

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 <u>http://www.dail.vermont.gov</u> 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 17, 2023

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

Dear Ms. Wood:

Enclosed is a copy of your acceptable plans of correction for the complaint investigation conducted on **July 27, 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,

Jamela M Cota RN

Pamela M. Cota, RN Licensing Chief

Enclosure

CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/11/2023 FORM APPROVED OMB NO 0938-0391

STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI			(X3) DATE SURVEY COMPLETED	
		475000		B. WING		С	
L		475020	D. WING			07/2	27/2023
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, S	TATE, ZIP CODE		
	EALTH & REHAB CTR			98 HOSPITALITY DRIVE			
				BARRE, VT 05641			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S	S PLAN OF CORRECTION		(X5)
PREFIX	-	YMUST BE PRECEDED BY FULL	PREFIX		CTIVE ACTION SHOULD B		COMPLETION
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG		NCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
F 000				state and federal	ection was written t guidelines. It is no compliance. Howe	t an	
	of complaint #22010 c offsite investigation th determine if the facility CFR Part 483, Requir	sing and Protection punced, on-site investigation on 7/18/2023, with additional at ensued until 7/27/23, to y was in compliance with 42 rements for Long Term Care ng regulatory violations were		is it the facility co and maintain con	mmitment to demo	nstrate	
F 635		Orders for Immediate Care	F 635 F635 Specific Corrective Action				
SS=G			1.00				
	 §483.20(a) Admission orders At the time each resident is admitted, the facility must have physician orders for the resident's immediate care. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility failed to obtain accurate physician orders to provide necessary care and services on admission for 3 of 3 applicable residents (Residents #1, #2, and #3). Findings include: Facility policy Standards and Procedures for All Licensed Independent Practitioners, revised 9/17/21, states, 			Resident #2 was o	discharged on 06/2 discharged on 7/19 discharged on 8/3/2	/2023.	
				to validate that th	ent orders was com le facility obtained to provide necessa	accurate	
				readmitted to the physician orders care. This is inclu reconciliation upo and approval of n attending physicia	es that residents a facility have accura- for the residents im sive of medication on admission/readn nedications from th an/designee. Licer actor, and APP will	ate imediate nission e ised	
	physician or advanced	of a patient, the attending d practice provider (APP) is propriate admission orders		re-educated to the	is process.	be	
	include comprehensiv signs, activity level, re appropriate testing to other laboratory and r advance care plans a	rule out active tuberculosis,		checks to validate obtained through the process. These au then weekly x 4 w months. Results of brought to the mo for further review a	ill complete admiss accurate physician the medication reco udits will be M-F x - reeks, then monthly of these audits will I nthly QAPI Commi and recommendati	n orders onciliatio 4 weeks, 7 x 3 De Itee	n
				Date of Complian	nce 8/23/23		
LABORATORY	DIRECTOR'S OR PROVIDER/S	SUPPLIER REPRESENTATIVE'S SIGNATURE		TITLE			(6) DATE
Hally Word, LNHO Admin 8:14:23							

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.

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

PRINTED: 08/11/2023 FORM APPROVED

TATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL		(X3) DATE SURVEY	
	F CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING			PLETED
						С
		475020	B. WING		07/27/2023	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD		
				98 HOSPITALITY DRIVE		
BERLINH	IEALTH & REHAB CTR			BARRE, VT 05641		
(X4) ID		STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CO		(X5)
PREFIX TAG		ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE		COMPLETIC DATE
IAG			IAO	DEFICIENCY)		
E 005						
F 635	Continued From page		F 638			
	Facility policy OPS424 Medication Reconciliation,			Tag F 635 POC accepted	on 8/15/23 bv	
	effective 9/1/2022, s			S. Stem/P. Cota		
	"The patient's medic		- i -			
		ransition of care. Medication				
		process of comparing a				
		edication orders to all the				
		s the patient has been taking.				
	· ·	s obtaining and maintaining a				
		ate list of current medication				
		ncare settings. Medication				
		es collaboration with the				
		e and multiple disciplines				
	including admission					
		d practice providers (APP),				
	licensed nurses, and					
		ation will be performed when				
		d/readmitted from hospital.				
		d from the hospital: obtain				
		f Medication Administration				
		eatment Administration				
		ns, and Physician's Order				
		y MAR/TAR information with				
	transfer forms and F					
		e patient's admission				
		the hospital and/or home				
		rs will be made. Information				
		udes but is not limited to:				
		tions; PRN [as needed]				
		s; vitamins; nutritional				
		tal nutrition; infusion				
		ounter medications; vaccines				
		tration, if known; medication				
		e dates. Clarify medication				
		taff from transferring hospital,				
		y discrepancies discovered				
		will be reported to the				
		re finalizing the current list of				
	medications.	on will be performed to				
	A repeat reconciliation	on will be performed to				

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT		(X3) DATE SURVEY COMPLETED			
			A. BUILDIN	NG			С	
		475020	B. WING			0	07/27/2023	
	ROVIDER OR SUPPLIER			98 H	et address, city, state, zip code Dspitality drive			
				BAR	RE, VT 05641			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	:	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETI DATE	
F 635	Continued From pag	je 2	F 6	35				
	compare hospital/ho medication listing to listing to MAR. Any o							
	1. A hospital transition of care report reveals that Resident #1 was transferred to the facility for sub-acute rehabilitation on 6/20/2023 with diagnoses that include: cancer, cancer related pain, severe malnutrition, compression fracture of the spine, and back pain. The note indicates that s/he has 7 wounds on his/her chest and abdomen							
	ECG [electrocardiog electrical activity of the electrode] on while in resonance imaging n magnets to create im	orevious provider leaving on ram; a test that records he heart] leads [metal n an MRI machine [Magnetic nachine; a scanner using nages of the body]. Resident						
	through 6/22/23. Disonystatin (antifungal n suspension, 5 mL by days. The hospital M	eding treatment for thrush charge medications include nedication), 100,000 units/ml r mouth 4 times daily for 3 IAR (medication d) reveals that Resident #1						
	received two doses of from the hospital to t additional doses at 5 hospital MAR also re	of nystatin prior to discharge he facility and was due for :00 PM and 9:00 PM. The eveals Resident #1 has an (a medication used to treat						
	nerve pain) 100 mg 3 received one dose of discharge from the h	3 times daily; Resident #1						
	following wound care Resident #1's chest	te dated 6/20/23 reveals the e to the blisters and burns on and abdomen: y wound care Mepitel One [a						

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

PRINTED: 08/11/2023 FORM APPROVED OMB NO. 0938-0391

STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		475020	B. WING			C 07/27/2023	
	NAME OF PROVIDER OR SUPPLIER BERLIN HEALTH & REHAB CTR			STREET ADDRESS, CITY, STATE, ZIP C 98 HOSPITALITY DRIVE BARRE, VT 05641	CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BI		
F 635	and minimize pain at a place for 7 - 14d [days One with saline [salt w layer of Aquaphor [oir cover with Mepilex [for right chest, left flank, r [right lower quadrant] with saline Continue u antibiotic] Cover with Resident #1's facility administration record) care orders to the blis #1's chest and abdom in the 6/20/23 hospita is a wound care order 6/20/23: "Cleanse are wound spray, pat dry, Vaseline to each area until resolved every da An admission nursing 6/20/23 reveals that F coated and has oral tf #1's physician admiss order for nystatin was provider note dated 6 visit because Residen mouth pain. The note burning sensation in ti coating on the inner a mouth and throat [S with swallowing."	ressing to promote healing dressing changes]- leave in s] Clean through Mepitel vater solution] Apply thin intment] If leaking noted, am] border dressing; Burns midline abdomen, RLQ - daily wound care Clean use of Silvadene [topical Mepilex border dressing." TAR (treatment oreveals different wound ters and burns on Resident then than what was indicated I wound note. The following or placed by the facility on as on chest/trunk with apply small amount of and cover with dry dressing ay shift every other day." assessment note dated Resident #1's tongue is brush. Review of Resident sion orders reveals that an never entered or placed. A /24/2023 reveals an acute it #1 was experiencing states, "patient has a he mouth as well as white spect of the lips and the /he] has mild discomfort	F6	35			
FORM CMS-256	7(02-99) Previous Versions Obs		1	Facility ID: 475020	If continu	uation sheet Page 4 of 36	

PRINTED: 08/11/2023 FORM APPROVED OMB NO 0938-0391

CENTERS FOR MEDICARE & MEDICAID SERVICES					OMB NO, 0938-0391	
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		475020	B. WING			C 07/27/2023
	NAME OF PROVIDER OR SUPPLIER BERLIN HEALTH & REHAB CTR			STREET ADDRESS, C 98 HOSPITALITY DR BARRE, VT 05641		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	X (EACH C	IDER'S PLAN OF CORRECTION ORRECTIVE ACTION SHOULD B FERENCED TO THE APPROPRI DEFICIENCY)	
F 635	was on the way. The resident stated, "I am were not doing anythi Emergency Room Pro states, "Patient [has] mg of gabapentin 3 tii 75 mg of extended re the gabapentin." Hosj on 6/21/23 at 5:16 AM for 100 mg of gabape Resident #1's Physici order for gabapentin w on his/her 6/20/23 add readmission. There is documented in Residu to why gabapentin wa on 6/20/23 or on retur department on 6/21/2 Per interview on 7/17/ Registered Nurse (RM #1's admission orders use the hospital MAR medications. S/He sai the wound care note. Per interview on 7/24/ Clinical Lead revealed process for obtaining new admission, would receives the transfer i facility. Nursing will re including the transfer summary, MAR, and a care with the new adm who will also review th discrepancies betwee	behalf and an ambulance nurse documented that the in excruciating pain and you ing about it." A hospital ovider note dated 6/21/23 not been receiving her 100 mes daily. Will prescribe the lease morphine as well as pital discharge orders signed <i>I</i> include discharge orders ntin 3 times daily. Review of an orders reveals that an was never entered or placed mission or 6/21/23 in o explanation ent #1's medical record as as not ordered on admission in from the emergency 3. /23 at 10:01 AM, the I) that entered in Resident is stated that s/he does not to reconcile the id that s/he never looked at /23 at 12:15 PM, the Market d that, per facility policy, the and entering orders for a d be as such: nursing nformation from the sending view the information, of care, discharge any other instructions for nission's facility provider, ne hospital information. Any in the information received	F	635		
ORM CMS-256	7(02-99) Previous Versions Obse	reconciled. The provider will Delete Event ID: 84K31	11	Facility ID: 475020	If continu	uation sheet Page 5 of 36

CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/11/2023 FORM APPROVED OMB NO, 0938-0391

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI			(X3) DATE SURVEY COMPLETED	
		475020	B. WING			С	
NAME OF P	ROVIDER OR SUPPLIER	473020	B. WING	STREET ADDRESS, CITY, STATE, ZI	P CODE	07/27/20	23
BERLIN H	BERLIN HEALTH & REHAB CTR			98 HOSPITALITY DRIVE BARRE, VT 05641			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG	X (EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE	сом	(X5) PLETION DATE
F 635	give nursing orders for when in person, or ov- enter in the orders int record). A second nur that were entered into transfer information for that the double check administering medica treatments. The Marl that Resident #1's ad reviewed by another in began and that Resid not based on the facil Per interview on 7/24. #1's Attending Physic that s/he does not alw care information from placing admission or nurses are supposed facility provider before sure if that always had does not use the hosp medications, and that sending facility to mal included on the disch- unaware that Resider gabapentin at the hosp admission orders. Du 7/26/23 at 5:00 PM, F Physician stated that Resident #1's wound the admitting RN and treatment order were the hospital wound no nystatin was not order aware that there is a	ar admission, either verbally, ver the phone. The nurse will o the EHR (electronic health res will review the orders o the EHR and the hospital or accuracy; best practice is of orders will occur before tions or providing ket Clinical Lead confirmed mission orders were not hurse before treatment ent #1's wound orders were ity's formulary. /23 at 3:29 PM, Resident ian/Medical Director stated vays review the transfer of the sending facility before lers. S/He stated that to obtain orders from the e entering them in but is not ppen. S/He said that s/he pital MAR to reconcile it is the responsibility of the ke sure that all orders are arge summary. S/He was nt #1 was receiving spital when s/he gave ring a follow up interview on Resident #1's Attending s/he did not discuss care treatment orders with does not know how or why changed from what was on ote. S/He stated that s/he is very big problem with the admission orders for new	F	535			
FORM CMS-256	67(02-99) Previous Versions Obs	olete Event ID:84K31	1	Facility ID: 475020	If continu	uation sheet Page	e 6 of 36

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING COMP	E SURVEY PLETED C /27/2023
475020 B. WING O7/ NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE BERLIN HEALTH & REHAB CTR 98 HOSPITALITY DRIVE BARRE, VT 05641 DOUBTED DI UND COODDODITION	(X5) COMPLETION
BERLIN HEALTH & REHAB CTR 98 HOSPITALITY DRIVE BARRE, VT 05641	COMPLETION
BERLIN HEALTH & REHAB CTR BARRE, VT 05641	COMPLETION
BARRE, VT 05641	COMPLETION
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION	COMPLETION
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	
the EHR [electronic medical record] on 7/10/23 with a start date and time of 7/11/23, 9:00 PM. Review of Resident #2's MAR confirms that s/he did not receive Lovenox until 9:00 PM on 7/11/23. Per interview on 7/20/23 at 10:01 AM, the Market Clinical Lead confirmed that the order for Resident #2's Lovenox should have been started on Resident #2's admission date, 7/10/23	

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

Facility ID: 475020

If continuation sheet Page 7 of 36

CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/11/2023 FORM APPROVED OMB NO. 0938-0391

OLIVIEN						DIVID NO.	0000 0001
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL		_	(X3) DATE SI COMPLE	
						C	
		475020	B. WING			07/27	7/2023
NAME OF P	ROVIDER OR SUPPLIER		· · · · ·	STREET ADDRESS, CITY,	STATE, ZIP CODE		
				98 HOSPITALITY DRIVE			
	BERLIN HEALTH & REHAB CTR			BARRE, VT 05641			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION Y MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE			(X5) COMPLETION DATE		
					DEFICIENCY)		
F 635	3. Record review reverses admitted to the facility therapy evaluation and hospital stay related to pneumonia. On admissinclude chronic obstruktion (disease that causes lungs), multiple science nervous system), hyp and s/he is bed bournes summary, dated 7/7/2 orders: Budesonide [i inflammation of the air suspension for nebuli mist for inhalation], 0. day]; cefdinir (antibiot PO [by mouth] BID [the to take the last dose to course; and doxycyclimg tablet, 100 mg PC with instructions to take complete the 5 day comedication was disco (antibiotic) 250 mg cat Record review of Reserveal that orders for cefdinir were never pl Budesonide was not plater admission, and discontinued prior to a ordered by Resident a from 7/8/23 at 5:00 PI Physician confirmed to hyclate, cefdinir, and been placed. S/He states a submarked and the state of th	eals that Resident #3 was y on 7/7/23 for physical ad treatment following a to breathing difficulties and ssion, his/her diagnoses uctive pulmonary disease obstructed airflow from the osis (disease of the central eertension, morbid obesity, d. A hospital discharge 23, include the following nhaled steroid to decrease inway] 0.5 mg/2 mL zation [changes liquid to a 5 mg inhalation BID [twice a tic) 300 mg capsule, 300 mg wice a day] with instructions tonight to complete the 5 day ine hyclate (antibiotic) 100 0 Q12H [every 12 hours] ke the last dose tonight to ourse. The following intinued: Cephalexin apsule, daily. sident #3's physician orders doxycycline hyclate and laced; an order for placed until 7/25/23, 18 days cephalexin, despite being admission to the facility, was #3's Attending physician /23.	F	635			
	the order for cephales	xin and confirmed that the					
FORM CMS-256	67(02-99) Previous Versions Obs	solete Event ID: 84K311	1	Facility ID: 475020	If continu	uation sheet I	Page 8 of 36

CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/11/2023 FORM APPROVED OMB NO. 0938-0391

CENTER	S FOR MEDICARE &	VIEDICAID SERVICES			ON DIN	0920-0291
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING		(X3) DATE SURVEY COMPLETED	
		475020	B. WING			
		470020			0//2	27/2023
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
BERLIN H	EALTH & REHAB CTR			98 HOSPITALITY DRIVE		
				BARRE, VT 05641		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 635	order should not have the discharge summa In summary, the facilit staff are not accurated the transferring facility effectively reviewing a	e been placed according to ry. ty physician and nursing y reconciling all orders from / for new admissions by not all transfer of care rately transcribing orders e admission orders for	F 635		*	
E 655	655 Baseline Care Plan		F 655	F655 Specific Corrective Action		
		(3)	F 055	,		
SS=G	Planning §483.21(a) Baseline (§483.21(a)(1) The fact implement a baseline that includes the instru- effective and person-of that meet professiona The baseline care pla (i) Be developed withi admission. (ii) Include the minimu- necessary to properly including, but not limit (A) Initial goals based (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommo- §483.21(a)(2) The fac- comprehensive care p care plan if the compre-	ive Person-Centered Care Care Plans ility must develop and care plan for each resident uctions needed to provide centered care of the resident I standards of quality care. In must- I standards of quality care. In must- I standards of a resident's Im healthcare information care for a resident ed to- I on admission orders.		Resident #1 was discharged on 06/2 Resident #2 was discharged on 7/19 An audit of residents baseline care plan place within 48 hours of a resident's admission and include the minimum healthcare information necessary to care for a resident including, but not to Initial goals based on admission of Physician orders, Dietary orders, Therapy services, Social services, F recommendation, if applicable. The facility developed baseline care within 48 hours of a resident's admis and include the minimum healthcare information necessary to properly ca a resident including, but not limited Initial goals based on admission or Physician orders, Dietary orders, Therapy services, Social services, F recommendation, if applicable.	9/2023. olans is are in properly t limited orders, PASRR e plans ssion e are for to lers, PASRR	

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

Event ID: 84K311

Facility ID: 475020

If continuation sheet Page 9 of 36

CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/11/2023 FORM APPROVED OMB NO. 0938-0391

STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	(X3) DATE	(X3) DATE SURVEY		
	FCORRECTION	IDENTIFICATION NUMBER:				PLETED	
					c		
		475020	B. WING				
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COL		27/2023	
	NOVIDEN ON SOFFEIEN			98 HOSPITALITY DRIVE			
BERLIN H	IEALTH & REHAB CTI	R					
				BARRE, VT 05641			
(X4) ID			ID PREFIX	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO		(X5) COMPLETIO	
PREFIX TAG		OR LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE		DATE	
				DEFICIENCY			
				5055			
F 655	Continued From pa	age 9	F 655	5 F655 cont			
	admission.	admission. ii) Meets the requirements set forth in paragraph					
	(ii) Meets the requi			DON/Designee will comple		1	
	(b) of this section (excepting paragraph (b)(2)(i) of			resident's care plan to vali	date they are		
	this section).			in place within 48 hours of			
				These audits will be M-F x			
	§483.21(a)(3) The	e facility must provide the		then weekly x 4 weeks, the months.	an monulity x5		
		representative with a summary		monuis.			
		e plan that includes but is not		Results of these audits wil	be brought to		
	limited to:			the montly QAPI Committe	e for further		
	(i) The initial goals	s of the resident.		review and recommendation	ons.		
		the resident's medications and					
	dietary instructions						
		and treatments to be					
		e facility and personnel acting		Date of Compliance	/23/2023		
	on behalf of the fac	· · · ·					
		formation based on the details					
		ive care plan, as necessary.		Tag E 655 DOC apported	on 9/45/22 by		
		NT is not met as evidenced		Tag F 655 POC accepted S. Stem/P. Cota	011 0/15/23 Dy		
	by:			S. Stem/P. Cola			
	•	w, record review, and review of					
		facility failed to develop and					
		ne care plan within 48 hours of					
		uded the minimum healthcare					
		ary to properly care for the					
		sampled residents (Residents					
	#1 and #2). Finding						
		eveals that Resident #2 was					
		ility on 7/10/23 for therapy					
		l stay related to a right hip					
	•	pair. On admission, his/her					
		hypertension, venous					
	• • •	oper blood flow), anemia, type					
		espiratory failure, history of					
		al pulmonary embolism [PE; a					
		traveled to the lungs], and					
	heart failure.						
	A skin check doour	mented in an admission					
	A SKIT CHECK DOCUL	nemeu in an aumission					

PRINTED: 08/11/2023 FORM APPROVED

STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE (A. BUILDING		(X3) DATE SURVEY COMPLETED
		475020	B. WING		C 07/27/2023
	NAME OF PROVIDER OR SUPPLIER BERLIN HEALTH & REHAB CTR		98	REET ADDRESS, CITY, STATE, ZIP CODE HOSPITALITY DRIVE IRRE, VT 05641	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	DBE COMPLETION
F 655	nursing assessment of Resident #2 had multi and legs and a right h documentation of any Resident #2's heels. 7/10/23 indicates that pressure ulcer (Partia his/her sacrum. A wo 7/13/23 reveals that f middle DTI (deep tiss injury to subcutaneou present on admission 26 cm squared, with sanguineous (bloody) Attending Physician a that Resident #2 has heel requiring antibio Nurse Practitioner no Resident #2's left hee	dated 7/10/23 reveals that tiple bruises on his/her arms hip incision. There is no y wounds on either of A wound assessment dated t Resident #2 has a stage 2 al-thickness skin loss) on und assessment dated Resident #2 has a right heel, sue injury; a pressure-related is tissues under intact skin), h, measuring approximately a moderate amount of discharge. A 7/13/23 admission visit note reveals cellulitis (infection) in his/her tic treatment. A 7/17/23 te reveals a wound on el.	F 655		
	Resident #2's skin, w is no evidence that in prevention, wound as wound monitoring, or created or implement Resident #2's admiss plan failed to address admission orders; ph orders; therapy servic required by the regula skin was created on Resident #2's admiss plan was never create cellulitis (infection) in	ounds, and diabetes. There terventions for wound issessment, wound treatment, diabetic foot checks were ed within 48 hours of sion . Additionally, the care initial goals based on ysician orders; dietary ces; and social services as ations. A care plan related to 7/17/23, seven days after sion, and a diabetes care ed. Resident #2 developed a right heel wound that was ted for three days. See F686			

STATEMENT OF DEFICIENCIES AND FLAN OF CORRECTION (20) PROVIDER SUPPLIER (20) MULTIFIC CONSTRUCTION A BUILDING (20) MULTIFIC CONSTRUCTION B HOB/TILLITY DRIVE BARRE, VT 06641 (20) MULTIFIC B HOB/TILLITY DRIVE BARRE, VT 06641 (20) MULTIFIC CONRECTIONE AND UND B HOB/TILLITY DRIVE BARRE, VT 06644 (20) MULTIFIC B HOB/TILLITY DRIVE BARRE, VT 06644 (20) MULTIFIC CONRECTIONE AND UND B HOB/TILLITY DRIVE B HOB/TILLITY DRIV	CENTERS FOR MEDICARE & MEDICAID SERVICES						OMB N	O. 0938-0391	
476020 B. WNG OT/27/2023 NAME OF PROMDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZP CODE STREET ADDRESS, CITY, STATE, ZP CODE BERLIN HEALTH & REHAB CTR STREET ADDRESS, CITY, STATE, ZP CODE STREET ADDRESS, CITY, STATE, ZP CODE Image: Comparison of the Component of the PROCENCIES PREST ADDRESS PLAN OF CORRECTION RESULATORY OR LSO DEMINING MYORMATCH D PROVIDER SPLAN OF CORRECTION RESULATORY OR LSO DEMINING MYORMATCH PROVIDER COMPACTION AS HOULD BE CONSERPTION AND HOULD BE CONSERPTION AND HOULD BE DEFICIENCY) D PROVIDER CORRECTION PROVIDER OF NAME OF DEFICIENCY D PROVIDER PROVIDER OF NAME OF DEFICIENCY D PROVIDER OF NAME OF DEFICIENCY D D PROVIDER OF NAME OF DEFICIENCY D PROVIDER OF NAME OF NA						JCTION			
NME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STRE, ZIP CODE BERLIN HEALTH & REHAB CTR SIMMARY STREMENT OF DEFICIENCIES. (200, D) (200,			475020	B. WING			1	- 1	
BERRE, VT 05641 04010 PREFX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MAST BE PRECIDED 97 ULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFX TAG PREFX (EACH CORRECTION (EACH CORRECTION CALL DE CROSS-REFERENCE TO THE APPROPRIATE DEFICIENCY MAST BE PREFX TAG PREFX (EACH CORRECTION (EACH CORRECTION CROSS-REFERENCE TO THE APPROPRIATE DEFICIENCY) 00 0000000000000000000000000000000000	NAME OF P	ROVIDER OR SUPPLIER			STREETAD	DRESS, CITY, STATE, ZIP CODE			
Preferix TxG (EACH DEFICIENCY MUST & PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING NORMATION) PREFX TxG (EACH DEFICIENCY TO IS SC IDENTIFYING NORMATION) PREFX TxG (EACH DEFICIENCY OR LSC IDENTIFYING NORMATION) DEFICIENCY F 655 Continued From page 11 F	BERLIN HEALTH & REHAB CTR								
 Facility policy NSG236 Skin Integrity and Wound Management, revised 2/1/23, indicates that the plan of care for skin integrity and wound management is based on wound evaluation and should include identifying prevention or treatment interventions, comprehensive skin and wound assessments, and daily monitoring of wounds. On 7/25/23 at 12:20 PM, the Market Clinical Lead stated that all wounds are to be monitored daily and should be documented on the TAR. S/He confirmed that this had not been done daily for Resident #2. S/He also confirmed that Resident #2 did not have a complete baseline care plan within 48 hours of admission. On 7/27/23 at 9:20 AM, the Market Clinical Lead confirmed that there were no wound treatment orders for Resident #2's right heel prior to the wound assessment on 7/13/23. 2. A hospital transition of care report reveals that Resident #1 was transferred to the facility for sub-acute rehabilitation on 6/20/2023 with diagnoses that include: cancer, cancer related pain, severe malhutthion, compression fracture of the spine, and back pain. The note indicates that s/he has 7 wounds on his/her chest and abdomen that resulted from a previous provider leaving on ECG [electrocardiogram; a test that records electrical activity of the heart] leads [metal 	PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFIX		(EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROP	DBE	COMPLETION	
resonance imaging machine; a scanner using magnets to create images of the body]. Resident #1's is identified as needing treatment for thrush through 6/22/23. A goal to follow up with oncology after completing rehab services is identified. Discharge medications include: Morphine 15 mg CR [extended release], 5 tablets every 12 hours	F 655	Facility policy NSG23 Management, revised plan of care for skin in management is based should include identify interventions, compre- assessments, and da On 7/25/23 at 12:20 F stated that all wounds and should be docum confirmed that this ha Resident #2. S/He als #2 did not have a com within 48 hours of adr AM, the Market Clinic were no wound treatm #2's right heel prior to 7/13/23. 2. A hospital transition Resident #1 was trans sub-acute rehabilitation diagnoses that include pain, severe malnutrit the spine, and back p s/he has 7 wounds or that resulted from a p ECG [electrocardiogra electrical activity of th electrode] on while in resonance imaging m magnets to create ima #1's is identified as no through 6/22/23. A go after completing rehal Discharge medication	6 Skin Integrity and Wound d 2/1/23, indicates that the netgrity and wound d on wound evaluation and ying prevention or treatment thensive skin and wound ily monitoring of wounds. PM, the Market Clinical Lead a are to be monitored daily ented on the TAR. S/He d not been done daily for so confirmed that Resident nplete baseline care plan mission. On 7/27/23 at 9:20 al Lead confirmed that there nent orders for Resident of care report reveals that sferred to the facility for on on 6/20/2023 with e: cancer, cancer related ion, compression fracture of ain. The note indicates that n his/her chest and abdomen revious provider leaving on am; a test that records e heart] leads [metal an MRI machine [magnetic achine; a scanner using ages of the body]. Resident eading treatment for thrush val to follow up with oncology b services is identified. is include: Morphine 15 mg	F	55				

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

Facility ID: 475020

If continuation sheet Page 12 of 36

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
			The DoleDinto		с
		475020	B. WING		07/27/2023
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	DE
BERLIN H	IEALTH & REHAB CTR			98 HOSPITALITY DRIVE BARRE, VT 05641	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	DN SHOULD BE COMPLETE IE APPROPRIATE DATE
F 655	for 2 days; morphine 1 tablet every 3 hours 120 mg a day; gabap treat nerve pain) 100 nystatin (antifungal m suspension, 5 mL by days. A hospital wour reveals the following w and burns on Resider "Blisters/Bullae - daily long staying wound du and minimize pain at place for 7 - 14d Cleas saline [salt water solu Aquaphor [ointment] I Mepilex [foam] border chest, left flank, midlin lower quadrant] - daily saline Continue use of antibiotic] Cover with The note also reveals prevent pressure injust to consider if Residern An admission nursing 6/20/23 identifies mul #1's chest and an abr buttock. There are no documentation of dail MAR, TAR, or in prog medical record. Review of physician of wound orders placed to scabbed abrasion of	15 mg [immediate release], as needed for pain up to entin (a medication used to mg 3 times daily; and edication), 100,000 units/ml mouth 4 times daily for 3 ad note dated 6/20/23 wound care to the blisters at #1's chest and abdomen: wound care Mepitel One [a ressing to promote healing dressing changes]- leave in in through Mepitel One with tion] Apply thin layer of f leaking noted, cover with dressing; Burns right he abdomen, RLQ [right y wound care Clean with f Silvadene [topical Mepilex border dressing." multiple interventions to ries, including interventions tt #1 is incontinent. assessment note dated tiple abrasions on Resident asion on the left inner wound assessments or y wound monitoring on the ress notes Resident #1's orders show the following on 6/20/23: "Apply skin prep on left inner buttock as tely resolved every day shift	F 65		-

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

Facility ID: 475020

If continuation sheet Page 13 of 36

CENTERS FOR MEDICARE & MEDICAID SERVICES						OMB NO	D. 0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION		E SURVEY PLETED
		475020	B. WING			1	C /27/2023
	ROVIDER OR SUPPLIER			98	TREET ADDRESS, CITY, STATE, ZIP CODE 8 HOSPITALITY DRIVE ARRE, VT 05641	1 01	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 655	dry dressing until resc other day." On 7/26/2 Attending Physician s know why the admitti wound treatments as wound care note. S/H though the wound car his/her name on the T changing the wound car hospital wound note. Resident #1's baselin on 6/22/23, states s/h breakdown related to skin breakdown Type buttocks, areas on ch incontinence," and incom- recommended by the note. In addition, per baseline care plan an failed to create and in wound assessment at Resident #1's baselin- daily living, initiated of improve the current le toileting and includes extensive assist of 1 f Resident #1 was cont Nursing aide documer Resident #1 became 6/22/23 and was inco- to his/her 6/26/23 tran- for increased skin bre	olved every day shift every 7 at 5:00 PM, Resident #1's tated that s/he does not ng nurse did not put in what was included on the e confirmed that even e orders were put under AR, s/he did not discuss care from what was on the e care plan for skin, initiated e "is at risk for skin weakness and or has actual scabbed abrasion left inner est and trunk, cludes an intervention to nent as ordered." However, ovide wound treatment as 6/20/23 hospital wound review of Resident #1's d medical record, the facility nplement interventions for nd wound monitoring. e care plan for activities of n 6/20/23, reveals a goal to ovel of functioning for an intervention to "provide or toileting," revealing that inent of urine on admission. ntation reveals that incontinent of urine 8 times prior usfer, putting him/her at risk ak down. The baseline care to include interventions	F	655			

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

Facility ID: 475020

If continuation sheet Page 14 of 36

PRINTED: 08/11/2023 FORM APPROVED

CENTER	S FOR MEDICARE &	MEDICAID SERVICES		_		OMB NO	D. 0938-0391
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	1 Y Y	E SURVEY PLETED
		475020	B. WING			1	C /27/2023
NAME OF P	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE	1 07	
					HOSPITALITY DRIVE		
BERLIN H	EALTH & REHAB CTR				ARRE, VT 05641		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 655	that Resident #1 was emergency room at 1 heartbeat. Per review Resident #1 was adm emergency on 6/26/22 nursing note dated 6/2 pressure ulcers (full th Resident #1's buttock Per interview on 7/21/ Registered Nurse (RN #1's skin check on ad 6/26/23 revealed that within 30 minutes of F his/her room. S/He ex chest and abdomen w uncovered and some Resident #1 also had on her buttock. S/He in hospital wound assess instructions and concl looked much worse th wound dressings did in instructions, and there on the buttocks area of reported that Residen the nursing facility stat to use the toilet and th s/he can void in bed A 6/21/23 nursing note Representative called early morning of 6/21/ was in extreme pain a emergency room. Per MAR, and confirmed to Resident #1 received	m dated 6/26/23, reveals transferred to the 1:00 AM due to an irregular of hospital records, itted to the hospital from the 3 at 4:05 PM. A hospital 26/23 reveals 2 stage 3 nickness skin loss) on s. (2023 at 3:48 PM, a hospital 4) that performed Resident mission to the hospital on the skin check took place Resident #1 arriving to splained that Resident #1's vounds were dry; some were were covered in paper tape. two stage 3 pressure ulcers reviewed the 6/20/23 sments and treatment luded that the burn wounds han they did on 6/20/23, the not match wound care e was no record of a wound on 6/20/23. The hospital RN t #1 had told him/her that ff did not help her out of bed hey double brief him/her so	F	355			
			1	1.			

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

Facility ID: 475020

If continuation sheet Page 15 of 36

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION	(X3) DATE COM	SURVEY PLETED
					с	
		475020	B. WING		07/	27/2023
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP	CODE	
BERLIN H	EALTH & REHAB CTR			98 HOSPITALITY DRIVE BARRE, VT 05641		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETIC DATE
F 655	the first day and night facility. Review of Res show that gabapentin assessment interview #1 on 6/23/23 reveals that s/he has experier in the last 5 days whice day-to-day activities. The be a "10." Resident #1's baseline on 6/20/23, states s/h comfort," and includes "administer medication of the MAR, Resident medications as orderer room visit on 6/21/23. baseline care plan into non-pharmaceutical p indicated in Resident facility failed to creater care plan to address F on admission. An admission nursing 6/20/23 reveals that F coated and has oral the physician note dated of Resident #1 has mouth was ordered treatment reveals that Resident for thrush until 6/25/23. The facility failed to cr	tal and discharged with on of his/her admission to the sident #1's physician orders was never ordered. A pain conducted with Resident that Resident #1 reported need pain almost constantly that Resident #1 reported need pain almost constantly that a limited his/her S/he reports his/her pain to e care plan for pain, initiated e "is at risk for alterations in a ste intervention to ns as ordered." Per review #1 did not receive ed prior to the emergency In addition, there are no erventions for ain-relieving interventions #1's baseline care plan. The and implement a baseline Resident #1's pain present assessment note dated Resident #1's tongue is nrush. An acute visit 6/24/23 reveals that th pain related to thrush and tt. Resident #1's MAR #1 did not receive treatment a, 5 days after admission. reate and implement a dressing Resident #1's	F	355		

Facility ID: 475020

If continuation sheet Page 16 of 36

STATEMENT	OF DEFICIENCIES F CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		ECONSTRUCTION	(X3) DATE COMP		
			A. BUILDING		0	с	
		475020	B. WING		07/2	27/2023	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COI 88 HOSPITALITY DRIVE	DE		
	1			BARRE, VT 05641			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETIC DATE	
F 655	Continued From page	e 16	F 655	5			
	and should be docum confirmed that there is wound monitoring or Resident #1, as per in S/He also confirmed	nented on the TAR and is not documentation of daily wound assessments for ndicated in the skin policy. that Resident #1 did not eline care plan within 48 nat addressed, pain-relief, thrush, or					
F 686 SS=G		event/Heal Pressure Ulcer	F 686	F686 Specific Corrective	Action		
	§483.25(b)(1) Pressu Based on the compre- resident, the facility m (i) A resident receives professional standard pressure ulcers and ou ulcers unless the indi- demonstrates that the (ii) A resident with pre- necessary treatment with professional star promote healing, pre- new ulcers from dever This REQUIREMENT by: Based on interview, facility policies, the fa- pressure ulcer treatm care, consistent with professional standard sampled residents (R providing timely and ou assessments, providi	483.25(b) Skin Integrity 483.25(b)(1) Pressure ulcers. ased on the comprehensive assessment of a esident, the facility must ensure that-) A resident receives care, consistent with rofessional standards of practice, to prevent ressure ulcers and does not develop pressure lcers unless the individual's clinical condition emonstrates that they were unavoidable; and i) A resident with pressure ulcers receives ecessary treatment and services, consistent vith professional standards of practice, to romote healing, prevent infection and prevent ew ulcers from developing. his REQUIREMENT is not met as evidenced		Resident #2 discharged on A facility wide skin sweep of and completed by 8/18/202 designee to evaluate each status to determine if any f and services were indicate A resident record audit wat to evaluate compliance wit skin care, head to toe skin shower schedule, treatmer of change. The facility completes a co- initial and ongoing nursing intrinsic and extrinsic factor skin health skin/wound im ability of a wound to heal. for the patient will be refeat findings from the compreh patient assessment and w Staff continually observe a patients for changes and i revisions to the plan of car	was performed 23 by DON/ resident's skin ollow-up care d. s also performed h preventative assessment, nt, notification omprehensive assessment of ors that influence pairment, and the The plan of care ctive of assessme ensive ound evaluation. and monitor mplement		

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

Facility ID: 475020

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SI COMPLE	
		475000			С	
		475020	B. WING			7/2023
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COE)E	
				98 HOSPITALITY DRIVE		
BERLINH	IEALTH & REHAB CTR			BARRE, VT 05641		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETI DATE
F 686	Continued From page	e 17	F 686	F686 cont		
	documenting daily monitoring of wounds. Findings include: Facility policy NSG236 Skin Integrity and Wound Management, revised 2/1/23, states, "A comprehensive initial and ongoing nursing assessment of intrinsic and extrinsic factors that influences skin health, skin/wound impairment, and the ability of a wound to heal will be performed. The plan of care for the patient will be reflective of assessment findings from the comprehensive patient assessment and wound evaluation. Staff will continually observe and			Licensed nursing staff will to this process as well as r education on change in co- integrity and wound manag care dressing guidelines, a assessment and documeta provided.	eceiving ndition, skin gement, wound idmission skin	
9 4				LNA staff will be re-educate as well as receiving educate relieving devices, nutrition/ repositioning, change in co schedule, diabetic and foot preventive skin care.	tion on pressure hydration, indition, shower	
ž	monitor patients for co revisions to the plan of standards include: 4. Identify patient's sk for prevention or treat review of all appropria 6.5 The licensed nurs evaluation upon admi in-house acquired, we decline in wounds. 6.6 Perform daily mon dressings for present declines. Document of ulcer/wound site with status of dressing (e.g of the tissue surround of new redness or sw	hanges and implement of care as needed. Practice in integrity status and need tment interventions through ate assessment information. we will complete wound ission/readmission, new eekly, and with unanticipated nitoring of wounds or we of complications or		The Unit Manager/designer audit of the electronic heal to evaluate documentation of scheduled skin care, we skin checks, weekly reside rounds, shower schedule a This will include visual rou care to evaluate staff com competency as well as ind skin status. Results of the UM/designer process will be included in monthly risk management improvement meeting for a consideration as determine These audits will be M-F x weekly x 4 weeks and ther months.	th record (EHR) of the completion exkly head to toe ent skin care and wound care. nds to visualize pletion and lividual resident e audit and the facility (quality addional ed appropriate. 4 weeks, then n monthly x 3	
	The American Diabetes Association "Standards of Care in Diabetes-2023" reveals on page S209 the recommendation for diabetics to perform daily examination of the feet to identify early foot problems.			of four residents to evaluat confirmation that anything appropriately identified by that the system was follow detection, notification of ch documentation. Any conce be addressed at the time of	present has been the system and red through nange, care and erns identified will	

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

PRINTED: 08/11/2023 FORM APPROVED

CENTER	S FOR MEDICARE &	MEDICAID SERVICES				OMB NC	0.0938-0391
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
							С
		475020	B. WING	-		07/	27/2023
NAME OF P	ROVIDER OR SUPPLIER	1,		S	TREET ADDRESS, CITY, STATE, ZIP CODE		
	EALTH & REHAB CTR			98	B HOSPITALITY DRIVE		
	EALTH & REHAD CTR		BARRE, VT 05641				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 686	admitted to the facility following a hospital st fracture surgical repa diagnoses include ver blood flow), anemia (I diabetes. A transition reveals that Resident wounds: right hip wou moisture associated s There is no document either of Resident #2's A skin check document nursing assessment of Resident #2 had mult and legs and a right h documentation of any Resident #2's heels. A 7/10/23 indicates that pressure ulcer (Partia his/her sacrum. A late 7/10/23, entered on 7 area on Resident #2's not include any asses wound. The Attending Physici dated 7/13/23 indicate concerned about a wo his/her right heel. The DTI [deep tissue injurt to subcutaneous tissue [right] heel with surrou	s that Resident #2 was y on 7/10/23 for therapy ay related to a right hip ir. On admission, his/her nous insufficiency (improper ack of blood), and type 2 of care report dated 7/10/23 #1 had the following ind, left foot laceration, and skin damage to the sacrum. tation of any compromise to s heels. nted in an admission dated 7/10/23 reveals that iple bruises on his/her arms ip incision. There is no wounds on either of A wound assessment dated Resident #2 has a stage 2 I-thickness skin loss) on e entry progress note dated /14/23 reveals a pressure a right heel. This note does isment information about the an admission visit note es that Resident #2 is bund on the bottom of a note states, "There is a y; a pressure-related injury ues under intact skin] on the unding erythema [redness],"		586	DEFICIENCY) F686 cont Results of the DON/Designee audit process will be included in the facilit risk management/quality improvement meeting for additional consideration determinded appropriate. These audit will be weekly x 4, then bi-weekly x then monthly x 3 months. Date of Compliance 8/23/2023. Tag F 686 POC accepted on 8/15/2 S. Stem/P. Cota	ty month ent a as udits 4, and	hly
	A Nurse Practitioner (NP) note dated 7/13/23					

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

Facility ID: 475020

If continuation sheet Page 19 of 36

CENTER	S FOR MEDICARE &	MEDICAID SERVICES				OMB NO. 0938-039
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED
		475020	B. WING			C 07/27/2023
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CI	TY, STATE, ZIP CODE	
BERLIN H	EALTH & REHAB CTR			98 HOSPITALITY DRI BARRE, VT 05641	VE	_
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIJ TAG	K (EACH CO	DER'S PLAN OF CORRECTION ORRECTIVE ACTION SHOULD BI FERENCED TO THE APPROPRIA DEFICIENCY)	
F 686	reveals that Resident requested a wound co wound care certified, in place for a right her describes the wound blood dark and drainin and serosanguineous posterior medial secti surrounded by 0.5 cm to the touch Some palpation." A wound assessment Resident #2 has a rig on admission, measu squared, with a mode (bloody) discharge. A NP note dated 7/17 has both a right and to reveals a wound on a was present on admis 1.06 cm x 1.19 cm. Po observation of the pho assessment, the area with a dark pressure a squared surrounded to skin and it is hard to co open or closed. Ther asout this wound. A s dated 7/18/23 reveals heel wound is approx	#2's Attending Physician onsult from the NP, who is to assess and put treatment el wound. The NP's note as "completely filled with ng large amount of blood i fluid from a pin hole at the on of the wound. Area was n of red, hot, tissue, tender pain of the right heel with a dated 7/13/23 reveals that ht heel, middle DTI, present ring approximately 26 cm arate amount of sanguineous /23 indicates Resident #2 eft heel wound. I assessment dated 7/18/23 n unidentified location that ssion (8 days old) measuring er this surveyor's otograph attached to this appears to be of a heel area approximately 1 cm by 1 cm of compromised determine if the wound is	F	586		

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

Facility ID: 475020

If continuation sheet Page 20 of 36

CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/11/2023 FORM APPROVED OMB NO. 0938-0391

STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED
AND PLAN OF	CORRECTION	IDENTIFICATION NOWDER.	A. BUILDI	NG		C
		475020	B. WING			07/27/2023
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, 98 HOSPITALITY DRIVE BARRE, VT 05641	ZIP CODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	(EACH CORRECTIVI CROSS-REFERENCED	N OF CORRECTION E ACTION SHOULD B D TO THE APPROPRIA CIENCY)	
F 686	for the right heel was three days after adm assessment of the le 7/18/23, eight days a Review of Resident is medication administra order for every other treatment administra order for every other treatment with a star documented as adm 7/19/23. There are n right heel prior to 7/1 wound treatment was of Resident #2's TAF wound sites and wou starting 7/18/23. The daily wound monitorin no evidence in Resid treatment was provid prior to 7/13/23, thre wound treatments we left heel, or that daily completed. Resident #2 did not 1 goals, or interventior diabetes until 7/17/2 and there is no evide checks. See F655 fo On 7/25/23 at 12:20 stated that all wound and should be docur confirmed that this h Resident #2 and cor	as being present on The first wound assessment a documented on 7/13/23, hission, and the first wound off heel was documented on after admission. #2's progress notes, ration record (MAR) and tion record (TAR) reveal: an of day right heel wound t date of 7/17/23 and inistered on 7/17/23 and o orders for treatment to the 7/23; an order for left heel s placed on 7/19/23. A review R reveals an order to monitor und dressings every day shift are is no documentation of ng prior to 7/18/23. There is bent #2's record that wound ded to Resident #2 right heel e days after admission, ere provided to Resident #2's of oot checks were have care plan focuses, ns related to skin and 3, 7 days after admission, ence of daily diabetic foot	F	586		
FORM CMS-256	7(02-99) Previous Versions Ob	solete Event ID: 84K31	1	Facility ID: 475020	If continu	ation sheet Page 21 of 36

CENTER	S FOR MEDICARE &	MEDICAID SERVICES			OMB NC	0. 0938-0391
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE COMP	SURVEY
		475020	B. WING			C 27/2023
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
BERLIN H	EALTH & REHAB CTR					
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 686 F 711 SS=G	admission. On 7/27/2 Clinical Lead confirme treatment orders for F to the wound assessin Physician Visits - Rev CFR(s): 483.30(b)(1)- §483.30(b) Physician The physician must- §483.30(b)(1) Review of care, including med each visit required by section; §483.30(b)(2) Write, s notes at each visit; an §483.30(b)(2) Write, s notes at each visit; an §483.30(b)(3) Sign an exception of influenza vaccines, which may physician-approved fa assessment for contra This REQUIREMENT by: Based on interview, r facility policies, the fa physician reviewed th during the required ac sampled residents (Re signed and dated prop policy for 3 of 3 samp #1, #2, and #3), and s orders for 3 of 3 samp #2, and #3). Findings	3 at 9:20 AM, the Market ed that there were no wound tesident #2's right heel prior nent on 7/13/23. tiew Care/Notes/Order (3) Visits the resident's total program dications and treatments, at paragraph (c) of this sign, and date progress d d date all orders with the and pneumococcal be administered per acility policy after an aindications. is not met as evidenced ecord review, and review of cility failed to ensure that a e total program of care trinsion visits for 2 of 3 esident #1 and #3), enter gress notes per facility led Residents (Resident #1,	F 68	F711 Specific Corrective Action Resident #1 was discharged on 06. Resident #2 was discharged on 7/1 Resident #3 was discharged on 8/3 An audit of the resident records wa completed to validate the physician the resident's total program of care medications and treatments, at eac This includes writing, dating and sig progress notes, signing and dating with the exception of influenza/pnet vaccines as this can be administere physician approved facilty policy. The resident physician/Designee of required visits that include review resident's total program of care, in medications and treatments, at ea This includes writing, dating and s progress notes and signing and dating orders with the exception of influe pneumococcal vaccines as this ca administered per physician approv facility policy. Physicians, APP, NH nursing leadership will be re-educat this process.	19/2023. S reviewecd including th visit. gning all orders umococca ed per completes of the cluding ch visit. igning ating all enzal in be ved HA and	d 9 al
(X4) ID PREFIX TAG F 686	SUMMARY ST/ (EACH DEFICIENCY REGULATORY OR I admission. On 7/27/2 Clinical Lead confirme treatment orders for F to the wound assess Physician Visits - Rev CFR(s): 483.30(b)(1)- §483.30(b) Physician The physician must- §483.30(b)(1) Review of care, including med each visit required by section; §483.30(b)(2) Write, s notes at each visit; an §483.30(b)(2) Write, s notes at each visit; an §483.30(b)(3) Sign an exception of influenza vaccines, which may physician-approved fa assessment for contra This REQUIREMENT by: Based on interview, r facility policies, the fa- physician reviewed th during the required ac sampled residents (Re signed and dated prop policy for 3 of 3 samp #1, #2, and #3), and s orders for 3 of 3 samp #2, and #3). Findings	A MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION) 2 21 3 at 9:20 AM, the Market ed that there were no wound Resident #2's right heel prior ment on 7/13/23. Tiew Care/Notes/Order (3) Visits 4 the resident's total program dications and treatments, at paragraph (c) of this bign, and date progress d ad date all orders with the and pneumococcal be administered per tacility policy after an aindications. Is not met as evidenced eccord review, and review of cility failed to ensure that a e total program of care Imission visits for 2 of 3 esident #1 and #3), enter gress notes per facility led Residents (Resident stign and date resident bled residents (Resident #1, include: rds and Procedures for All	PREFIX TAG F 68	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE RATE /26/2023. 9/2023. 9/2023. 8/2023. 8/2023. 8/2023. 8/2023. 9/2024. 9/2024. 9/2024. 9/2024. 9/2024. 9/2024. 9/2024. 9/2024. 9/2024. 9/2024. 9/2024. 9/2024. 9/2024. 9/2024. 9/2024. 9/2024. 9/2024. 9/2024. 9/2024. 9/2002. 9/2002. 9/2002. 9/20	COMPLETIC DATE

Facility ID: 475020

	EMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		1			. 0938-03
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	(X3) DATE COMP	
		475020	B. WING		07/	C 27/2023
NAME OF F	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP		2112023
				98 HOSPITALITY DRIVE		
BERLIN	IEALTH & REHAB CTR			BARRE, VT 05641		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES DY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OI (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETIO DATE
F 711	9/17/21, states, "Upon the admission physician or advance required to: Enter ap- on the day of admissi include comprehensi signs, activity level, r appropriate testing to other laboratory and advance care plans a medications and othe The practitioner must patient chart at the fui progress note must s problems and reflect condition, as well as starting, continuing, a and other treatment. signed and dated, an record within 24 hour manually, through [th EHR]. Practitioners are resp complete and accura accordance with stat orders must be signe with federal or state no orders must be mana to the electronic char protocol Telephon the physicians next v 1. A hospital transitio 6/20/203 with 7 wou abdomen that results	a of a patient, the attending ed practice provider (APP) is propriate admission orders sion. These orders should we directions as to diet, vital ehabilitation services, o rule out active tuberculosis, radio graphic testing, and limitations of treatment, er treatments and services. t write a progress note to the me of each visit. The state the current medical the patients present medical contain a rationale for and discontinuing of drugs The progress note must be ad provided to the medical rs of the visit, either ne electronic health record; consible for maintaining a the medical record in e and federal law All ed and dated in accordance requirements Electronic aged and validated pursuant t document management ne orders must be signed on	F 7	F711 cont	aplete audits of new hts due for hsure this process its will be weekly x4 eeks, then monthly these audits will be I for further review /23/2023	

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

STATE DRAW OF CORRECTION XP1 PROVIDER SUPPLIERCIAN MUMBER: XP2 MALTIFLE CONSTRUCTION YP2 MALE THE CONSTRUCTION <td< th=""><th>CENTER</th><th>S FOR MEDICARE &</th><th>MEDICAID SERVICES</th><th></th><th></th><th></th><th>OMB NC</th><th>0.0938-0391</th></td<>	CENTER	S FOR MEDICARE &	MEDICAID SERVICES				OMB NC	0.0938-0391
VAME OF PROVIDER OR SUPPLIER 475020 IL VING OT/27/2023 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, QP COOLE IS HOSPITALITY DRIVE BARRE, VT 05841 STREET ADDRESS, CITY, STATE, QP COOLE IS HOSPITALITY DRIVE BARRE, VT 05841 Common PROVIDER'S FLANCE CONTRICTION (INCLUENCE CALL THAT CONTRICTION OF DEFICIENCE) STREET ADDRESS, CITY, STATE, QP COOLE IS HOSPITALITY DRIVE BARRE, VT 05841 ID OPROVIDER'S FLANCE CONTRICTION (INCLUENCE CALL THAT CONTRICTION OF DEFICIENCE) Common OPERATION (INCLUENCE CALL THAT CONTRICTION (INTERNITY CALL THAT THE CALL THAT THAT THAT THAT THAT THAT (INCLUENCE CALL THAT THAT THAT THAT THAT THAT THAT T								
NWE OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STREET, 2000 BERLIN HEALTH & REHAB CTR STREET ADDRESS, CITY, STREET, 2000 OVED DESTINATION PROVE PROVIDER CONCENTION AND THE PROVIDERS (EACH DEPROCEMY WIST DE RECEDED BY FULL RECOLLATORY OR LSC IDENTIFYING INFORMATION) PROVIDERS TALLY STREET, 2000 F 711 Continued From page 23 (metal electrode] while in an MRI machine (magnetic resonance imaging machine; a scanner using magnets to create images of the body], and is identified as needing treatment for thrush through 6/22/23. Discharge medications include ny statin (antifing al medication), 100,000 units/ml suspension, 5 mL by mouth 4 times daily for 3 days. A hospital wound note dated 6/20/22 reveals the following wound create to the blisters and burns on Resident #1's chest and abdomen, RLQ (reveals the following wound create to the blisters and burns on Resident #1's chest and abdomen, RLQ (right lower quadrant) - daily wound care Clean with saline [Satt water solution] Apply thin layer of Aquaphor [orithment] Heaking noted, cover with Meplies (foam) border dressing; WIT saline [Satt water solution] Apply thin layer of Aquaphor [orithment] Heaking noted, cover with Meplies (the dated dift 1's tongue is coated and has oral thrush. Three are no admission nursing assessment note dated 6/20/23 reveals that Resident #1's tongue is coated and has oral thrush. There are no admission wound evaluations for Resident #1's blisters and burns. A review of Resident #1's blisters and burns. A review of Resident #1's admission order reveals the following wound care order. "Cleanse areas on chest/trutk with wound gray, pat for all mount of Vaseline to each area and cover with dry dressing until resolved every day shift every other day." Record review of Resident #1's brigation andres			475020	B. WING				
BERRIN HEALTH & REHAB CTR BINOSPITALITY DRIVE BARRE, VT 05641 MM ID MEERX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULTORY OR LSC IDENTIFYING INFORMATION) IP PREFX (EACH CORRECT LSC ADDITION SINFORMATION) IP COMMATION PREFX TAG CACH DEFICIENCY MUST BE PRECEDED BY FULL PREFX (EACH CORRECT LSC IDENTIFYING INFORMATION) IP CACH CORRECT LSC ADDITION SINFORMATION) IP CROSS-REFERENCE OT OTHER APPROPRIATE DATE F 711 Continued From page 23 (metal electrode] while in an MRI machine magnetic resonance imaging machine; a scanner using magnets to create images of the body]; and is identified as needing treatment for thrush through 6/2222. Discharge medications include systam (antifungal medication), 100,000 unitstmil supension, 5 mL by mouth 4 times daily for 3 days. A hospital wound are to the blisters and burns on Resident #1's chest and abdomen: "Bisters/Bullae - daily wound care to the blisters and burns on Resident #1's chest and abdomen. "Bisters/Bullae - daily wound care Mepitel One with saline [Salt watersolution] Apply thin layer of Aquaphor [ointmet] Hiekking noted, cover with Mepilex (foam] border dressing; Burns right chest, left flank, midine abdomer, RLQ [right thew equalations for Resident #1's tongue is coated and has oral thrush. There are no admission oruder evealst the following wound care order: "Cleanse areas on chest/truck with wound garay, pat dry, apply small amount of Vaseline to each area and cover with dry dressing until resolved every day shift every other day." Record review of Resident #1's hysician orders Heading abdomes and shift endowed and thrush. There are no admission oruder sreases the following wound care order: "Cleans	NAME OF PI	ROVIDER OR SUPPLIER		-	ST	REET ADDRESS, CITY, STATE, ZIP CODE	017	
PREERX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR USC DENTIFYING INFORMATION) PREERX TAG CEACH CORRECTVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) Continued DATE F 711 Continued From page 23 [metal electrode] while in an MRI machine [magnetic resonance imaging machine, a scanner using magnets to create images of the body]; and is identified as needing treatment for thrush through 6/22/23. Discharge medications include nystatin (antifungal medication), 100,000 units/ml suspension, 5 mL by mouth a times daily for 3 days. A hospital wound note date d6/20/23 reveals the following wound care to the blisters and burns on Resident #1's toest and abdomen. "Blisters/Bullae - daily wound care Mepitel One [a long staying wound dreasing to promote healing and minimize pain at dressing change]- leave in place for 7 - 14d [days] Clean through Mepitel One with saline Continue use of Silvadene [topical antibiotic] Cover with Mepilex [foram] border dressing." An admission nursing assessment note dated 6/20/23 reveals that Resident #1's torgue is coaded and has oral thrush. Three are no admission wound evaluations for Resident #1's blisters and burns. A review of Resident #1's blisters and burns and cover with dry dressing	BERLIN H	EALTH & REHAB CTR						
[metal electrode] while in an MRI machine [magnetic resonance imaging machine; a scanner using magnets to create images of the body]; and is identified as needing treatment for thrush through 6/22/23. Discharge medications include nystatin (antifungal medication), 100,000 units/mi suspension, 5 mL by mouth 4 times daily for 3 days. A hospital wound note dated 6/20/23 reveals the following wound care to the bilisters and burns on Resident #1's chest and abdomen: "Bilsters/Bullae - daily wound care to the bilisters and burns on Resident #1's chest and abdomen: "Bilsters/Bullae - daily wound care to the bilisters and minimize pain at dressing changes]- leave in place for 7 - 14d [days] Clean through Mepitel One with saline [salt water solution] Apply thin layer of Aquaphor [ointment] If leaking noted, cover with Mepilex [foam] border dressing; Burns right chest, left flank, midline abdomen, RLQ [right lower quadrant] - daily wound care Clean with saline Continue use of Silvadene [topical antibiotic] Cover with Mepilex border dressing." An admission nursing assessment note dated 6/20/23 reveals that Resident #1's tongue is coated and has oral thrush. There are no admission wound evaluations for Resident #1's blisters and burns. A review of Resident #1's blisters and burns. A review of Resident #1's admission others reveals the following wound care order: "Cleanse areas on chest/trunk with wound spray, pat dy, apply small amount of Vaseline to each area and cover with dry dressing until resolved every day shift every other day." Record review of Resident #1's physician orders	PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFI		(EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA		COMPLETION
entered or placed. Resident #1's Attending Physician progress notes for an admission visit on 6/22/23 does not reflect a review of the resident's wounds, wound	F 711	[metal electrode] while [magnetic resonance scanner using magne body]; and is identified thrush through 6/22/2 include nystatin (antif units/ml suspension, 4 for 3 days. A hospital reveals the following v and burns on Resider "Blisters/Bullae - daily long staying wound du and minimize pain at a place for 7 - 14d [day: One with saline [salt v layer of Aquaphor [oir cover with Mepilex [for right chest, left flank, [right lower quadrant] with saline Continue u antibiotic] Cover with An admission nursing 6/20/23 reveals that F coated and has oral th admission orders reve care order: "Cleanse wound spray, pat dry, Vaseline to each area until resolved every d Record review of Res reveals that an order entered or placed. Resident #1's Attendii for an admission visit	e in an MRI machine imaging machine; a ets to create images of the d as needing treatment for (3. Discharge medications ungal medication), 100,000 5 mL by mouth 4 times daily wound note dated 6/20/23 wound care to the blisters nt #1's chest and abdomen: wound care Mepitel One [a ressing to promote healing dressing changes]- leave in s] Clean through Mepitel water solution] Apply thin ntment] If leaking noted, am] border dressing; Burns midline abdomen, RLQ - daily wound care Clean use of Silvadene [topical Mepilex border dressing."	F	711			

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

Facility ID: 475020

If continuation sheet Page 24 of 36

PRINTED: 08/11/2023 FORM APPROVED

CENTER	S FOR MEDICARE &	MEDICAID SERVICES		_		DWR N	<u>0, 0938-0391</u>
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD				E SURVEY PLETED
		475020	B. WING				C
		475020	1			07	/27/2023
NAME OF PI	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
BERLIN H	EALTH & REHAB CTR			9	8 HOSPITALITY DRIVE		
				В	BARRE, VT 05641		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 711	treatment, thrush, or the A Physician note date acute visit because R experiencing mouth p "patient has a burning well as white coating a lips and the mouth and discomfort with swalled On 7/26/23 at 5:00 PM Physician stated that Resident #1's wound the admitting Register know how or why treat from what was on the is unsure why nystatin 2. Record review reveated admitted to the facility therapy evaluation an hospital stay related to pneumonia. On admiss include chronic obstruk (disease that causes of lungs), multiple scleror nervous system), hype and s/he is bed bound summary dated 7/7/22 discharge orders: Buck decrease inflammation mL suspension for ne a mist for inhalation], a day]; cefdinir (antibia mg PO [by mouth] BID instructions to take the complete the 5 day complete the 5 day complete the 5 day complete the state of the summary date the sumplete the state of the summary date the state of the	Areatment for thrush. and 6/24/2023 reveals an esident #1 was ain. The note states, a sensation in the mouth as on the inner aspect of the d throat [S/he] has mild owing." A, Resident #1's Attending s/he did not discuss care treatment orders with red Nurse and does not thment orders were changed hospital wound note. S/He in was not ordered. The airway of the central obstructed airflow from the usis (disease of the central ertension, morbid obesity, d. A hospital discharge bis (disease of the central ertension, morbid obesity, d. A hospital discharge bis (clisease of the central ertension, morbid obesity, d. A hospital discharge bis (clisease of the central ertension, morbid obesity, d. A hospital discharge bis (clisease of the central ertension, morbid obesity, d. A hospital discharge bis (clisease of the central ertension, morbid obesity, d. A hospital discharge bis (clisease of the central ertension, morbid obesity, d. A hospital discharge bis (clisease of the central ertension, morbid obesity, d. A hospital discharge bis (clisease of the central ertension, morbid obesity, d. A hospital discharge bis (clisease of the central ertension, morbid obesity, d. A hospital discharge bis (clisease of the central ertension, morbid obesity, d. A hospital discharge bis (clisease of the central ertension, morbid obesity, d. A hospital discharge bis (clisease of the central ertension, morbid obesity, d. A hospital discharge bis (clisease of the central ertension, morbid obesity, d. A hospital discharge bis (clisease of the central ertension, morbid obesity, d. A hospital discharge bis (clisease of the central ertension, morbid obesity, d. A hospital discharge bis (clisease of the central ertension, morbid obesity, d. A hospital discharge bis (clisease of the central ertension, morbid obesity, d. A hospital discharge bis (clisease of the central ertension, morbid obesity, d. A hospital discharge bis (clisease of the central ertension, morbid obesi	F	711	DEFICIENCY)		
		0 mg tablet, 100 mg PO a] with instructions to take					

FORM CMS-2567(0299) Previous Versions Obsolete

Facility ID: 475020

If continuation sheet Page 25 of 36

ATEMENT		MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO	NSTRUCTION	(X3) DA	NO: 0938-03 TE SURVEY MPLETED
			A. BUILDING			C
		475020	B. WING		0	7/27/2023
				ET ADDRESS, CITY, STATE, ZIP CC DSPITALITY DRIVE	DDE	
BERLIN H	EALTH & REHAB CTR		BAR	RE, VT 05641		
(X 4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE	(X5) COMPLETIC DATE
F 711	Continued From page	e 25	F 711			
	the last dose tonight course. The following	to complete the 5 day				
	reveal that orders for cefdinir were never p Budesonide was not after admission, and Resident #3's Attendi until 7/10/23, even the discontinued at the h	placed until 7/25/23, 18 days cephalexin was ordered by ing Physician from 7/8/23 nough cephalexin was ospital. Resident #3's MAR administered cephalexin on				
	for an admission visit "Continue cefdinir and discharge Continu- twice daily." The note Resident #3's MAR work note does not address have orders or receive cefdinir or doxycyclin completed on the day orders or receive bud admitted, and had ord cephalexin between	d doxycycline, per hospital e nebulized budesonide e does not indicate that vas reviewed at this visit. The s that Resident #3: did not e his/her last dose of e, which should have been v of admission, did not have lesonide since they were ders and received 7/8/23 and 7/10/23, when the mmary indicated that the				
	Physician indicated th resident's MAR on ac 5:00 PM, Resident #3 stated that s/he is un orders for doxycycline	M, Resident #3's Attending nat s/he is to review each Imission visits. On 7/26/23 at 3's Attending Physician sure why there were not e hyclate, cefdinir, and irmed that it should have				

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

Facility ID: 475020

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

PRINTED: 08/11/2023 FORM APPROVED OMB NO: 0938-0391

STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT			(X3) DATE SURVEY COMPLETED	
AND PLAN O	CORRECTION	IDENTIFICATION NUMBER.	A. BUILDI	NG		C	
		475020	B. WING			07/27/2023	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE 98 HOSPITALITY DRIVE BARRE, VT 05641	, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIZ TAG	C (EACH CORRECTIV CROSS-REFERENCE	AN OF CORRECTION TE ACTION SHOULD B D TO THE APPROPRIA CIENCY)		
SS=G	been. S/He stated tha order for cephalexin a should not have been discharge summary. 3. A review of progress Resident #1's 6/22/23 admission visit progres into the EHR until 7/2 Resident #2's 7/13/23 admission visit progres into the EHR until 7/2 and Resident #3's 7/13 admission visit progres into the EHR until 7/2 and Resident #3's 7/13 admission visit progres into the EHR until 7/2 On 7/26/23 at 5:00 PI Attending Physician s that, per facility policy are to be in residents ¹⁴ 4. Record review of R physician orders on 7 #1's admission orders morphine, Resident # Resident #3's admiss by the ordering provid On 7/25/23 at 12:20 F confirmed that Reside had not been signed 1 On 7/26/23 at 5:00 PI Attending Physician s her/him for signature weeks before s/he signature	at s/he did not place the and confirmed that the order is placed according to the as notes shows that 3 Attending Physician ass note was not entered 0/23, 29 days after the visit; 3 Attending Physician ass note was not entered 3/23, 10 days after the visit; 13/23 Attending Physician ass note was not entered 3/23, 10 days after the visit. W, Resident #1, #2, and #3's tated that s/he was aware by physician progress notes charts within 24 hours. Resident #1, #2, and #3's (25/23 reveal that Resident as, with the exception of 52's admission orders, and ion orders were not signed der. PM, the Market Clinical Lead ents #1, #2, and #3's orders by the ordering provider. W, Resident #1, #2, and #3's tated that orders get sent to in batches and it could be gns resident orders. f Significant Med Errors	F7	711 760		ation sheet Page 27 of 36	

	OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE	. 0938-03 SURVEY
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		COMP	LETED
		475020	B. WING		07/2	; 27/2023
NAME OF P	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STATE, ZIP CODE		
BERLIN H	EALTH & REHAB CTR		I	8 HOSPITALITY DRIVE BARRE, VT 05641		
	CLIMMADY CT	ATEMENT OF DEFICIENCIES				_
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORE (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETI DATE
F 760	Continued From page	9 27	F 760	F760 Specific Corrective Ac	tion	
	The facility must ensu	ire that its_				
	§483.45(f)(2) Resider medication errors.	is not met as evidenced		Resident #1 was discharged Resident #2 was discharged Resident #3 was discharged	on 7/19/2023.	
	Based on interview a failed to ensure 3 of 3 (Residents #1, #2, an significant medication 1. A hospital transition	•		An audit of resident records a to validate medication orders correctly, correct medications ordered and medication not a have MD notification in regar alternative medications or tre needed.	are transcribed s are given as available ds to	ł
	pain, severe malnutrit the spine, and back p s/he has 7 wounds or	on on 6/20/2023 with e: cancer, cancer related ion, compression fracture of ain. The note indicates that n his/her chest and abdomen revious provider leaving on		Medication errors occurring a will be investigated and appro interventions will be impleme licensed staff will be re-educa process.	opriate nted. Facility	
	electrical activity of th electrode] on while in resonance imaging m magnets to create ima pain was controlled w immediate release mo the following as disch	am; a test that records e heart] leads [metal an MRI machine [magnetic achine; a scanner using ages of the body]. His/Her ith extended release and orphine. The report reveals arge medications orders: extended release], 5 tablets		Don/Designee will complete a admission charts to validate r reconciliations are completed are transcribed correctly. These audits weekly x4, bi-we monthly x3. The results of the be brought to the monthly QA for further review and recomm	nedication and medication eekly x4 and ese audits will PI committee	d
	every 12 hours for 2 of [immediate release], 1 needed for pain up to medication administra 6/20/23 reveals that p nursing facility she red release morphine at 8 his/her next dose at 9	tays; and morphine 15 mg tablet every 3 hours as 120 mg a day. The hospital tition record (MAR) for rior to her transfer to the ceived 75 mg of extended to 4 AM and was due for to 9 PM, and 15-30 mg of ine at 12:20 AM, 4:29 AM,		Date of Compliance 8/23/20 Tag F 760 POC accepted or S. Stem/P. Cota		

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

Facility ID: 475020

If continuation sheet Page 28 of 36

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				TE SURVEY
			A. BUILDIN	6		С
		475020	B. WING		0	7/27/2023
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP	CODE	
BERLIN H	EALTH & REHAB CTR			98 HOSPITALITY DRIVE BARRE, VT 05641		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE	(X5) COMPLETIO DATE
F 760	pain (on a scale of 0- 6/20/23 was document at 4:11 PM, a 10 at 6: a 6 at 10:45 PM. On 6 documented as an 8 AM. Review of Resident # Resident #1 received medications on the at admission, 6/20/23, at 15 mg of immediate r PM, 15 mg of immediate r P	1's vitals reveal that his/her 10, 10 being the worst) on nted as a 3 at 2:25 PM, a 10 30 PM, a 5 at 6:51 PM, and 6/21/23, his/her pain was at 12:10 AM and a 5 at 3:10 1's facility MAR reveals that the following pain-relieving fternoon and evening of ind early morning 6/21/23: elease morphine at 4:11 ate release morphine at g of immediate release	F 76	50		
	indicates the reason f facility was that Resid	Medical Services) report for their dispatch to the lent #1 was in extreme pain ess to pain meds. The note				

FORM CM S-2567(02-99) Previous Versions Obsolete

Facility ID: 475020

If continuation sheet Page 29 of 36

CENTER	S FOR MEDICARE &	MEDICAID SERVICES		And Statements Descent	OMB N	IO: 0938-03
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CC A. BUILDING			E SURVEY
		475020	B. WING		0'	C 7/27/2023
NAME OF P			STRE	EET ADDRESS, CITY, STATE, ZIP CO	ODE	
	IEALTH & REHAB CTR		98 H	OSPITALITY DRIVE		
			BAR	RRE, VT 05641		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETIC DATE
F 760	not getting [his/her] pa ordered and in time to is taking [his/her] med [s/he] is in excruciatin [his/her] chest and ba before her pain was m asked states [s/he] did dose but does not bell full dose." Record review of Res reveal that orders for were put in correctly of nurse. These correct struck out by the Nurs incorrectly reentered if for the extended releat one 15 mg tab every mg tabs every 12 hour On 7/24/23 at 12:15 F Stated that s/he had a Practitioner who reveat s/he entered the orde The Market Clinical Lo facility had not received medications from the approximately midnig #1's admission, and the received much earlier expected to get medic [medication dispension medication is received morphine in the Pyxis	getting to rehab today and is ain medications, not as o manage [his/her] pain and dications. patient states g pain all over especially in tock, which is the way it was nanaged in hospital. When d get [his/her] morphine lieve that [s/he] got [his/her] dident #2's physician orders Resident #1's morphine on admission by a registered orders were subsequently se Practitioner and into the system. The order ase morphine was put in for 12 hours instead of five 15 irs. PM the Market Clinical Lead an interview with the Nurse aled that NP confirmed that rr into the system incorrectly. ead explained that the ed Resident #1's pharmacy until ht on the night of Resident hey should have been . In this case, the nurse is cations from the Pyxis ng machine] until the	F 760			

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

Facility ID: 475020

If continuation sheet Page 30 of 36

CENTER	S FOR MEDICARE &	VIEDICAID SERVICES		_		OINR NC	7. 0838-0381
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					PLETED
		475020	B. WING			1	C 27/2023
NAME OF PI	ROVIDER OR SUPPLIER			s	STREET ADDRESS, CITY, STATE, ZIP CODE		
				9	88 HOSPITALITY DRIVE		
BERLIN H	EALTH & REHAB CTR			E	BARRE, VT 05641		
A(A) 15		ATEMENT OF DEFICIENCIES	ID	-	PROVIDER'S PLAN OF CORRECTION		016
(X4) ID PREFIX		Y MUST BE PRECEDED BY FULL	PREF	IX	(EACH CORRECTIVE ACTION SHOULD B	E	(X5) COMPLETION
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	;	CROSS-REFERENCED TO THE APPROPRIA	πE	DATE
				_	DEFICIENCY)		
F 760	1.5		F	760			
	resident did not receiv						
	morphine at the facilit	y until the following day.					
	A						
		slip, dated 6/21/23 and					
		/ the facility on 6/21/23, #1's morphine IR and					
		t delivered to the facility					
	until the day after s/he	-					
	and the day after one						
	Resident #1's hospita	I transition of care note,					
	dated 6/20/23, reveals	s that Resident #1 is being					
	treated for thrush and	has the following discharge					2
		ystatin (antifungal) 100,000					
		5 mL by mouth 4 times daily					
	for 3 days.						
	order for nystatin.	t #1's MAR, there is not an					
	order for hystatin.						
	A telehealth evaluatio	n note dated 6/24/2023					
		call provider was notified					
		experiencing mouth pain.					
	The note states, "patie	ent has a burning sensation					
	in the mouth as well a	s white coating on the inner					
		the mouth and throat					
	[S/he] has mild discor	nfort with swallowing."					
	On 7/24/22 at 2:20 DA	A Desident #110 Attending					
		I, Resident #1's Attending s/he was not sure why the					
	nystatin was not order						
	confirmed that it shou						
	2. Record review reve	eals that Resident #2 was					
	admitted to the facility	on 7/10/23 for therapy					
		ay related to a right hip					
		r. On admission, his/her					
		nous insufficiency, anemia,					
	type 2 diabetes, acute						
	post-surgical pulmona	ary embolism [PE; a blood		_			

		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE (CONSTRUCTION		
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	7		MPLETED
		475020	B. WING		0	C 7/27/2023
NAME OF P	ROVIDER OR SUPPLIER		ST	REET ADDRESS, CITY, STATE, ZIP CO		
BERLIN H	EALTH & REHAB CTR			HOSPITALITY DRIVE		
				NRRE, VT 05641		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES XY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETIO DATE
F 760	Continued From page	e 31	F 760			
		to the lungs], and heart				
		tion of care note discharge				
		'enoxaparin [Lovenox;] 80 ng into the skin every 12				
		ovenox is an anticoagulant				
		to treat and prevent deep				
	· · ·	Γ; blood clots in a deep vein] blism. Resident #2 is at risk				
		or PE because s/he is over				
	60, is post-surgery, a	nd has a history of PE.				
	Per interview on 7/17	/23 at 11:40 AM, Resident				
	#2 stated that s/he w	as concerned that s/he was				
		enox the night of admission				
	or the following morn	ing.				
	Per record review of	Resident #2's physician				
		Resident #2's Lovenox was				
		[electronic medical record] correct start date and time of				
		eview of Resident #2's MAR				
		d not receive Lovenox until				
	9:00 PM on 7/11/23.					
	Per interview on 7/20	0/23 at 10:01 AM, the Market				
		hat it looks like there was a				
		entering in Resident #2's Lovenox and confirmed that				
		e been started on 7/10/23.				
	2 Depart review	a la that Davidant #2 was				
		eals that Resident #3 was y on 7/7/23 for physical				
		nd treatment following a				
	hospital stay related	to breathing difficulties and				
		ssion, his/her diagnoses uctive pulmonary disease				
		obstructed airflow from the				
	lungs), multiple sclere	osis (disease of the central				
	nervous system), urg	e incontinence (urinary				

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

Facility ID: 475020

If continuation sheet Page 32 of 36

		ID HUMAN SERVICES MEDICAID SERVICES				PRINTED: 08/11/2023 FORM APPROVED OMB NO. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED
		475020	B. WING			C 07/27/2023
NAME OF PI	ROVIDER OR SUPPLIER		,	STREET ADDRESS, CITY, STATE,	ZIP CODE	
				98 HOSPITALITY DRIVE		
BERLINH	EALTH & REHAB CTR			BARRE, VT 05641		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIV CROSS-REFERENCE	AN OF CORRECTION E ACTION SHOULD BI D TO THE APPROPRIA CIENCY)	
F 760	s/he is bed bound. Per summary dated 7/7/23 discharged with the for [inhaled steroid to dec airway] 0.5 mg/2 mL s [changes liquid to a m inhalation BID [twice a medication was disco (antibiotic) 250 mg ca Review of Resident #3 are no orders for Budo 7/7/23 through 7/25/2 Cephalexin was docu 7/8/23, 7/9/23, and 7/ Per review of Resider order for "Cephalexin (Cephalexin) Give 1 c day for infection for 5 a prescriber written or Attending Physician g and entered into the E by a licensed nurse. On 7/26/23 at 5:00 PM Physician confirmed t have been ordered or that s/he did not place and confirmed that the been placed according summary. In summary, the facilit correct dose and frequ day of admission and the transfer of care; re	ension, morbid obesity, and er a hospital discharge 3, Resident #3 was blowing order: Budesonide crease inflammation of the suspension for nebulization hist for inhalation], 0.5 mg a day]. The following ntinued: Cephalexin psule, daily. 3's MAR reveals that there esonide treatment from 3, totaling 18 days, and mented as administered on 10/23. ht #3's physician orders, an Oral Capsule 250 MG apsule by mouth one time a Days," reveals that this was der from Resident #1's iven at 7/7/23 at 12:09 PM EHR on 7/7/23 at 12:13 PM M, Resident #3's Attending hat Budesonide should n admission. S/He stated e the order for cephalexin e order should not have g to the discharge	F 74			
FORM CMS-256	7(02-99) Previous Versions Obs	n the night of admission, olete Event ID: 84K311		Facility ID: 475020	If continue	ation sheet Page 33 of 36

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING C 475020 B. WING 07/27/2023 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 98 HOSPITALITY DRIVE **BERLIN HEALTH & REHAB CTR** BARRE, VT 05641 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES ID (X5) COMPLETION (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) F 760 Continued From page 33 F 760 and mouth pain related to untreated thrush. The facility failed to administer two doses of Lovenox for Resident #2, putting Resident #2 at risk for developing a DVT or PE. The facility failed to provide orders for and administer budesonide for Resident #3, putting them at risk for breathing complications, and administered cephalexin, which was not ordered by the provider. Responsibilities of Medical Director F 841 F841 Specific Corrective Action F 841 CFR(s): 483.70(h)(1)(2) SS=G The current medical director's contract was terminated on 8/11/2023. This includes her §483.70(h) Medical director. privileges as an attending physician. Patients/residents are now assigned to the §483.70(h)(1) The facility must designate a physician to serve as medical director. new attending physician, who will also serve as the centers medical director beginning §483.70(h)(2) The medical director is responsible 8/11/2023. for-(i) Implementation of resident care policies; and All residents have the potential to be (ii) The coordination of medical care in the facility. affected by the deficient practice. This REQUIREMENT is not met as evidenced The center medical director coordinates bv: medical care in the center and provides Based on interview and review of facility policies, clinical guidance and oversight regarding the facility failed to ensure that the medical the implementation of patient care policies. director fulfilled his/her responsibility to coordinate He/she helps the center idenitfy, evaluate medical care with facility providers and nursing and address/resolve medical and clinical staff related to obtaining and implementing concerns and issues that affect patient care, provider orders for necessary care and services medical care of quality of life, or are related for 3 of 3 sampled residents (Residents #1, #2, to the provision of services by physicians and other licensed health care practitioners. and #3). Findings include: Providers and adminstrative staff will be re-educated to this process. Facility policy OPS123 Medical Director Responsibilities, last reviewed 1/25/18, states, "The Center Medical Director coordinates medical care in the Center and provides clinical guidance and oversight regarding the implementation of patient care policies. He/she helps the Center identify, evaluate, and address/resolve medical and clinical concerns and issues that: Affect

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

Facility ID: 475020

PRINTED: 08/11/2023

				CONSTRUCTION		. 0938-039
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING		(X3) DATE S COMPL	ETED
		475020	B. WING		07/2	; 27/2023
NAME OF PI	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, STATE, ZIP COI	DE	
			9	8 HOSPITALITY DRIVE		
	EALTH & REHAB CTR		B	ARRE, VT 05641		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETIO DATE
F 841	Continued From page	e 34	F 841	F841 cont		
	patient care, medical related to the provisio and other licensed he Record review reveals transfer of care dated hospital medication ar orders for nystatin (ar morphine extended re medication used to tra accurately reconciled, accuracy by a second Resident #2's transfer 7/10/23, orders for Lo medication used to tra thrombosis (DVT; bloc pulmonary embolism traveled to the lungs)] transcribed or checke nurse. Per Resident # dated 7/8/23, orders f steroid to decrease in Cephalexin (antibiotic doxycycline hyclate (a accuracy by a second a result, Resident #1 which s/he sought relii room, was not treated wound identified as a admission, significant two stage 3 pressure loss); Resident #2 wa DVT or PE; and Resid	care of quality of life; or are in of services by physicians alth care practitioners." is that, per Resident #1's 6/20/23 and the 6/20/23 dministration record (MAR), ntifungal medication), elease, and gabapentin (a eat nerve pain), were not , transcribed, or checked for I nurse per facility policy. Per r of care of care dated venox [an anticoagulant eat and prevent deep vein od clots in a deep vein) and (PE; a blood clot that has were not accurately d for accuracy by a second t3's discharge summary or Budesonide (inhaled flammation of the airway),), cefdinir (antibiotic), and antibiotic) were not t, transcribed, or checked for I nurse per facility policy. As suffered extreme pain for te for at the emergency I for thrush for 5 days, and a small scab, present on ly deteriorated to become ulcers (full thickness skin s at risk for developing a	F 041	NHA/Designee will audit re records to validate that the fulfills his/her duty to coord care with providers and nu to obtaining and implement orders for necessary care This includes validation of reconciliation. These audit x4, bi-weekly x4 and then Results of the audit will be montly QAPI. Date of Compliance 8/23 Tag F 841 POC accepted S. Stem/P. Cota	e medical director dinate medical ursing staff related and services. medication its will be weekly monthly x3. discussed in	
		fer of care orders were not y the Attending				

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

Event ID: 84K311

Facility ID: 475020

If continuation sheet Page 35 of 36

CENTER	S FOR MEDICARE &	MEDICAID SERVICES					<u>OMB NC</u>	0:0938-0391
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILDI					PLETED
		475020	B. WING					C 27/2023
NAME OF PF	ROVIDER OR SUPPLIER	·		STREET ADDR	ESS, CITY, STATE, ZIP COD	DE		
	EALTH & REHAB CTR			98 HOSPITALI	ITY DRIVE			
BERLINT		₩		BARRE, VT	05641			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CC EACH CORRECTIVE ACTION DSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BI E APPROPRIA		(X5) COMPLETION DATE
F 841	Continued From page properly transcribed, a second nurse per fa more information. Based on interviews of 3:29 PM and 7/26/23 Director confirmed tha admission orders wer with hospital transfer that the process of pr admission orders sho the transferring hospi is the facility's respon a procedure in place fo orders are being dout not hers/his. S/He stat that the facility policy Reconciliation, effecti his/her time as Medic staff to review the hos admission orders and ever reviewed the pol s/he has been aware widespread problems and ensuring resident meet all their care nee time. S/He stated that problem to past facilit there have been multi nursing directors, no a correct the issues by been medical director has not brought the is QAPI (quality assuran improvement program	a 35 or checked for accuracy by acility policy. See F635 for conducted on 7/24/23 at at 5:00 PM, the Medical at Resident #1, #2, and #3's e not accurately reconciled information. S/He stated oviding comprehensive uld be the responsibility of tal, not the facility, and that it sibility to make sure there is to ensure that admission ble checked for accuracy, ted that s/he was not aware titled, OPS424 Medication ve on 9/1/2022 during al Director, instructed facility epital MAR while reconciling cannot recall if s/he had icy. S/He indicated that that there have been with the transfer of care s have complete orders to eas on admission for a long the has brought this y leadership but because ple administrators and action has been taken to the facility since s/he has . S/He confirmed that she sues with transfer of care to	-	341			TE	DATE

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

Facility ID: 475020

If continuation sheet Page 36 of 36