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

February 28, 2023

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

Dear Ms. Russell:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **February 9, 2023.** 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 02/09/2023

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

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F 000	INITIAL COMMENTS The Division of Licensing and Protection conducted an onsite, unannounced investigation of one complaint on 2/9/2023. The following regulatory deficiencies were identified:	F 000		2/28/23
F 657 SS=E	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on interview, record review, and facility	F 657	Resident #1 was discharged to another nursing facility on 2/2/23. An audit of resident's records for upcoming CP meetings was completed to validate resident and residents were invited to participate to the extent practicable with an explanation included in the resident's medical record if the participation of the resident and their resident representative is determined not practicable . The facility and the IDT reviews and revises the care plan after each Minimum Data Set (MDS) 3.0 assessments. This includes invitation to participation of the resident and resident's representative to the extent practicable. An explanation is included in the resident's medical record if the participation of the resident and their resident representative is determined not practicable , after each Minimum Data Set (MDS) 3.0 assessments. Facility IDT staff have been re-educated to this process and will be educated on an on-going basis as needed. NHA/Designee will complete random weekly Audit x 4 weeks, then monthly x 2 months of scheduled CP Meetings to validate an invitation to participation was made to the resident and resident's representative to the extent practicable. The results of these audits will be brought to the Monthly QAPI Committee for further review and recommendations.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

[signature] LNHA 2/27/23

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 657	Continued From page 1 policy review, the facility failed to routinely include a resident representative to participate in care planning meetings for 1 of 3 sampled residents. Findings include: Record review reveals that Resident #1 was admitted to the facility on 6/10/22 with diagnoses that include dementia and congestive heart failure. Resident #1's medical record did not reveal documentation that Resident #1's representative had been invited to a care plan meeting, Resident #1's representative had attended a care plan meeting, or an explanation as to why participation was determined impracticable for Resident #1's representative to participate in the development of Resident #1's care plan. Per interview on 2/9/23 at 11:42 AM, Resident #1's representative stated that s/he had never been invited or attended a care plan meeting for Resident #1 since s/he was admitted to the facility. Facility policy titled OPS416 Person-Centered Care Plan, revised 10/24/22, states on page 4 "The Center has the responsibility to assist patients to participate by ... [f]acilitating the inclusion of the patient/ resident representative(s) to attend." The facility was unable to produce evidence of the above when requested on 1/10/23 at approximately 12:30 PM by the surveyor.	F 657	**Tag F 657 POC accepted on 2/28/23 by S. Stem/P. Cota**	02/28/23
F 660 SS=E	Discharge Planning Process CFR(s): 483.21(c)(1)(i)-(ix) §483.21(c)(1) Discharge Planning Process	F 660	Resident #1 was discharged to another nursing facility on 2/2/23. Resident#2 was discharged to an assisted living facility on 1/19/23. Resident #3 was discharged to an assisted living facility on 12/6/22.	

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F 660	Continued From page 2 The facility must develop and implement an effective discharge planning process that focuses on the resident's discharge goals, the preparation of residents to be active partners and effectively transition them to post-discharge care, and the reduction of factors leading to preventable readmissions. The facility's discharge planning process must be consistent with the discharge rights set forth at 483.15(b) as applicable and- (i) Ensure that the discharge needs of each resident are identified and result in the development of a discharge plan for each resident. (ii) Include regular re-evaluation of residents to identify changes that require modification of the discharge plan. The discharge plan must be updated, as needed, to reflect these changes. (iii) Involve the interdisciplinary team, as defined by §483.21(b)(2)(ii), in the ongoing process of developing the discharge plan. (iv) Consider caregiver/support person availability and the resident's or caregiver's/support person(s) capacity and capability to perform required care, as part of the identification of discharge needs. (v) Involve the resident and resident representative in the development of the discharge plan and inform the resident and resident representative of the final plan. (vi) Address the resident's goals of care and treatment preferences. (vii) Document that a resident has been asked about their interest in receiving information regarding returning to the community. (A) If the resident indicates an interest in returning to the community, the facility must document any referrals to local contact agencies or other appropriate entities made for this purpose.	F 660	An audit of residents that are expected to discharge was completed to validate that discharge care plans are in place and a discharge plan has been initiated. The facility ensures that the discharge needs of each resident are identified and results in the development of a discharge plan for each resident i ncluding the update of a resident's comprehensive care plan. IDT members have been educated on this process and on-going education will be completed as needed. Administrator/ designee will complete audits weekly x 4 weeks then monthly x 2 months of new admissions to validate discharge care plans are in place and documented in the plan of care. Results of these audits will be brought to the monthly QAPI Committee for further review and recommendations. **Tag F 660 POC accepted on 2/28/23 by S. Stem/P. Cota**	

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F 660	Continued From page 3 (B) Facilities must update a resident's comprehensive care plan and discharge plan, as appropriate, in response to information received from referrals to local contact agencies or other appropriate entities. (C) If discharge to the community is determined to not be feasible, the facility must document who made the determination and why. (viii) For residents who are transferred to another SNF or who are discharged to a HHA, IRF, or LTCH, assist residents and their resident representatives in selecting a post-acute care provider by using data that includes, but is not limited to SNF, HHA, IRF, or LTCH standardized patient assessment data, data on quality measures, and data on resource use to the extent the data is available. The facility must ensure that the post-acute care standardized patient assessment data, data on quality measures, and data on resource use is relevant and applicable to the resident's goals of care and treatment preferences. (ix) Document, complete on a timely basis based on the resident's needs, and include in the clinical record, the evaluation of the resident's discharge needs and discharge plan. The results of the evaluation must be discussed with the resident or resident's representative. All relevant resident information must be incorporated into the discharge plan to facilitate its implementation and to avoid unnecessary delays in the resident's discharge or transfer. This REQUIREMENT is not met as evidenced by: Based on interview, record review, and facility policy review, the facility failed to address discharge goals in the plan of care and complete a discharge plan in a timely manner for 3 of 3 sampled residents (Residents #1, #2, and #3).	F 660		

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F 660	Continued From page 4 Findings include: 1. Record review reveals that Resident #1 was admitted to the facility on 6/10/22 with diagnoses that include dementia and congestive heart failure. Resident #1 was discharged to another nursing facility on 2/2/23. Resident #1's care plan does not reveal a focus or goal of care for discharge. A discharge plan [discharge plan documentation user defined assessment] was initiated on 1/31/23, two days before his/her discharge. On 2/9/23 at 11:42 AM, Resident #1's representative stated that s/he did not like the care that Resident #1 was receiving at the facility. S/he stated that she had initiated discharge three weeks prior to Resident #1 being discharged. S/he explained that the admitting nursing facility was ready to admit Resident #1 immediately but was unable to due to the delay in the discharge process. S/He stated that s/he had never been invited or attended a care plan meeting for Resident #1 since s/he was admitted to the facility in June. On 2/9/23 at approximately 12:15 PM, the Social Service Specialist stated that Resident #1's information was sent by fax to the admitting nursing facility on 1/16/23, confirming that the facility was aware of the Resident #1's desire to discharge 16 days prior to discharge planning was initiated and 18 days prior to actual discharge. 2. Record review reveals that Resident #2 was admitted to the facility on 8/30/22 with diagnoses that include type 2 diabetes mellitus and congestive heart failure. Resident #2 was	F 660		

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F 660	Continued From page 5	F 660		

discharged to an assisted living facility on 1/19/23. Resident #2's care plan does not reveal a focus or goal of care for discharge. A discharge plan was initiated on 1/16/23, three days before his/her discharge.

3. Record review reveals that Resident #3 was admitted to the facility on 11/18/18 with diagnoses that include chronic obstructive pulmonary disease, type 2 diabetes mellitus, and hypertension. Resident #3 was discharged to an assisted living facility on 12/6/22. Resident #3's care plan does not reveal a focus or goal of care for discharge. A discharge plan was initiated on 12/2/22, four days before his/her discharge.

Facility policy titled OPS406 Discharge Planning Process, revised on 11/15/22, reveals on page 1, "Discharge planning will begin upon admission and be completed as part of the Person-Centered Care Plan process." Page 3 reveals "Discharge Plan Documentation UDA [user defined assessment] will begin as early as admission and no later than seven days prior to patient discharge.

Per interview on 2/9/23 at approximately 3:15 PM, the substitute Director of Nursing confirmed that there were no discharge care plans for Residents #1, #2, and #3.