**AGENCY OF HUMAN SERVICES**

**DEPARTMENT OF DISABILITIES, AGING AND INDEPENDENT LIVING**

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

August 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,

Pamela M Cota RN

Pamela M. Cota, RN
Licensing Chief

Enclosure

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| **BERLIN HEALTH & REHAB CTR** | **98 HOSPITALITY DRIVE BARRE, VT 05641** |

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| F 000 | INITIAL COMMENTS<br><br>The Division of Licensing and Protection conducted an unannounced, on-site investigation of complaint #22010 on 7/18/2023, with additional offsite investigation that ensued until 7/27/23, to determine if the facility was in compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. The following regulatory violations were identified as a result: | F 000 | This plan of correction was written to follow state and federal guidelines. It is not an admission of noncompliance. However, is it the facility commitment to demonstrate and maintain compliance. | |
| F 635 SS=G | Admission Physician Orders for Immediate Care CFR(s): 483.20(a)<br><br>§483.20(a) Admission orders<br>At the time each resident is admitted, the facility must have physician orders for the resident's immediate care.<br>This REQUIREMENT is not met as evidenced by:<br>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:<br><br>Facility policy Standards and Procedures for All Licensed Independent Practitioners, revised 9/17/21, states,<br>"Upon the admission of a patient, the attending physician or advanced practice provider (APP) is required to: Enter appropriate admission orders on the day of admission. These orders should include comprehensive directions as to diet, vital signs, activity level, rehabilitation services, appropriate testing to rule out active tuberculosis, other laboratory and radio graphic testing, advance care plans and limitations of treatment, medications and other treatments and services." | F 635 | F635 Specific Corrective Action<br><br>Resident #1 was discharged on 06/26/2023.<br>Resident #2 was discharged on 7/19/2023.<br>Resident #3 was discharged on 8/3/2023.<br><br>An audit of resident orders was completed to validate that the facility obtained accurate physician orders to provide necessary care and services.<br><br>The facility ensures that residents admitted/ readmitted to the facility have accurate physician orders for the residents immediate care. This is inclusive of medication reconciliation upon admission/readmission and approval of medications from the attending physician/designee. Licensed staff, medical director, and APP will be re-educated to this process.<br><br>DON/Designee will complete admission chart checks to validate accurate physician orders obtained through the medication reconciliation process. These audits will be M-F x 4 weeks, then weekly x 4 weeks, then monthly x 3 months. Results of these audits will be brought to the monthly QAPI Committee for further review and recommendations.<br><br>Date of Compliance 8/23/23 | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Holly Wood, LNHA
TITLE: Admin
(X6) DATE: 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.

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| F 635 | Continued From page 1<br>Facility policy OPS424 Medication Reconciliation, effective 9/1/2022, states,<br>"The patient's medication orders will be reconciled at each transition of care. Medication reconciliation is the process of comparing a patient's existing medication orders to all the previous medications the patient has been taking. The process involves obtaining and maintaining a complete and accurate list of current medication use across all healthcare settings. Medication reconciliation involves collaboration with the patient representative and multiple disciplines including admission liaisons, physicians/advanced practice providers (APP), licensed nurses, and pharmacy.<br>Medication reconciliation will be performed when patients are admitted/readmitted from hospital.<br>For patients admitted from the hospital: obtain and review copies of Medication Administration Records (MARs), Treatment Administration (TARs), transfer forms, and Physician's Order Sheets (POS). Verify MAR/TAR information with transfer forms and POS, if available.<br>A reconciliation of the patient's admission medication orders to the hospital and/or home care discharge orders will be made. Information to be reconciled includes but is not limited to: prescription medications; PRN [as needed] medications; herbals; vitamins; nutritional supplements; parental nutrition; infusion solutions; over the counter medications; vaccines and date of administration, if known; medication start and discontinue dates. Clarify medication orders with clinical staff from transferring hospital, when necessary. Any discrepancies discovered during reconciliation will be reported to the physician/APP before finalizing the current list of medications.<br>A repeat reconciliation will be performed to | F 635 | **Tag F 635 POC accepted on 8/15/23 by S. Stem/P. Cota** | |

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| F 635 | | F 635 | | |

Continued From page 2

compare hospital/home care discharge medication listing to current center medication listing to MAR. Any discrepancy discovered during repeat reconciliation will be reported to the physician/APP."

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 that resulted from a previous provider leaving on ECG [electrocardiogram; a test that records electrical activity of the heart] leads [metal electrode] on while in an MRI machine [Magnetic resonance imaging machine; a scanner using magnets to create images of the body]. Resident #1 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 4 times daily for 3 days. The hospital MAR (medication administration record) reveals that Resident #1 received two doses of nystatin prior to discharge from the hospital to the facility and was due for additional doses at 5:00 PM and 9:00 PM. The hospital MAR also reveals Resident #1 has an order for gabapentin (a medication used to treat nerve pain) 100 mg 3 times daily; Resident #1 received one dose of gabapentin prior to discharge from the hospital to the facility and was due for additional doses at 2:00 PM and 9:00 PM.

A hospital wound note dated 6/20/23 reveals the following wound care to the blisters and burns on Resident #1's chest and abdomen:
"Blisters/Bullae - daily wound care Mepitel One [a

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|---|---|---|---|---|

F 635 Continued From page 3 F 635

long staying wound dressing to promote healing 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."

Resident #1's facility TAR (treatment administration record) reveals different wound care orders to the blisters and burns on Resident #1's chest and abdomen than what was indicated in the 6/20/23 hospital wound note. The following is a wound care order placed by the facility on 6/20/23: "Cleanse areas on chest/trunk with wound spray, pat dry, apply small amount of Vaseline to each area and cover with dry dressing until resolved every day shift every other day."

An admission nursing assessment note dated 6/20/23 reveals that Resident #1's tongue is coated and has oral thrush. Review of Resident #1's physician admission orders reveals that an order for nystatin was never entered or placed. A provider note dated 6/24/2023 reveals an acute visit because Resident #1 was experiencing mouth pain. The note states, "patient has a burning sensation in the mouth as well as white coating on the inner aspect of the lips and the mouth and throat... [S/he] has mild discomfort with swallowing."

A nurse progress note dated 6/21/23 reveals that Resident #1 had used the call bell at 3:10 AM to ask for pain medication and the resident explained to the nurse that a family member

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|---|---|---|---|---|
| F 635 | Continued From page 4 | F 635 | | |

called 911 on his/her behalf and an ambulance was on the way. The nurse documented that the resident stated, "I am in excruciating pain and you were not doing anything about it." A hospital Emergency Room Provider note dated 6/21/23 states, "Patient [has] not been receiving her 100 mg of gabapentin 3 times daily. Will prescribe the 75 mg of extended release morphine as well as the gabapentin." Hospital discharge orders signed on 6/21/23 at 5:16 AM include discharge orders for 100 mg of gabapentin 3 times daily. Review of Resident #1's Physician orders reveals that an order for gabapentin was never entered or placed on his/her 6/20/23 admission or 6/21/23 readmission. There is no explanation documented in Resident #1's medical record as to why gabapentin was not ordered on admission on 6/20/23 or on return from the emergency department on 6/21/23.

Per interview on 7/17/23 at 10:01 AM, the Registered Nurse (RN) that entered in Resident #1's admission orders stated that s/he does not use the hospital MAR to reconcile the medications. S/He said that s/he never looked at the wound care note.

Per interview on 7/24/23 at 12:15 PM, the Market Clinical Lead revealed that, per facility policy, the process for obtaining and entering orders for a new admission, would be as such: nursing receives the transfer information from the sending facility. Nursing will review the information, including the transfer of care, discharge summary, MAR, and any other instructions for care with the new admission's facility provider, who will also review the hospital information. Any discrepancies between the information received will be reviewed and reconciled. The provider will

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|---|---|---|---|---|
| F 635 | Continued From page 5 | F 635 | | |

give nursing orders for admission, either verbally, when in person, or over the phone. The nurse will enter in the orders into the EHR (electronic health record). A second nurse will review the orders that were entered into the EHR and the hospital transfer information for accuracy; best practice is that the double check of orders will occur before administering medications or providing treatments. The Market Clinical Lead confirmed that Resident #1's admission orders were not reviewed by another nurse before treatment began and that Resident #1's wound orders were not based on the facility's formulary.

Per interview on 7/24/23 at 3:29 PM, Resident #1's Attending Physician/Medical Director stated that s/he does not always review the transfer of care information from the sending facility before placing admission orders. S/He stated that nurses are supposed to obtain orders from the facility provider before entering them in but is not sure if that always happen. S/He said that s/he does not use the hospital MAR to reconcile medications, and that it is the responsibility of the sending facility to make sure that all orders are included on the discharge summary. S/He was unaware that Resident #1 was receiving gabapentin at the hospital when s/he gave admission orders. During a follow up interview on 7/26/23 at 5:00 PM, Resident #1's Attending Physician stated that s/he did not discuss Resident #1's wound care treatment orders with the admitting RN and does not know how or why treatment order were changed from what was on the hospital wound note. S/He is unsure why nystatin was not ordered. S/He stated that s/he is aware that there is a very big problem with the process of obtaining admission orders for new residents. See F841 for more information.

F 635 Continued From page 6 F 635

2. Record review reveals that Resident #2 was admitted to the facility on 7/10/23 for therapy following a hospital stay related to a right hip fracture surgical repair. On admission, his/her diagnoses include venous insufficiency, anemia (lack of blood), type 2 diabetes, acute respiratory failure, post-surgical pulmonary embolism [PE; a blood clot that has traveled to the lungs], and heart failure. Resident #2 is at risk for developing a DVT (deep vein thrombosis; blood clots in a deep vein) or PE because s/he is over 60, is post-surgery, and has a history of PE. Per the transition of care note, discharge medications include: "enoxaparin [Lovenox; an anticoagulant medication used to treat and prevent DVT and PE] 80 mg/0.8 ml. Inject 80 mg into the skin every 12 hours for 30 days." The hospital MAR reveals that Resident #2 received one dose of Lovenox the morning of transfer to the facility and was due for a second dose that evening.

Per interview on 7/17/23 at 11:40 AM, Resident #2 stated that s/he was concerned that s/he was not administered Lovenox the night of admission (7/10/23) or the following morning (7/11/23).

Per record review of Resident #2's physicians orders, Resident #2's Lovenox was entered into 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.

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| F 635 | Continued From page 7 | F 635 | | |

3. Record review reveals that Resident #3 was admitted to the facility on 7/7/23 for physical therapy evaluation and treatment following a hospital stay related to breathing difficulties and pneumonia. On admission, his/her diagnoses include chronic obstructive pulmonary disease (disease that causes obstructed airflow from the lungs), multiple sclerosis (disease of the central nervous system), hypertension, morbid obesity, and s/he is bed bound. A hospital discharge summary, dated 7/7/23, include the following orders: Budesonide [inhaled steroid to decrease inflammation of the airway] 0.5 mg/2 mL suspension for nebulization [changes liquid to a mist for inhalation], 0.5 mg inhalation BID [twice a day]; cefdinir (antibiotic) 300 mg capsule, 300 mg PO [by mouth] BID [twice a day] with instructions to take the last dose tonight to complete the 5 day course; and doxycycline hyclate (antibiotic) 100 mg tablet, 100 mg PO Q12H [every 12 hours] with instructions to take the last dose tonight to complete the 5 day course. The following medication was discontinued: Cephalexin (antibiotic) 250 mg capsule, daily.

Record review of Resident #3's physician orders reveal that orders for doxycycline hyclate and cefdinir were never placed; an order for Budesonide was not placed until 7/25/23, 18 days after admission, and cephalexin, despite being discontinued prior to admission to the facility, was ordered by Resident #3's Attending physician from 7/8/23 until 7/10/23 .

On 7/26/23 at 5:00 PM, Resident #3's Attending Physician confirmed that orders for doxycycline hyclate, cefdinir, and budesonide should have been placed. S/He stated that s/he did not place the order for cephalexin and confirmed that the

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|---|---|---|---|---|

F 635 Continued From page 8

order should not have been placed according to the discharge summary.

In summary, the facility physician and nursing staff are not accurately reconciling all orders from the transferring facility for new admissions by not effectively reviewing all transfer of care information and accurately transcribing orders resulting in inaccurate admission orders for residents' immediate care.

F 635

F 655 SS=G Baseline Care Plan
CFR(s): 483.21(a)(1)-(3)

§483.21 Comprehensive Person-Centered Care Planning
§483.21(a) Baseline Care Plans
§483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must-
(i) Be developed within 48 hours of a resident's admission.
(ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to-
(A) Initial goals based on admission orders.
(B) Physician orders.
(C) Dietary orders.
(D) Therapy services.
(E) Social services.
(F) PASARR recommendation, if applicable.

§483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan-
(i) Is developed within 48 hours of the resident's

F 655 F655 Specific Corrective Action

Resident #1 was discharged on 06/26/2023.
Resident #2 was discharged on 7/19/2023.

An audit of residents baseline care plans was completed to validate care plans are in place within 48 hours of a resident's admission and include the minimum healthcare information necessary to properly care for a resident including, but not limited to Initial goals based on admission orders, Physician orders, Dietary orders, Therapy services, Social services, PASRR recommendation, if applicable.

The facility developed baseline care plans within 48 hours of a resident's admission and include the minimum healthcare information necessary to properly care for a resident including, but not limited to Initial goals based on admission orders, Physician orders, Dietary orders, Therapy services, Social services, PASRR recommendation, if applicable.
Licensed staff will be re-educated to this process.

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| F 655 | Continued From page 9<br>admission.<br>(ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section).<br><br>§483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to:<br>(i) The initial goals of the resident.<br>(ii) A summary of the resident's medications and dietary instructions.<br>(iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility.<br>(iv) Any updated information based on the details of the comprehensive care plan, as necessary.<br>This REQUIREMENT is not met as evidenced by:<br>Based on interview, record review, and review of facility policies, the facility failed to develop and implement a baseline care plan within 48 hours of admission that included the minimum healthcare information necessary to properly care for the resident for 2 of 3 sampled residents (Residents #1 and #2). Findings include:<br><br>1. Record review reveals that Resident #2 was admitted to the facility on 7/10/23 for therapy following a hospital stay related to a right hip fracture surgical repair. On admission, his/her diagnoses include hypertension, venous insufficiency (improper blood flow), anemia, type 2 diabetes, acute respiratory failure, history of falling, post-surgical pulmonary embolism [PE; a blood clot that has traveled to the lungs], and heart failure.<br><br>A skin check documented in an admission | F 655 | F655 cont...<br><br>DON/Designee will complete audits of resident's care plan to validate they are in place within 48 hours of admission. These audits will be M-F x4 weeks, then weekly x 4 weeks, then monthly x3 months.<br><br>Results of these audits will be brought to the montly QAPI Committee for further review and recommendations.<br><br>Date of Compliance 8/23/2023<br><br>**Tag F 655 POC accepted on 8/15/23 by S. Stem/P. Cota** | |

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| F 655 | Continued From page 10 | F 655 | | |

nursing assessment dated 7/10/23 reveals that Resident #2 had multiple bruises on his/her arms and legs and a right hip incision. There is no documentation of any wounds on either of Resident #2's heels. A wound assessment dated 7/10/23 indicates that Resident #2 has a stage 2 pressure ulcer (Partial-thickness skin loss) on his/her sacrum. A wound assessment dated 7/13/23 reveals that Resident #2 has a right heel, middle DTI (deep tissue injury; a pressure-related injury to subcutaneous tissues under intact skin), present on admission, measuring approximately 26 cm squared, with a moderate amount of sanguineous (bloody) discharge. A 7/13/23 Attending Physician admission visit note reveals that Resident #2 has cellulitis (infection) in his/her heel requiring antibiotic treatment. A 7/17/23 Nurse Practitioner note reveals a wound on Resident #2's left heel.

Per record review, the facility failed to create and implement a baseline care plan to address Resident #2's skin, wounds, and diabetes. There is no evidence that interventions for wound prevention, wound assessment, wound treatment, wound monitoring, or diabetic foot checks were created or implemented within 48 hours of Resident #2's admission . Additionally, the care plan failed to address initial goals based on admission orders; physician orders; dietary orders; therapy services; and social services as required by the regulations. A care plan related to skin was created on 7/17/23, seven days after Resident #2's admission, and a diabetes care plan was never created. Resident #2 developed cellulitis (infection) in a right heel wound that was not evaluated or treated for three days. See F686 for additional information.

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| BERLIN HEALTH & REHAB CTR | 98 HOSPITALITY DRIVE BARRE, VT 05641 |

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| F 655 | Continued From page 11 | F 655 | | |

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 malnutrition, 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 electrode] on while in an MRI machine [magnetic 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

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| BERLIN HEALTH & REHAB CTR | 98 HOSPITALITY DRIVE BARRE, VT 05641 |

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F 655 Continued From page 12 F 655

for 2 days; morphine 15 mg [immediate release], 1 tablet every 3 hours as needed for pain up to 120 mg a day; gabapentin (a medication used to treat nerve pain) 100 mg 3 times daily; and nystatin (antifungal medication), 100,000 units/ml 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 blisters and burns on Resident #1's chest and abdomen: "Blisters/Bullae - daily wound care Mepitel One [a long staying wound dressing to promote healing and minimize pain at dressing changes]- leave in place for 7 - 14d 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." The note also reveals multiple interventions to prevent pressure injuries, including interventions to consider if Resident #1 is incontinent.

An admission nursing assessment note dated 6/20/23 identifies multiple abrasions on Resident #1's chest and an abrasion on the left inner buttock. There are no wound assessments or documentation of daily wound monitoring on the MAR, TAR, or in progress notes Resident #1's medical record.

Review of physician orders show the following wound orders placed on 6/20/23: "Apply skin prep to scabbed abrasion on left inner buttock as indicated until completely resolved every day shift every other day," and "Cleanse areas on chest/trunk with wound spray, pat dry, apply small amount of Vaseline to each area and cover with

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| BERLIN HEALTH & REHAB CTR | 98 HOSPITALITY DRIVE BARRE, VT 05641 |

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| F 655 | Continued From page 13 dry dressing until resolved every day shift every other day." On 7/26/27 at 5:00 PM, Resident #1's Attending Physician stated that s/he does not know why the admitting nurse did not put in wound treatments as what was included on the wound care note. S/He confirmed that even though the wound care orders were put under his/her name on the TAR, s/he did not discuss changing the wound care from what was on the hospital wound note.<br><br>Resident #1's baseline care plan for skin, initiated on 6/22/23, states s/he "is at risk for skin breakdown related to weakness and or has actual skin breakdown Type: scabbed abrasion left inner buttocks, areas on chest and trunk, incontinence," and includes an intervention to "provide wound treatment as ordered." However, the facility failed to provide wound treatment as recommended by the 6/20/23 hospital wound note. In addition, per review of Resident #1's baseline care plan and medical record, the facility failed to create and implement interventions for wound assessment and wound monitoring.<br><br>Resident #1's baseline care plan for activities of daily living, initiated on 6/20/23, reveals a goal to improve the current level of functioning for toileting and includes an intervention to "provide extensive assist of 1 for toileting," revealing that Resident #1 was continent of urine on admission. Nursing aide documentation reveals that Resident #1 became incontinent of urine starting 6/22/23 and was incontinent of urine 8 times prior to his/her 6/26/23 transfer, putting him/her at risk for increased skin break down. The baseline care plan was not revised to include interventions related to urinary incontinence. | F 655 | | |

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|---|---|---|---|
| | 475020 | A. BUILDING ______ B. WING ______ | C 07/27/2023 |

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

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|---|---|---|---|---|
| F 655 | Continued From page 14 | F 655 | | |

A hospital transfer form dated 6/26/23, reveals that Resident #1 was transferred to the emergency room at 11:00 AM due to an irregular heartbeat. Per review of hospital records, Resident #1 was admitted to the hospital from the emergency on 6/26/23 at 4:05 PM. A hospital nursing note dated 6/26/23 reveals 2 stage 3 pressure ulcers (full thickness skin loss) on Resident #1's buttocks.

Per interview on 7/21/2023 at 3:48 PM, a hospital Registered Nurse (RN) that performed Resident #1's skin check on admission to the hospital on 6/26/23 revealed that the skin check took place within 30 minutes of Resident #1 arriving to his/her room. S/He explained that Resident #1's chest and abdomen wounds were dry; some were uncovered and some were covered in paper tape. Resident #1 also had two stage 3 pressure ulcers on her buttock. S/He reviewed the 6/20/23 hospital wound assessments and treatment instructions and concluded that the burn wounds looked much worse than they did on 6/20/23, the wound dressings did not match wound care instructions, and there was no record of a wound on the buttocks area on 6/20/23. The hospital RN reported that Resident #1 had told him/her that the nursing facility staff did not help her out of bed to use the toilet and they double brief him/her so s/he can void in bed .

A 6/21/23 nursing note reveals that Resident #1's Representative called for EMS services in the early morning of 6/21/23 because Resident #1 was in extreme pain and was transferred to the emergency room. Per review of Resident #1's MAR, and confirmed by a NP note dated 6/22/23, Resident #1 received morphine at a significantly lower frequency and dose as was previously

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
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| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| **BERLIN HEALTH & REHAB CTR** | **98 HOSPITALITY DRIVE BARRE, VT 05641** |

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|---|---|---|---|---|
| F 655 | Continued From page 15 | F 655 | | |

provided by the hospital and discharged with on the first day and night of his/her admission to the facility. Review of Resident #1's physician orders show that gabapentin was never ordered. A pain assessment interview conducted with Resident #1 on 6/23/23 reveals that Resident #1 reported that s/he has experienced pain almost constantly in the last 5 days which has limited his/her day-to-day activities. S/he reports his/her pain to be a "10."

Resident #1's baseline care plan for pain, initiated on 6/20/23, states s/he "is at risk for alterations in comfort," and includes the intervention to "administer medications as ordered." Per review of the MAR, Resident #1 did not receive medications as ordered prior to the emergency room visit on 6/21/23. In addition, there are no baseline care plan interventions for non-pharmaceutical pain-relieving interventions indicated in Resident #1's baseline care plan. The facility failed to create and implement a baseline care plan to address Resident #1's pain present on admission.

An admission nursing assessment note dated 6/20/23 reveals that Resident #1's tongue is coated and has oral thrush. An acute visit physician note dated 6/24/23 reveals that Resident #1 has mouth pain related to thrush and was ordered treatment. Resident #1's MAR reveals that Resident #1 did not receive treatment for thrush until 6/25/23, 5 days after admission. The facility failed to create and implement a baseline care plan addressing Resident #1's thrush present on admission.

On 7/25/23 at 12:10 PM, the Market Clinical Lead stated that all wounds are to be monitored daily

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
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| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| BERLIN HEALTH & REHAB CTR | 98 HOSPITALITY DRIVE BARRE, VT 05641 |

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| F 655 | Continued From page 16<br>and should be documented on the TAR and confirmed that there is not documentation of daily wound monitoring or wound assessments for Resident #1, as per indicated in the skin policy. S/He also confirmed that Resident #1 did not have a complete baseline care plan within 48 hours of admission that addressed, non-pharmaceutical pain-relief, thrush, or incontinence and it should have. | F 655 | | |
| F 686 SS=G | Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii)<br><br>§483.25(b) Skin Integrity<br>§483.25(b)(1) Pressure ulcers.<br>Based on the comprehensive assessment of a resident, the facility must ensure that-<br>(i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and<br>(ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing.<br>This REQUIREMENT is not met as evidenced by:<br>Based on interview, record review, and review of facility policies, the facility failed to provide pressure ulcer treatment and preventative skin care, consistent with facility policy and professional standards of practice, for 1 of 2 sampled residents (Resident #2) related to not: providing timely and complete wound assessments, providing timely pressure ulcer treatment, creating a baseline care plans for skin, documenting daily diabetic foot checks, or | F 686 | F686 Specific Corrective Action<br><br>Resident #2 discharged on 07/19/2023.<br><br>A facility wide skin sweep was performed and completed by 8/18/2023 by DON/ designee to evaluate each resident's skin status to determine if any follow-up care and services were indicated.<br>A resident record audit was also performed to evaluate compliance with preventative skin care, head to toe skin assessment, shower schedule, treatment, notification of change.<br><br>The facility completes a comprehensive initial and ongoing nursing assessment of intrinsic and extrinsic factors that influence skin health skin/wound impairment, and the ability of a wound to heal. The plan of care for the patient will be refelctive of assessment findings from the comprehensive patient assessment and wound evaluation. Staff continually observe and monitor patients for changes and implement revisions to the plan of care as needed. | |

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|---|---|---|---|
| | 475020 | A. BUILDING ______ B. WING ______ | C 07/27/2023 |

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

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|---|---|---|---|---|

F 686

Continued From page 17

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 monitor patients for changes and implement revisions to the plan of care as needed. Practice standards include:
4. Identify patient's skin integrity status and need for prevention or treatment interventions through review of all appropriate assessment information.
6.5 The licensed nurse will complete wound evaluation upon admission/readmission, new in-house acquired, weekly, and with unanticipated decline in wounds.
6.6 Perform daily monitoring of wounds or dressings for presence of complications or declines. Document daily monitoring of ulcer/wound site with or without dressing. Monitor: status of dressing (e.g., intact and clean); status of the tissue surrounding the dressing (e.g., Free of new redness or swelling); adequate control of wound associated pain; signs of decline in wound status.

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.

F 686

F686 cont...

Licensed nursing staff will be re-educated to this process as well as receiving education on change in condition, skin integrity and wound management, wound care dressing guidelines, admission skin assessment and documetation of skin care provided.

LNA staff will be re-educated to this process as well as receiving education on pressure relieving devices, nutrition/hydration, repositioning, change in condition, shower schedule, diabetic and foot care and preventive skin care.

The Unit Manager/designee will do an audit of the electronic health record (EHR) to evaluate documentation of the completion of scheduled skin care, weekly head to toe skin checks, weekly resident skin care rounds, shower schedule and wound care. This will include visual rounds to visualize care to evaluate staff completion and competency as well as individual resident skin status.
Results of the UM/designee audit and process will be included in the facility monthly risk management/quality improvement meeting for addional consideration as determined appropriate. These audits will be M-F x4 weeks, then weekly x 4 weeks and then monthly x 3 months.

The DON/disignee will complete an audit of four residents to evaluate their skin status, confirmation that anything present has been appropriately identified by the system and that the system was followed through detection, notification of change, care and documentation. Any concerns identified will be addressed at the time of recognition.

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|---|---|---|---|
| | 475020 | A. BUILDING ______ B. WING ______ | C 07/27/2023 |

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

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| F 686 | Continued From page 18<br>Record review reveals that Resident #2 was admitted to the facility on 7/10/23 for therapy following a hospital stay related to a right hip fracture surgical repair. On admission, his/her diagnoses include venous insufficiency (improper blood flow), anemia (lack of blood), and type 2 diabetes. A transition of care report dated 7/10/23 reveals that Resident #1 had the following wounds: right hip wound, left foot laceration, and moisture associated skin damage to the sacrum. There is no documentation of any compromise to either of Resident #2's heels.<br><br>A skin check documented in an admission nursing assessment dated 7/10/23 reveals that Resident #2 had multiple bruises on his/her arms and legs and a right hip incision. There is no documentation of any wounds on either of Resident #2's heels. A wound assessment dated 7/10/23 indicates that Resident #2 has a stage 2 pressure ulcer (Partial-thickness skin loss) on his/her sacrum. A late entry progress note dated 7/10/23, entered on 7/14/23 reveals a pressure area on Resident #2's right heel. This note does not include any assessment information about the wound.<br><br>The Attending Physician admission visit note dated 7/13/23 indicates that Resident #2 is concerned about a wound on the bottom of his/her right heel. The note states, "There is a DTI [deep tissue injury; a pressure-related injury to subcutaneous tissues under intact skin] on the [right] heel with surrounding erythema [redness]," and indicates that Resident #2 has cellulitis (infection) in his/her right heel which requires antibiotic treatment.<br><br>A Nurse Practitioner (NP) note dated 7/13/23 | F 686 | F686 cont....<br><br>Results of the DON/Designee audit and process will be included in the facility monthly risk management/quality improvement meeting for additional consideration as determinded appropriate. These audits will be weekly x 4, then bi-weekly x4, and then monthly x 3 months.<br><br>Date of Compliance 8/23/2023.<br><br>**Tag F 686 POC accepted on 8/15/23 by S. Stem/P. Cota** | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 475020 | A. BUILDING ______ B. WING ______ | C 07/27/2023 |

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

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|---|---|---|---|---|
| F 686 | Continued From page 19 | F 686 | | |

reveals that Resident #2's Attending Physician requested a wound consult from the NP, who is wound care certified, to assess and put treatment in place for a right heel wound. The NP's note describes the wound as "completely filled with blood dark and draining large amount of blood and serosanguineous fluid from a pin hole at the posterior medial section of the wound. Area was surrounded by 0.5 cm of red, hot, tissue, tender to the touch. . .Some pain of the right heel with palpation."
A wound assessment dated 7/13/23 reveals that Resident #2 has a right heel, middle DTI, present on admission, measuring approximately 26 cm squared, with a moderate amount of sanguineous (bloody) discharge.

A NP note dated 7/17/23 indicates Resident #2 has both a right and left heel wound.

An incomplete wound assessment dated 7/18/23 reveals a wound on an unidentified location that was present on admission (8 days old) measuring 1.06 cm x 1.19 cm. Per this surveyor's observation of the photograph attached to this assessment, the area appears to be of a heel with a dark pressure area approximately 1 cm squared surrounded by 1 cm of compromised skin and it is hard to determine if the wound is open or closed. There is no additional assessment information and no additional entries about this wound. A separate wound assessment dated 7/18/23 reveals that Resident #2's right heel wound is approximately 25 cm squared.

There is no evidence in Resident #2's medical record that wound assessments were completed on admission for both Resident #2's right and left heel wounds, which are both documented on later

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 475020 | A. BUILDING ______ B. WING ______ | C 07/27/2023 |

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

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|---|---|---|---|---|
| F 686 | Continued From page 20 | F 686 | | |

wound assessments as being present on admission (7/10/23). The first wound assessment for the right heel was documented on 7/13/23, three days after admission, and the first wound assessment of the left heel was documented on 7/18/23, eight days after admission.

Review of Resident #2's progress notes, medication administration record (MAR) and treatment administration record (TAR) reveal: an order for every other day right heel wound treatment with a start date of 7/17/23 and documented as administered on 7/17/23 and 7/19/23. There are no orders for treatment to the right heel prior to 7/17/23; an order for left heel wound treatment was placed on 7/19/23. A review of Resident #2's TAR reveals an order to monitor wound sites and wound dressings every day shift starting 7/18/23. There is no documentation of daily wound monitoring prior to 7/18/23. There is no evidence in Resident #2's record that wound treatment was provided to Resident #2 right heel prior to 7/13/23, three days after admission, wound treatments were provided to Resident #2's left heel, or that daily foot checks were completed.

Resident #2 did not have care plan focuses, goals, or interventions related to skin and diabetes until 7/17/23, 7 days after admission, and there is no evidence of daily diabetic foot checks. See F655 for more information.

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 and confirmed that Resident #2 did not have a baseline care plan within 48 hours of

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 475020 | A. BUILDING ______ B. WING ______ | C 07/27/2023 |

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

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|---|---|---|---|---|

F 686 Continued From page 21

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.

F 711 SS=G Physician Visits - Review Care/Notes/Order
CFR(s): 483.30(b)(1)-(3)

§483.30(b) Physician Visits
The physician must-

§483.30(b)(1) Review the resident's total program of care, including medications and treatments, at each visit required by paragraph (c) of this section;

§483.30(b)(2) Write, sign, and date progress notes at each visit; and

§483.30(b)(3) Sign and date all orders with the exception of influenza and pneumococcal vaccines, which may be administered per physician-approved facility policy after an assessment for contraindications.
This REQUIREMENT is not met as evidenced by:
Based on interview, record review, and review of facility policies, the facility failed to ensure that a physician reviewed the total program of care during the required admission visits for 2 of 3 sampled residents (Resident #1 and #3), enter signed and dated progress notes per facility policy for 3 of 3 sampled Residents (Residents #1, #2, and #3), and sign and date resident orders for 3 of 3 sampled residents (Resident #1, #2, and #3). Findings include:

Facility policy Standards and Procedures for All Licensed Independent Practitioners, last revised

F 686

F 711 F711 Specific Corrective Action

Resident #1 was discharged on 06/26/2023.
Resident #2 was discharged on 7/19/2023.
Resident #3 was discharged on 8/3/2023.

An audit of the resident records was completed to validate the physician reviewed the resident's total program of care, including medications and treatments, at each visit. This includes writing, dating and signing progress notes, signing and dating all orders with the exception of influenza/pneumococcal vaccines as this can be administered per physician approved facilty policy.

The resident physician/Designee completes required visits that include review of the resident's total program of care, including medications and treatments, at each visit. This includes writing, dating and signing progress notes and signing and dating all orders with the exception of influenza/ pneumococcal vaccines as this can be administered per physician approved facility policy. Physicians, APP, NHA and nursing leadership will be re-educated to this process.

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 475020 | A. BUILDING ______ B. WING ______ | C 07/27/2023 |

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

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 711 | Continued From page 22<br>9/17/21, states,<br>"Upon the admission of a patient, the attending physician or advanced practice provider (APP) is required to: Enter appropriate admission orders on the day of admission. These orders should include comprehensive directions as to diet, vital signs, activity level, rehabilitation services, appropriate testing to rule out active tuberculosis, other laboratory and radio graphic testing, advance care plans and limitations of treatment, medications and other treatments and services. The practitioner must write a progress note to the patient chart at the time of each visit. The progress note must state the current medical problems and reflect the patients present medical condition, as well as contain a rationale for starting, continuing, and discontinuing of drugs and other treatment. The progress note must be signed and dated, and provided to the medical record within 24 hours of the visit, either manually, through [the electronic health record; EHR].<br>Practitioners are responsible for maintaining a complete and accurate medical record in accordance with state and federal law. . .. All orders must be signed and dated in accordance with federal or state requirements ... Electronic orders must be managed and validated pursuant to the electronic chart document management protocol. . .. Telephone orders must be signed on the physicians next visit to the center."<br><br>1. A hospital transition of care report dated 6/20/23 reveals that Resident #1 was transferred to the facility for sub-acute rehabilitation on 6/20/2023 with 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 on | F 711 | F711 cont...<br><br>NHA/Designee will complete audits of new admissions and residents due for required MD visits to ensure this process is followed. These audits will be weekly x4 weeks, bi-weekly x 4 weeks, then monthly x3 months. Results of these audits will be brought to monlty QAPI for further review and recommendations.<br><br>Date of Compliance 8/23/2023<br><br>**Tag F 711 POC accepted on 8/15/23 by S. Stem/P. Cota** | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 475020 | A. BUILDING ______ B. WING ______ | C 07/27/2023 |

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

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|---|---|---|---|---|
| F 711 | Continued From page 23 | F 711 | | |

[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 4 times daily for 3 days. A hospital wound note dated 6/20/23 reveals the following wound care to the blisters and burns on Resident #1's chest and abdomen: "Blisters/Bullae - daily wound care Mepitel One [a long staying wound dressing to promote healing 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 admission orders reveals the following wound care order: "Cleanse areas on chest/trunk with wound spray, 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 physician orders reveals that an order for nystatin was never 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

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 475020 | A. BUILDING ______ B. WING ______ | C 07/27/2023 |

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

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|---|---|---|---|---|
| F 711 | Continued From page 24 | F 711 | | |

treatment, thrush, or treatment for thrush.

A Physician note dated 6/24/2023 reveals an acute visit because Resident #1 was experiencing mouth pain. The note states, "patient has a burning sensation in the mouth as well as white coating on the inner aspect of the lips and the mouth and throat... [S/he] has mild discomfort with swallowing."

On 7/26/23 at 5:00 PM, Resident #1's Attending Physician stated that s/he did not discuss Resident #1's wound care treatment orders with the admitting Registered Nurse and does not know how or why treatment orders were changed from what was on the hospital wound note. S/He is unsure why nystatin was not ordered.

2. Record review reveals that Resident #3 was admitted to the facility on 7/7/23 for physical therapy evaluation and treatment following a hospital stay related to breathing difficulties and pneumonia. On admission, his/her diagnoses include chronic obstructive pulmonary disease (disease that causes obstructed airflow from the lungs), multiple sclerosis (disease of the central nervous system), hypertension, morbid obesity, and s/he is bed bound. A hospital discharge summary dated 7/7/23, includes the following discharge orders: Budesonide [inhaled steroid to decrease inflammation of the airway] 0.5 mg/2 mL suspension for nebulization [changes liquid to a mist for inhalation], 0.5 mg inhalation BID [twice a day]; cefdinir (antibiotic) 300 mg capsule, 300 mg PO [by mouth] BID [twice a day] with instructions to take the last dose tonight to complete the 5 day course; and doxycycline hyclate (antibiotic) 100 mg tablet, 100 mg PO Q12H [every 12 hours] with instructions to take

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 475020 | A. BUILDING ____ B. WING ____ | C 07/27/2023 |

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

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|---|---|---|---|---|
| F 711 | Continued From page 25 | F 711 | | |

the last dose tonight to complete the 5 day course. The following medication was discontinued: Cephalexin (antibiotic) 250 mg capsule, daily.

Record review of Resident #3's physician orders reveal that orders for doxycycline hyclate and cefdinir were never placed; an order for Budesonide was not placed until 7/25/23, 18 days after admission, and cephalexin was ordered by Resident #3's Attending Physician from 7/8/23 until 7/10/23 , even though cephalexin was discontinued at the hospital. Resident #3's MAR reveals that s/he was administered cephalexin on 7/8/23 through 7/10/23.

Resident #3's Attending Physician progress note for an admission visit on 7/13/23 states, "Continue cefdinir and doxycycline, per hospital discharge. . . Continue nebulized budesonide twice daily." The note does not indicate that Resident #3's MAR was reviewed at this visit. The note does not address that Resident #3: did not have orders or receive his/her last dose of cefdinir or doxycycline, which should have been completed on the day of admission, did not have orders or receive budesonide since they were admitted, and had orders and received cephalexin between 7/8/23 and 7/10/23, when the hospital discharge summary indicated that the medication was to be discontinued.

On 7/25/23 at 1:25 PM, Resident #3's Attending Physician indicated that s/he is to review each resident's MAR on admission visits. On 7/26/23 at 5:00 PM, Resident #3's Attending Physician stated that s/he is unsure why there were not orders for doxycycline hyclate, cefdinir, and budesonide and confirmed that it should have

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 475020 | A. BUILDING ______ B. WING ______ | C 07/27/2023 |

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

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|---|---|---|---|---|
| F 711 | Continued From page 26<br>been. S/He stated that s/he did not place the order for cephalexin and confirmed that the order should not have been placed according to the discharge summary.<br><br>3. A review of progress notes shows that Resident #1's 6/22/23 Attending Physician admission visit progress note was not entered into the EHR until 7/20/23, 29 days after the visit; Resident #2's 7/13/23 Attending Physician admission visit progress note was not entered into the EHR until 7/23/23, 10 days after the visit; and Resident #3's 7/13/23 Attending Physician admission visit progress note was not entered into the EHR until 7/23/23, 10 days after the visit.<br><br>On 7/26/23 at 5:00 PM, Resident #1, #2, and #3's Attending Physician stated that s/he was aware that, per facility policy, physician progress notes are to be in residents' charts within 24 hours.<br><br>4. Record review of Resident #1, #2, and #3's physician orders on 7/25/23 reveal that Resident #1's admission orders, with the exception of morphine, Resident #2's admission orders, and Resident #3's admission orders were not signed by the ordering provider.<br><br>On 7/25/23 at 12:20 PM, the Market Clinical Lead confirmed that Residents #1, #2, and #3's orders had not been signed by the ordering provider.<br><br>On 7/26/23 at 5:00 PM, Resident #1, #2, and #3's Attending Physician stated that orders get sent to her/him for signature in batches and it could be weeks before s/he signs resident orders. | F 711 | | |
| F 760 SS=G | Residents are Free of Significant Med Errors<br>CFR(s): 483.45(f)(2) | F 760 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 475020 | A. BUILDING ______ B. WING ______ | C 07/27/2023 |

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|---|---|
| BERLIN HEALTH & REHAB CTR | 98 HOSPITALITY DRIVE BARRE, VT 05641 |

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|---|---|---|---|---|
| F 760 | Continued From page 27<br><br>The facility must ensure that its-<br>§483.45(f)(2) Residents are free of any significant medication errors.<br>This REQUIREMENT is not met as evidenced by:<br>Based on interview and record review, the facility failed to ensure 3 of 3 sampled resident (Residents #1, #2, and #3) are free from significant medication errors. Findings include:<br><br>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 that resulted from a previous provider leaving on ECG [electrocardiogram; a test that records electrical activity of the heart] leads [metal electrode] on while in an MRI machine [magnetic resonance imaging machine; a scanner using magnets to create images of the body]. His/Her pain was controlled with extended release and immediate release morphine. The report reveals the following as discharge medications orders: Morphine 15 mg CR [extended release], 5 tablets every 12 hours for 2 days; and morphine 15 mg [immediate release], 1 tablet every 3 hours as needed for pain up to 120 mg a day. The hospital medication administration record (MAR) for 6/20/23 reveals that prior to her transfer to the nursing facility she received 75 mg of extended release morphine at 8:04 AM and was due for his/her next dose at 9:00 PM, and 15-30 mg of instant release morphine at 12:20 AM, 4:29 AM, 6:07 AM, 8:11 AM, and 11:41 AM. | F 760 | F760 Specific Corrective Action<br><br>Resident #1 was discharged on 06/26/2023.<br>Resident #2 was discharged on 7/19/2023.<br>Resident #3 was discharged on 8/3/2023.<br><br>An audit of resident records was completed to validate medication orders are transcribed correctly, correct medications are given as ordered and medication not available have MD notification in regards to alternative medications or treatments as needed.<br><br>Medication errors occurring at the center will be investigated and appropriate interventions will be implemented. Facility licensed staff will be re-educated to this process.<br><br>Don/Designee will complete audits of new admission charts to validate medication reconciliations are completed and medications are transcribed correctly.<br>These audits weekly x4, bi-weekly x4 and monthly x3. The results of these audits will be brought to the monthly QAPI committee for further review and recommendations.<br><br>Date of Compliance 8/23/2023<br><br>**Tag F 760 POC accepted on 8/15/23 by S. Stem/P. Cota** | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 475020 | A. BUILDING ______ B. WING ______ | C 07/27/2023 |

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

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|---|---|---|---|---|
| F 760 | Continued From page 28 | F 760 | | |

Review of Resident #1's vitals reveal that his/her pain (on a scale of 0-10, 10 being the worst) on 6/20/23 was documented as a 3 at 2:25 PM, a 10 at 4:11 PM, a 10 at 6:30 PM, a 5 at 6:51 PM, and a 6 at 10:45 PM. On 6/21/23, his/her pain was documented as an 8 at 12:10 AM and a 5 at 3:10 AM.

Review of Resident #1's facility MAR reveals that Resident #1 received the following pain-relieving medications on the afternoon and evening of admission, 6/20/23, and early morning 6/21/23: 15 mg of immediate release morphine at 4:11 PM, 15 mg of immediate release morphine at 10:45 PM, and 15 mg of immediate release morphine at 12:10 AM.

A telehealth evaluation note dated 6/20/2023 at 7:14 PM indicates that the on-call provider was notified of Resident #1's pain and was requesting additional pain-relieving medication because they did not have pain medication ordered. The note states that Resident #1's pain rating is at a 9. This provider orders Tylenol 1000 every 6 hours as needed.

A nurse progress note dated 6/21/23 reveals that Resident #1 had used the call bell at 3:10 AM to ask for her morphine. The resident explained to the nurse that a family member called 911 on his/her behalf and an ambulance was on the way. The nurse documented that the resident stated, "I am in excruciating pain and you were not doing anything about it."

An EMS (Emergency Medical Services) report indicates the reason for their dispatch to the facility was that Resident #1 was in extreme pain and did not have access to pain meds. The note

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 475020 | A. BUILDING ______ B. WING ______ | C 07/27/2023 |

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

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|---|---|---|---|---|
| F 760 | Continued From page 29 | F 760 | | |

states, "Patient state getting to rehab today and is not getting [his/her] pain medications, not as ordered and in time to manage [his/her] pain and is taking [his/her] medications. patient states [s/he] is in excruciating pain all over especially in [his/her] chest and back, which is the way it was before her pain was managed in hospital. When asked states [s/he] did get [his/her] morphine dose but does not believe that [s/he] got [his/her] full dose."

Record review of Resident #2's physician orders reveal that orders for Resident #1's morphine were put in correctly on admission by a registered nurse. These correct orders were subsequently struck out by the Nurse Practitioner and incorrectly reentered into the system. The order for the extended release morphine was put in for one 15 mg tab every 12 hours instead of five 15 mg tabs every 12 hours.

On 7/24/23 at 12:15 PM the Market Clinical Lead Stated that s/he had an interview with the Nurse Practitioner who revealed that NP confirmed that s/he entered the order into the system incorrectly. The Market Clinical Lead explained that the facility had not received Resident #1's medications from the pharmacy until approximately midnight on the night of Resident #1's admission, and they should have been received much earlier. In this case, the nurse is expected to get medications from the Pyxis [medication dispensing machine] until the medication is received. The only available morphine in the Pyxis was extended release morphine and the dose of immediate release morphine that was documented on the MAR as administered on 6/20/23 at 4:11 PM was actually extended release morphine. She confirmed that

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 475020 | A. BUILDING ______ B. WING ______ | C 07/27/2023 |

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|---|---|
| **BERLIN HEALTH & REHAB CTR** | **98 HOSPITALITY DRIVE BARRE, VT 05641** |

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|---|---|---|---|---|
| F 760 | Continued From page 30 | F 760 | | |

resident did not receive the correct dose of morphine at the facility until the following day.

A pharmacy packing slip, dated 6/21/23 and signed as received by the facility on 6/21/23, reveals that Resident #1's morphine IR and morphine ER were not delivered to the facility until the day after s/he was admitted.

Resident #1's hospital transition of care note, dated 6/20/23, reveals that Resident #1 is being treated for thrush and has the following discharge medications orders: nystatin (antifungal) 100,000 units/ml suspension, 5 mL by mouth 4 times daily for 3 days.

On review of Resident #1's MAR, there is not an order for nystatin.

A telehealth evaluation note dated 6/24/2023 indicates that the on-call provider was notified that Resident #1 was experiencing mouth pain. The note states, "patient has a burning sensation in the mouth as well as white coating on the inner aspect of the lips and the mouth and throat... [S/he] has mild discomfort with swallowing."

On 7/24/23 at 3:29 PM, Resident #1's Attending Physician stated that s/he was not sure why the nystatin was not ordered on admission and confirmed that it should have been.

2. Record review reveals that Resident #2 was admitted to the facility on 7/10/23 for therapy following a hospital stay related to a right hip fracture surgical repair. On admission, his/her diagnoses include venous insufficiency, anemia, type 2 diabetes, acute respiratory failure, post-surgical pulmonary embolism [PE; a blood

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 475020 | A. BUILDING ____ B. WING ____ | C 07/27/2023 |

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

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|---|---|---|---|---|
| F 760 | Continued From page 31 | F 760 | | |

clot that has traveled to the lungs], and heart failure. Per the transition of care note discharge medications include "enoxaparin [Lovenox;] 80 mg/0.8 ml. Inject 80 mg into the skin every 12 hours for 30 days." Lovenox is an anticoagulant medication. It is used to treat and prevent deep vein thrombosis [DVT; blood clots in a deep vein] and pulmonary embolism. Resident #2 is at risk for developing a DVT or PE because s/he is over 60, is post-surgery, and has a history of PE.

Per interview on 7/17/23 at 11:40 AM, Resident #2 stated that s/he was concerned that s/he was not administered Lovenox the night of admission or the following morning.

Per record review of Resident #2's physician orders, the order for Resident #2's Lovenox was entered into the EHR [electronic medical record] on 7/10/23 with an incorrect 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 stated that it looks like there was a transcription error in entering in Resident #2's admission orders for Lovenox and confirmed that the order should have been started on 7/10/23.

3. Record review reveals that Resident #3 was admitted to the facility on 7/7/23 for physical therapy evaluation and treatment following a hospital stay related to breathing difficulties and pneumonia. On admission, his/her diagnoses include chronic obstructive pulmonary disease (disease that causes obstructed airflow from the lungs), multiple sclerosis (disease of the central nervous system), urge incontinence (urinary

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
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| **BERLIN HEALTH & REHAB CTR** | **98 HOSPITALITY DRIVE BARRE, VT 05641** |

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|---|---|---|---|---|
| F 760 | Continued From page 32 | F 760 | | |

incontinence), hypertension, morbid obesity, and s/he is bed bound. Per a hospital discharge summary dated 7/7/23, Resident #3 was discharged with the following order: Budesonide [inhaled steroid to decrease inflammation of the airway] 0.5 mg/2 mL suspension for nebulization [changes liquid to a mist for inhalation], 0.5 mg inhalation BID [twice a day]. The following medication was discontinued: Cephalexin (antibiotic) 250 mg capsule, daily.

Review of Resident #3's MAR reveals that there are no orders for Budesonide treatment from 7/7/23 through 7/25/23, totaling 18 days, and Cephalexin was documented as administered on 7/8/23, 7/9/23, and 7/10/23.

Per review of Resident #3's physician orders, an order for "Cephalexin Oral Capsule 250 MG (Cephalexin) Give 1 capsule by mouth one time a day for infection for 5 Days," reveals that this was a prescriber written order from Resident #1's Attending Physician given at 7/7/23 at 12:09 PM and entered into the EHR on 7/7/23 at 12:13 PM by a licensed nurse.

On 7/26/23 at 5:00 PM, Resident #3's Attending Physician confirmed that Budesonide should have been ordered on admission. S/He stated that s/he did not place the order for cephalexin and confirmed that the order should not have been placed according to the discharge summary.

In summary, the facility failed to administer the correct dose and frequency of morphine on the day of admission and nystatin for Resident #1 per the transfer of care; resulting in Resident #1 to suffer extreme pain on the night of admission,

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|---|---|---|---|
| | 475020 | A. BUILDING ______ B. WING ______ | C 07/27/2023 |

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

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
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F 760 Continued From page 33

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.

F 841 SS=G Responsibilities of Medical Director
CFR(s): 483.70(h)(1)(2)

§483.70(h) Medical director.
§483.70(h)(1) The facility must designate a physician to serve as medical director.

§483.70(h)(2) The medical director is responsible for-
(i) Implementation of resident care policies; and
(ii) The coordination of medical care in the facility.
This REQUIREMENT is not met as evidenced by:
Based on interview and review of facility policies, the facility failed to ensure that the medical director fulfilled his/her responsibility to coordinate medical care with facility providers and nursing staff related to obtaining and implementing provider orders for necessary care and services for 3 of 3 sampled residents (Residents #1, #2, and #3). Findings include:

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

**F 841 — Provider's Plan of Correction**

F841 Specific Corrective Action

The current medical director's contract was terminated on 8/11/2023. This includes her privileges as an attending physician. Patients/residents are now assigned to the new attending physician, who will also serve as the centers medical director beginning 8/11/2023.

All residents have the potential to be affected by the deficient practice.

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 idenitfy, evaluate and address/resolve medical and clinical concerns and issues that affect patient care, medical care of quality of life, or are related to the provision of services by physicians and other licensed health care practitioners. Providers and adminstrative staff will be re-educated to this process.

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| F 841 | Continued From page 34<br>patient care, medical care of quality of life; or are related to the provision of services by physicians and other licensed health care practitioners."<br><br>Record review reveals that, per Resident #1's transfer of care dated 6/20/23 and the 6/20/23 hospital medication administration record (MAR), orders for nystatin (antifungal medication), morphine extended release, and gabapentin (a medication used to treat nerve pain), were not accurately reconciled, transcribed, or checked for accuracy by a second nurse per facility policy. Per Resident #2's transfer of care of care dated 7/10/23, orders for Lovenox [an anticoagulant medication used to treat and prevent deep vein thrombosis (DVT; blood clots in a deep vein) and pulmonary embolism (PE; a blood clot that has traveled to the lungs)] were not accurately transcribed or checked for accuracy by a second nurse. Per Resident #3's discharge summary dated 7/8/23, orders for Budesonide (inhaled steroid to decrease inflammation of the airway), Cephalexin (antibiotic), cefdinir (antibiotic), and doxycycline hyclate (antibiotic) were not accurately reconciled, transcribed, or checked for accuracy by a second nurse per facility policy. As a result, Resident #1 suffered extreme pain for which s/he sought relief for at the emergency room, was not treated for thrush for 5 days, and a wound identified as a small scab, present on admission, significantly deteriorated to become two stage 3 pressure ulcers (full thickness skin loss); Resident #2 was at risk for developing a DVT or PE; and Resident #3 was at risk for breathing complications. On 7/25/23 at 12:20 PM, the Market Clinical Lead confirmed that Resident #1, #2, and #3's transfer of care orders were not effectively reviewed by the Attending Provider/Medical Director or nursing staff, | F 841 | F841 cont...<br><br>NHA/Designee will audit resident admission records to validate that the medical director fulfills his/her duty to coordinate medical care with providers and nursing staff related to obtaining and implementing provider orders for necessary care and services. This includes validation of medication reconciliation. These audits will be weekly x4, bi-weekly x4 and then monthly x3. Results of the audit will be discussed in montly QAPI.<br><br>Date of Compliance 8/23/2023<br><br>**Tag F 841 POC accepted on 8/15/23 by S. Stem/P. Cota** | |

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

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| F 841 | Continued From page 35 properly transcribed, or checked for accuracy by a second nurse per facility policy. See F635 for more information.<br><br>Based on interviews conducted on 7/24/23 at 3:29 PM and 7/26/23 at 5:00 PM, the Medical Director confirmed that Resident #1, #2, and #3's admission orders were not accurately reconciled with hospital transfer information. S/He stated that the process of providing comprehensive admission orders should be the responsibility of the transferring hospital, not the facility, and that it is the facility's responsibility to make sure there is a procedure in place to ensure that admission orders are being double checked for accuracy, not hers/his. S/He stated that s/he was not aware that the facility policy titled, OPS424 Medication Reconciliation, effective on 9/1/2022 during his/her time as Medical Director, instructed facility staff to review the hospital MAR while reconciling admission orders and cannot recall if s/he had ever reviewed the policy. S/He indicated that s/he has been aware that there have been widespread problems with the transfer of care and ensuring residents have complete orders to meet all their care needs on admission for a long time. S/He stated that she has brought this problem to past facility leadership but because there have been multiple administrators and nursing directors, no action has been taken to correct the issues by the facility since s/he has been medical director. S/He confirmed that she has not brought the issues with transfer of care to QAPI (quality assurance and performance improvement program) and has not initiated or organized any training with staff about this issue. | F 841 | | |