VERMONT

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

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

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,

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
	475020	A. BUILDING _____ B. WING _____	C 08/18/2023

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

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F 000	INITIAL COMMENTS The Division of Licensing and Protection conducted an unannounced, on-site investigation of complaints #22117 & 22114 on 8/10/23 with further off site investigation on 08/18/23 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	Type text here	
F 658 SS=E	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on interview, record review, and a review of policies, the facility failed to maintain compliance with Professional Standards related to inaccurate documentation for two of three sampled residents [Residents #1 and #2] Findings include: 1. Per record review, Resident #1 was admitted to the facility on 3/24/23 with a diagnosis of spinal cord compression due to prostate cancer that has spread to her/his spine and other bones, and a diagnosis of Type 2 Diabetes. S/he was transferred and admitted to the hospital on 7/29/2023 with a diagnosis of sepsis (sepsis is a life-threatening condition in which the body responds improperly to an infection; Sepsis can rapidly progress to septic shock, causing damage to the lungs, kidneys, liver, and other vital organs). A Nursing note dated 7/29/23 indicates	F 658	F658 Specific Corrective Action 1. Resident #1 discharged 7/29/2023. Resident #2 is receiving treatments as ordered by the MD and these treatments are signed off as completed in the TAR. 2. An audit of resident TAR/MAR was completed to validate physician orders are followed and documented as completed. 3. The facility follows professional standards in regards to following MD orders, inclusive of documentation of completed treatments. Licensed staff will be dedicated to this process. 4. DON/Designee will complete random audits weekly x4, biweekly x4, and monthly x3 to validate treatments are completed and documented. Results of these audits will be brought to the monthly QAPI committee for further review and recommendations. Date of compliance 9/11/2023 **Tag F 658 POC accepted on 9/7/23 by D. Hoffman/P. Cota**	

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

Dacosta LNHA 9/5/2023

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 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 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 pressure ulcers and four 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 left ischium (back 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 kerlix; cover with a dry dressing or Abdominal pad, and secure with tape. A second Physician's order dated 7/5/23 reads Nystatin powder to the sacrum topically every morning and at bedtime. A review of the resident's Treatment Administration Record (Tar) indicates the dressing change for the right Ischial wound was not documented as complete on July 8,14, 15 and 16. There was no documentation that the Nystatin Power was applied on July 14 and 16th. 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		

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F 658	Continued From page 2 10.2 Patient's Response; 10.3 Patient's refusal of treatment, if applicable; 10.4 Notification of physician /APP [Advanced Practice Provider], if applicable. There is no documented evidence that 10.1 - 10.4 of the Treatment Policy was followed on the dates that the treatments were not signed by a nurse to indicate it was completed. Per interview on 8/9/23 at 3:00 PM with the Registered Nurse Unit Manager (UM), the resident was discharged from the hospital on Hospice Care. The RN reviewed the Resident #1's progress notes and confirmed that there was no evidence of documentation regarding the gaps in the TAR. There is no evidence of provider notification of missed treatments, which is inconsistent with the facility treatment policy. 2. Per record review, Resident #2 has bilateral stage three pressure ulcers to their heels. Review of the resident's treatment administration record revels a Physician's order dated 6/29/23 for dressing change to bilateral heels states to cleanse with wound cleanser, pat dry; cover with Medi honey gel and calcium alginate to the remaining area and cover with non-adhesive foam every Tuesday, Thursday, and Saturday. A review of the TAR indicates no evidence that wound care was performed on Tuesday, 7/4/23, Thursday, 7/13/23, and Saturday, 7/15/23. Review of a Skin and Wound Evaluation dated 7/18/23 indicates measurements of the right heel wound, 9.3 cm total area, a length of 3.0 cm, and a width of 4.0 cm. A Skin and Wound Evaluation dated 7/25/23 indicates measurements of a right heel wound covering an area of 11.7 cm, a length	F 658		

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F 658	Continued From page 3 of 3.3 cm, and a width of 4.5 cm. These measurements indicate that the wound had worsened by the increase in size. During an interview with the UM on 8/10/23 at approximately 3:00 PM, s/he confirmed that Resident #2's TAR displayed evidence of gaps in documentation for both dressing changes and treatments. The UM reviewed progress notes and confirmed that there is no evidence of documentation regarding the gaps nor is there evidence of provider notification, per facility treatment policy. S/he confirmed there is no evidence that the dressings were changed as ordered. S/he further confirmed that the documented measurements indicate that the wound worsened after the missed treatments. Ref: Lippincott Manual of Nursing Practice (9th Edition) Wolters, Kluwer Health/Lippincott, Williams, & Wilkens	F 658		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observations, interview, and record review the facility failed to provide weekly showers and assist with incontinence care as needed for 1 of 3 residents in the applicable sample (Resident #3). Findings include: Per interview with Resident #3 on 8/10/2023 at 2:00 PM the following was communicated: S/He	F 677	F677 Specific Corrective Action 1. Resident #3 is currently receiving incontinence care and showers at his/her preference. 2. Residents are being interviewed to validate their incontinence care and bathing is being performed according to their preference. 3. Education is being completed with direct care staff regarding following patient preference in regards to bathing and incontinence care.	

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F 677	Continued From page 4 had rung their call light at 11:30 this morning and requested assistance with changing her/his soiled pants. S/he gets up between 5:30 and 6:30 AM every day. S/he had been up since 6:30 AM this morning and has not received help as of 2:00 PM. The resident reports that s/he is incontinent of urine and 8 hours is a long time to be up without being changed. This is not new and happens just about every day. The resident stated that the staff come in, say they need to get someone to help them, shut off the call light, leave, and don't come back. Resident #3 was observed sitting in a wheelchair while s/he explained that staff use a Hoyer (mechanical lift) to put her/him back to bed to change her/him. During this interview, a Licensed Nursing Assistant (LNA) entered the room and asked Resident #3 if they wanted to get changed now or wait until they were done talking. The resident stated "No, get me ready now and then go get help, you will never come back." The LNA put a pad on the bed and placed a Hoyer pad under the resident then left the room to go get help. Resident #3 also stated that if s/he did not get a shower this evening it would be the 5th week that s/he has not had a shower. S/he said that for two of the weeks it was thunder and lightning and for the others there was not enough staff. S/he also stated that the staff do not offer to give her/him a shower at another time if it is missed. Per observation of the Hoyer lift transfer and incontinence care on 8/10/23 at 2:25 PM, Resident #3's brief was saturated and leaking urine and there was a very foul urine smell. The wheelchair that s/he had been sitting in was wet with urine and there was urine noted on the floor	F 677	F677 cont... 4. The Director of Nursing (DON)/designee will conduct weekly audits x4, monthly x3 to ensure resident showers are being completed to the residents' preference. Compliance date of 9/11/2023 **Tag F 677 POC accepted on 9/7/23 by D. Hoffman/P. Cota**	

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F 677	Continued From page 5 under the wheelchair, an LNA placed a towel over the urine on the chair cushion. When the resident's brief was removed there was a medium bowel movement formed to her/his buttocks as well. After incontinence care and dressing, the resident was assisted back to the chair with the Hoyer. A care plan focus for ADL (Activities of Daily) Self Care Performance Deficit related to activity intolerance, impaired balance initiated on 8/1/2023 lists interventions that include "Resident prefers showers" and "BATHING: TOTAL ASSISTANCE of 2 on Thursday evenings or per [resident's] preference." July and August 2023 Documentation Survey Reports (LNA's documentation of care provided to the resident) reveals documentation that Resident #3 did not receive a shower from 7/6 - 8/10/2023. S/he had been without a shower for 34 days. Per interview with the LNA on 8/10/23 at 6:00 PM, if there are three staff members on the unit it is hard to get to the resident's showers done especially because the resident requires a Hoyer lift. The LNA stated that s/he felt it might be better for Resident #3 to get their shower in the morning since s/he gets up so early. Per interview with the Center Executive Director (CED) on 8/18/2023 at 3:11 PM Resident #3 had refused to have a shower on two of the occasions due to thunder and lightning storms, and that the expectation would be that staff would offered the resident a shower on another day. The CED confirmed that the resident had not received showers as indicated and that there was no evidence that the resident was offered a shower on an alternate day.	F 677		