to reside at the facility and has their needs met. Residents with wound treatments have the potential to be affected by the alleged deficient practice.	

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F 684	Continued From page 4 This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility staff failed to ensure that 1of 3 applicable resident of the sample of 29 (Resident #24) was provided needed care and services that are resident centered, in accordance with the resident's preferences and goals for care that will meet each resident's physical, mental, and psychosocial needs. Findings include: Staff did not provide treatment to Resident # 24's wound as ordered by the medical provider. Resident # 24 has a wound on his/her right great toe requiring daily and as needed treatment. A Nurse Practitioner order dated 7/6/22 stated " Cleanse area and pat dry. Cover wound bed with manuka honey. Cover with foam between toes and wrap with kling. Change daily and PRN (as needed). The resident's wound did not improve and h/she was transfered to an acute care hospital on 8/4/22. On 08/09/22 at 12:23 PM, the Center Nurse Executive (CNE) confirmed that there is no indication on the July 2022 Treatment Administration Record (TAR) that wound treatment was done as ordered on 7/12, 7/14 and 7/18/22.	F 684	All nurses were re-educated on the NSG 241 Treatments Policy and NSG 246 Wound Dressing Policy. This is also part of the orientation process for all newly hired nurses. DON or designee will conduct random audits of wound care. Signed off as ordered weekly X4 and monthly X2. The audit results will be reviewed at QAPI for further interventions if needed. Tag F684 accepted on 8/31/2022 by R. Trumbley JPMC	
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(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	F 689	F 689 Resident #31 continues to reside in the facility and has their needs met. Residents who reside at the center have the potential to be affected.	

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F 689	Continued From page 5 accidents. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility created a hazard thus failing to ensure the environment remains as free of accident hazards as possible for 1 applicable resident (resident #31). Findings include: On August 8, 2022, an unsecured yellow extension cord plugged into a wall outlet was noted on the floor beneath the edge of the resident #31's bed, creating a potential accident hazard. The extension cord had a built-in power strip with numerous outlets noted to have 5 cords plugged into it. The extension cord and 5 additional cords were tangled with the resident's oxygen tubing resulting in a jumble of cords. Each cord was traced with the following equipment identified as sources; the electric bed, a pressure reducing mattress, an oxygen compressor used to deliver oxygen to the resident, a portable air conditioner and what appeared to be a phone charger which was plugged into the power strip with the other end lying on the floor. The electric bed cord was noted to originate from the right side of the bed, was threaded across the head of the bed between the frame and mattress to the left side where it was then plugged into the power strip. At 2:30 on August 8, 2022, the Director of Maintenance viewed the extension cord and confirmed it should not be in use. Per the Electrical Safety Foundation International Resource Library Power strips are not designed to be used with medical devices in patient care areas.	F 689	A house-wide fire safety audit was completed by the maintenance director and no other infractions found. Staff education will occur regarding the proper use of extension cords within the facility. Maintenance or designee will continue audits weekly X4 and monthly X2. The audit results will be reviewed at QAPI for further interventions if needed. Tag F689 PoC accepted on 8/31/2022 by R. Tremblay / PMC	

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F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of	F 880	F 880 Resident #278 continues to reside at the facility and has their needs met. All residents who receive fingerstick blood glucose measurements are at potential risk for this alleged deficient practice. All nurses and MNAs performed competencies regarding fingerstick glucose measurement. All nurses and MNAs were re-educated on policy NSG 126 and the proper compliance with fingerstick glucose measurement procedure to include infection control measures. This is part of the orientation process for new nursing staff upon hire. DON or designee will conduct random glucose measurement audits weekly X4 and monthly X2. The audit results will be reviewed at QAPI for further interventions if needed.	

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F 880	Continued From page 7 infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and a review of facility policy the facility staff failed to adhere to infection control practice when providing care for 1 applicable resident in the sample of 29 (Resident #278). Findings include: A staff nurse did not perform hand hygiene, don	F 880		

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F 880	Continued From page 8 gloves or place a clean barrier on the bedside table for supplies prior to checking residents #278's glucose level. Per observation on August 8, 2022, at 9:20 AM, a staff nurse checked the blood glucose of resident # 278 using a lancet to pierce the residents finger to obtain a blood sample. The nurse entered the resident's room and placed the supplies for the procedure on the overbed table next to the residents breakfast tray. H/she proceeded to conduct the procedure without performing hand hygiene or donning gloves. Per interview with the nurse following this incident h/she confirmed h/she should have placed a clean barrier on the bedside table for supplies, performed hand hygiene and donned gloves prior to the procedure. A review of the facility policy entitled Fingerstick glucose Measurement with a revision date of 06/15/2022 the following steps are specified: #8. Place supplies on a clean barrier on the bedside table. #9. Perform hand hygiene. #10. Put on gloves.	F 880	Tag F880 PoC accepted on 8/31/2022 by R. Trentley / PMC	