

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

September 7, 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 **August 18, 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,

famila MCotaRN

Pamela M. Cota, RN Licensing Chief

Enclosure

| CENTER | S FOR MEDICARE & | MEDICAID SERVICES | | | OMB NO. 0938-03 | 1391 |
|--|---|---|---------------------|--|---|------|
| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION UMBER: | | | PLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED | | |
| | | 475020 | B. WING | | C 08/18/2023 | |
| NAME OF P | ROVIDER OR SUPPLIER | | <u> </u> | STREET ADDRESS, CITY, STATE, ZIP CODE | | |
| | | | | 98 HOSPITALITY DRIVE | | |
| BERLIN H | EALTH & REHAB CTR | | | BARRE, VT 05641 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI | D BE COMPLETI | |
| | | | | DEFICIENCY) | | |
| F 000 | INITIAL COMMENTS | | F 0 | 00 | | |
| | | unced, on-site investigation & 22114 on 8/10/23 with | | Type text her | e | |
| | determine if the facilit CFR Part 483, Requir | y was in compliance with 42 ements for Long Term Care ng regulatory violations were | | a | | |
| | Services Provided Me CFR(s): 483.21(b)(3)(| et Professional Standards i) | F 6 | ⁵⁸ F658 Specific Corrective Action | | |
| | as outlined by the con must- | l or arranged by the facility, nprehensive care plan, | 12 | 1. Resident #1 discharged 7/29/2 Resident #2 is receiving treatmen ordered by the MD and these trea signed off as completed in the TA | ts as itments are | |
| | by: | is not met as evidenced ecord review, and a review | | 2. An audit of resident TAR/MAR completed to validate physician of followed and documented as completed to complete the second s | rders are | |
| | compliance with Profe | ssional Standards related ntation for two of three | | 3. The facility follows professiona in regards to following MD orders of documentation of completed tru Licensed staff will be dedicated to process. | , inclusive eatments. | |
| | to the facility on 3/24/2 cord compression due spread to her/his spin diagnosis of Type 2 D transferred and admitt 7/29/2023 with a diag | ed to the hospital on nosis of sepsis (sepsis is a | x | 4. DON/Designee will complete ra audits weekly x4, biweekly x4, an x3 to validate treatments are com documented. Results of these aud brought to the monthly QAPI com further review and recommendation | d monthly pleted and dits will be mittee for | |
| | rapidly progress to se to the lungs, kidneys, | o an infection; Sepsis can otic shock, causing damage | | Date of compliance 9/11/2023 Tag F 658 POC accepted on 9/7 | 7/23 by | |
| | - Julie, Fritaronig It | | | D. Hoffman/P. Cota | | |
| ABORATORY I | | UPPLIER REPRESENTATIVE'S SIGNATURE | | TITLE | (X6) DATE | |
| | U)Za | costo 1 | ~NH | <u> </u> | 9/5/20 | 023 |

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.

CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/31/2023 FORM APPROVED OMB NO. 0938-0391

| AND FLAN OF CORRECTION Intermitication NUMBER: A. BULDING C AND FLAN OF CORRECTION 475020 9 WNG C C DEMONDER OR SUPPLER STREET ADDRESS, CITY, STATE, ZIP CODE 98 MIG9TIALITY DRIVE BERLIN HEALTH & RENAB CTR 91 MIG9TIALITY DRIVE D PROPTICE TO TRANSPORT 000000000000000000000000000000000000 | STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA | | (X2) MULTIPLE CONSTRUCTION | | | (X3) DATE SURVEY | | | | | |
|---|---|--|---|-----------------|-----------------------|---|----------------|-----------|--|--|--|
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| BERLIN HEALTH & REHAB CTR SMMARY STATEMENT OF DEFICIENCIES BARRE, VT 0641 SMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MIST BE PRECEDED BY FULL RECULTORY OR LSC IDENTIFYING INFORMATION) DD PROVIDENCE FLAM OF CORRECTION (EACH CORRECTIVE ACTION BIOLD BE CROSS-REFERENCED OF IDE APPROPRIATE DEFICIENCY) DO F 658 Continued From page 1 the resident was pale in color and they could not obtain an Oxygen Saturation reading (measurement of Oxygen level in the blood) and indicates a foul door and darkening of the tissue were observed during a dressing change to a wound on the Resident's hip. The physician was notified, and s/he was sent to the Emergency Department for evaluation with a concern for sepsis. F 658 F S Per review of the Minimum Data Set (MDS - a standardized assessment tool that measures health status in nursing home residents) dated 5/23/23, the resident had two facility-acquired deep tissue injuries. A physician's order for Resident #1 shows a treatment offor facility-acquired deep tissue injuries. A physician's order for Resident #1 shows a treatment offor data (7/52/3 for Dakin's solution X strength (a solution used to cleanse wounds to prevent infection). The order states to wound with quarter strength Dakin's soaked kerkir, cover with a dry dressing or Abdominal pad, and secure with tape. A second Physician's order dated 7/52/23 reads Nystatin powder to the sacrum topically every morning and at bedtime. A review of the residents the dressing or Abdominal pad, and secure with tape. A second Physician's order dated 7/52/23 reads Nystatin powder to the sacrum topically every morning and at bedtime. A review of the residents the dressing ro Abdominal pad, and secure with tape. A second Physician's order dated 7/52/23 reads Nystatin powder to the saccrum topica | | | 475020 | | | 08/18/2 | 2023 | | | | |
| BERL VT 05641 (Y410) TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH CPERCEXY MUST BE PRECEDED BY ULL REGULATORY OR LSC IDENTIFYING INFORMATION) PD TAG PROVIDENTIFY REGULATORY OR LSC IDENTIFYING INFORMATION) PD TAG PROVIDENTIFYING INFORMATION) PM CACH CORRECTIVE ACTOR SHOLD DE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) CM DEFICIENCY F 658 Continued From page 1 the resident was pale in color and they could not obtain an Oxygen Saturation reading (measurement of Oxygen Isevel in the blood) and indicates a foul door and darkening of the tissue were observed during a dressing change to a wound on the Resident's hip. The physician was notified, and s/he was sent to the Emergency Department for evaluation with a concern for sepsis. F 658 Per review of the Minimum Data Set (MDS - a standardized assessment tool that measures health status in nursing home residents) dated 5/2/3/2, the resident had two facility-acquired pressure ulcers and four facility-acquired deep tissue injuries. A physician's order for Resident #11 shows a treatment offer Otack of hip) topically two times a day for pressure infection. The order states to apply to the fet fischium (mack of hip) topically two times a day for pressure injury, cleanse wound to left ischium with wound cleanser and pat dry; pack wound with quarter strength Dakins soaked kerkir, cover with a dry dressing change for the right Ischial wound was not documented as complete on July 3,14, 15 and 16. There was no documentation that the Nystatin Power was | NAME OF PROVIDER OR SUPPLIER | | | | STREET ADDRESS, CITY, | STATE, ZIP CODE | | | | | |
| ONE ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEPICIENCY MUST BE PRECEDED BY FULL REDULTION OF LSC IDEMIFYING INFORMATION REDULTION OF LSC IDEMIFYING INFORMATION ADDIESTICATION OF LSC IDEMIFYING INFORMATION TAG PROVIDEN'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOLD BE CROSSREEFERENCE) COMPLETION (EACH CORRECTIVE ACTION SHOLD BE CROSSREEFERENCE) COMPLETION (EACH CORRECTIVE ACTION (EACH CORRECTIVE ACTION (EACH CORRECTIVE ACTION (EACH CORRECTIVE ACTION (EACH CORRECTIVE ACTION (CROSSREEFERENCE) COMPLETION (EACH CORRECTIVE (EACH CORRECTIVE ACTION (CROSSREEFERENCE) COMPLETION (CROSSREEFERENCE) COMPLETION (CROSSREEFERENCE) COMPLETION (CROSSREEFERENCE) COMPLETION (CROSSREEFERENCE) COMPLETION (CROSSREEFERENCE) COMPLETION (CROSSREEFERENCE) COMPLETION (CROSSREEFERENCE) COMPLETION (CROSSREEFERENCE) COMPLETION (CROSSREEFERENCE) <thcompletion (CROSSREEFERENCE) <thcompletion (CROSSREEFER</thcompletion </thcompletion | BERLIN HEALTH & REHAB CTR | | | | | | | | | | |
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| the resident was pale in color and they could not obtain an Oxygen Saturation reading (measurement of Oxygen level in the blood) and indicates a foul odor and darkening of the tissue were observed during a dressing change to a wound on the Resident's hip. The physician was notified, and s/he was sent to the Emergency Department for evaluation with a concern for sepsis. Per review of the Minimum Data Set (MDS - a standardized assessment tool that measures health status in nursing home residents) dated. 5/23/23, the resident had two facility-acquired deep tissue injuries. A physician's order for Resident #1 shows a treatment order dated 7/5/23 for Dakin's solution ¼ strength (a solution used to cleanse wounds to prevent infection). The order states to apply to the fit ischium (back of hip) topically two times a day for pressure injury, cleanse wound to left ischium with quarter strength Dakin's soaked kerlix; cover with a dry dressing or Abdominal pad, and secure with tape. A second Physician's order dated 7/5/23 reads Nysitatin powder to the sacrum topically every morning and at bedtime. A review of the resident's Treatment Administration Record (Tar) indicates the dressing or for the right lschial wound was not documented as complete on July 8,14, 15 and 16. There was no documentation that the Nystain Powder was | PREFIX | (EACH DEFICIENC) | Y MUST BE PRECEDED BY FULL | PREFIX | (EACH COR | RECTIVE ACTION SHOULD BI RENCED TO THE APPROPRIA | | OMPLETION | | | |
| A review of the Genesis Center's Nursing Policies/Treatment policy indicate the following: #10 Document 10.1 Administration on the Treatment Administration Record (TAR); | F 658 | the resident was pale obtain an Oxygen Sat (measurement of Oxy indicates a foul odor a were observed during wound on the Resider notified, and s/he was Department for evalua sepsis. Per review of the Mini standardized assess health status in nursin 5/23/23, the resident I pressure ulcers and fot tissue injuries. A phys shows a treatment or solution ¼ strength (a wounds to prevent inf apply to the left ischiu times a day for pressu left ischium with woun pack wound with quar kerlix; cover with a dry pad, and secure with order dated 7/5/23 resist the right Ischial wound complete on July 8,14 documentation that th applied on July 14 and A review of the Geness Policies/Treatment po #10 Document 10.1 Administration on | in color and they could not turation reading gen level in the blood) and and darkening of the tissue a dressing change to a nt's hip. The physician was a sent to the Emergency ation with a concern for mum Data Set (MDS - a nent tool that measures ing home residents) dated had two facility-acquired our facility-acquired deep bician's order for Resident #1 der dated 7/5/23 for Dakin's solution used to cleanse ection). The order states to m (back of hip) topically two ure injury; cleanse wound to id cleanser and pat dry; ter strength Dakins soaked y dressing or Abdominal tape. A second Physician's as Nystatin powder to the y morning and at bedtime. A 's Treatment Administration is the dressing change for d was not documented as 1, 15 and 16. There was no e Nystatin Power was d 16th. sis Center's Nursing licy indicate the following : in the Treatment | F 6 | 58 | DEFICIENCY) | | | | | |
| ORM CMS-2567(02-99) Previous Versions Obsolete Event ID:05KY11 Facility ID: 475020 If continuation sheet Page 2 of 7 | CODMOND 250 | | | | Expility ID: 475020 | 12 | unting chart D | | | | |

CENTERS FOR MEDICARE & MEDICAID SERVICES

| CENTERS FOR MEDICARE & MEDICAID SERVICES | | | | | OWR N | 0.0938-0391 | | |
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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | (X3) DATE SURVEY COMPLETED C | | |
| 475020 | | B. WING | | 08/18/2023 | | | | |
| 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 | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREF TAG | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY) | BE | (X5) COMPLETION DATE | |
| F 658 | 10.2 Patient's Respor 10.3 Patient's refusal 10.4 Notification of ph Practice Provider], if a There is no document of the Treatment Polic that the treatment Polic that the treatment Polic that the treatment was indicate it was comple Per interview on 8/9/2 Registered Nurse Unit resident was discharg Hospice Care. The RM #1's progress notes at no evidence of docum in the TAR. There is n notification of missed inconsistent with the fi 2. Per record review, I stage three pressure of Review of the resident record revels a Physic for dressing change to cleanse with wound cl Medi honey gel and ca remaining area and co foam every Tuesday, ' review of the TAR indi wound care was perfor Thursday, 7/13/23, an Review of a Skin and 7/18/23 indicates mea wound, 9.3 cm total at a width of 4.0 cm. A S dated 7/25/23 indicates | nse; of treatment, if applicable; ysician /APP [Advanced applicable. red evidence that 10.1 - 10.4 cy was followed on the dates ere not signed by a nurse to oted. 3 at 3:00 PM with the t Manager (UM), the ed from the hospital on N reviewed the Resident and confirmed that there was rentation regarding the gaps o evidence of provider treatments, which is acility treatment policy. Resident #2 has bilateral ulcers to their heels. t's treatment administration cian's order dated 6/29/23 o bilateral heels states to eanser, pat dry; cover with alcium alginate to the over with non-adhesive Thursday, and Saturday. A cates no evidence that urmed on Tuesday, 7/4/23, | F | 658 | Β | | | |

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

Event ID: 05KY11

Facility ID: 475020

If continuation sheet Page 3 of 7

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | | | MULTIPLE CONSTRUCTION JILDING | | | (X3) DATE SURVEY COMPLETED | |
|---|---|---|---------------------|-------------------------------|--|--|-------------------------------|--|
| | | 475020 | B. WING _ | | | C 08/18/2023 | | |
| | ROVIDER OR SUPPLIER | | | 98 | TREET ADDRESS, CITY, STATE, ZIP CODE 8 HOSPITALITY DRIVE CARRE, VT 05641 | 1 00 | 10/2023 | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION) | ID PREFIX TAG | ¢ | PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY) | LD BE | (X5) COMPLETIC DATE | |
| F 658 F 677 SS=D | approximately 3:00 P Resident #2's TAR dis documentation for bot treatments. The UM r confirmed that there is documentation regard evidence of provider r treatment policy. S/he evidence that the dres ordered. S/he further documented measure wound worsened after Ref: Lippincott Manua Edition) Wolters, Kluw Williams, & Wilkens ADL Care Provided for CFR(s): 483.24(a)(2) §483.24(a)(2) A residu out activities of daily is services to maintain g personal and oral hyg This REQUIREMENT by: Based on observation review the facility faile showers and assist w needed for 1 of 3 resid | n of 4.5 cm. These te that the wound had ease in size. ith the UM on 8/10/23 at M, s/he confirmed that splayed evidence of gaps in th dressing changes and eviewed progress notes and s no evidence of ling the gaps nor is there notification, per facility e confirmed there is no asings were changed as confirmed that the ments indicate that the r the missed treatments. It of Nursing Practice (9th ver Health/Lippincott, or Dependent Residents ent who is unable to carry iving receives the necessary lood nutrition, grooming, and iene; is not met as evidenced ms, interview, and record d to provide weekly ith incontinence care as dents in the applicable | F 6 | | F677 Specific Corrective Action 1. Resident #3 is currently receivincontinence care and showers a preference. 2. Residents are being interview validate their incontinence care is being performed according to preference. 3. Education is being completed care staff regarding following pat in regards to bathing and incontinence to b | ing t his/her ed to and bathing their with direct ient prefere | nce | |
| | | sident #3 on 8/10/2023 at was communicated: S/He | | | | | | |

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Facility ID: 475020

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PRINTED: 08/31/2023 FORM APPROVED

| CENTERS FOR MEDICARE & MEDICAID SERVICES | | | | | DWR NO: 0938-0391 |
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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | (X3) DATE SURVEY COMPLETED |
| | | | | C 08/18/2023 | |
| NAME OF PROVIDER OR SUPPLIER BERLIN HEALTH & REHAB CTR | | | 9 | TREET ADDRESS, CITY, STATE, ZIP CODE 8 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 BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | |
| F 677 | had rung their call ligh requested assistance pants. S/he gets up be every day. S/he had be morning and has not r The resident reports the urine and 8 hours is a being changed. This is about every day. The come in, say they neet them, shut off the call back. Resident #3 was obset while s/he explained to (machanical lift) to put change her/him. Durin Nursing Assistant (LN asked Resident #3 if to now or wait until they resident stated "No, gi go get help, you will n put a pad on the bed a under the resident the help. Resident #3 also get a shower this ever week that s/he has not that for two of the weet lightning and for the o staff. S/he also stated give her/him a shower missed. Per observation of the incontinence care on a Resident #3's brief wa urine and there was a wheelchair that s/he her | that at 11:30 this morning and with changing her/his soiled etween 5:30 and 6:30 AM been up since 6:30 AM this received help as of 2:00 PM. hat s/he is incontinent of long time to be up without is not new and happens just resident stated that the staff d to get someone to help light, leave, and don't come erved sitting in a wheelchair hat staff use a Hoyer ther/him back to bed to ing this interview, a Licensed A) entered the room and hey wanted to get changed were done talking. The et me ready now and then ever come back." The LNA and placed a Hoyer pad in left the room to go get o stated that if s/he did not hing it would be the 5th t had a shower. S/he said eks it was thunder and thers there was not enough that the staff do not offer to a tanother time if it is | F 677 | F677 cont 4. The Director of Nursing (DON)/de will conduct weekly audits x4, mont to ensure resident showers are bein completed to the residents' preferen Compliance date of 9/11/2023 Tag F 677 POC accepted on 9/7/2 D. Hoffman/P. Cota | thly x3 ng nce. |
| ODM CMC 256 | 7(02-99) Previous Versions Obso | Diete Event ID: 05KY1 | 1 59 | cility ID: 475020 If contin | nuation sheet Page 5 of 7 |

| CENTER | S FOR MEDICARE & | MEDICAID SERVICES | | | | OMB NO | D: 0938-0391 | |
|---|--|---|--------------------|--------------------------------------|--|--------|-------------------------------|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | 2) MULTIPLE CONSTRUCTION BUILDING | | | (X3) DATE SURVEY COMPLETED | |
| | 475020 | | B. WING | | C 08/18/2023 | | | |
| NAME OF PROVIDER OR SUPPLIER | | | - | STREE | T ADDRESS, CITY, STATE, ZIP CODE | , | | |
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| BERLIN H | EALTH & REHAB CTR | | | BARR | RE, VT 05641 | | | |
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| F 677 | Continued From page under the wheelchain the urine on the chain resident's brief was re bowel movement form well. After incontinent resident was assisted Hoyer. A care plan focus for Care Performance De intolerance, impaired 8/1/2023 lists interver prefers showers" and ASSISTANCE of 2 or [resident's] preference Documentation Surve documentation of care reveals documentation receive a shower from been without a showed Per interview with the if there are three staff hard to get to the resi especially because the lift. The LNA stated the for Resident #3 to get since s/he gets up so Per interview with the (CED) on 8/18/2023 a refused to have a sho due to thunder and lig expectation would be | a 5 an LNA placed a towel over cushion. When the emoved there was a medium hed to her/his buttocks as ac care and dressing, the back to the chair with the ADL (Activities of Daily) Self efficit related to activity balance initiated on titions that include "Resident "BATHING: TOTAL Thursday evenings or per e." July and August 2023 by Reports (LNA's e provided to the resident) in that Resident #3 did not in 7/6 - 8/10/2023. S/he had er for 34 days. LNA on 8/10/23 at 6:00 PM, members on the unit it is dent's showers done e resident requires a Hoyer at s/he felt it might be better their shower in the morning | | 577 | | | | |
| | showers as indicated | ident had not received and that there was no dent was offered a shower | | | | | | |

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

Facility ID: 475020