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 30, 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 22, 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

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

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 08/22/2023

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 000	INITIAL COMMENTS The Division of Licensing and Protection conducted an onsite, unannounced investigation of two facility reported incidents (ACTS #22148 and #22149) on 8/22/2023 to determine compliance with 42 CFR Part 483 requirements for Long Term Care Facilities. The following regulatory deficiency was identified:	F 000	This plan of correction was written to follow state and federal guidelines. It is not an admission of noncompliance. However, it is the facility commitment to demonstrate and maintain compliance.	
F 557 SS=E	Respect, Dignity/Right to have Prsnl Property CFR(s): 483.10(e)(2) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(2) The right to retain and use personal possessions, including furnishings, and clothing, as space permits, unless to do so would infringe upon the rights or health and safety of other residents. This REQUIREMENT is not met as evidenced by: Based on resident interviews, staff interviews, and record review, the facility failed to ensure each resident was treated with respect and dignity during personal care so as to not cause pain or discomfort for 3 of 3 sampled residents (Residents #1, #2, and #3). Findings include: 1. Per record review, Resident #1 has a history of chronic right rotator cuff injury and requires assistance of 1-2 staff for mobility needs. Per the Nurse Practitioner's Acute Visit note from 8/9/2023, the note reads that Resident #1 "described what happened and why [their] shoulder hurts. Reports last night after being repositioned by lifting [them] under the arms ... request for shoulder X-ray." X-ray records show	F 557	F 557 Specific Corrective Action 1. Residents #1, #2, and #3 are currently receiving ADL's with dignity and respect. 2. Residents/Patients are being interviewed to validate they are receiving ADL's with dignity and respect. 3. Education is being done with licensed staff on treating residents with dignity and respect, especially during ADL care to include soft, slow and calm approach. Education will be done with residents in resident council to explain their rights to be treated with dignity and respect and to report any issues they may have immediately. 4. Administrator/Designee will continue to review resident interview results and audit 5 residents weekly x3, biweekly x3 and then monthly x3. Date of Compliance 9/5/2023 **Tag F 557 POC accepted on 8/30/23 by K. Ruffe/P. Cota**	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Holly Wood, LNHA — TITLE: Admin — (X6) DATE: 8-29-23

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 557	Continued From page 1	F 557		

no new injury to the right shoulder.

Per review of the facility reported incident investigation documentation, LNA 2 (licensed nursing assistant) notified the Administrator on 8/9/2023 that Resident #1 reported rough handling by LNA 1 during the 8/8/2023 night shift. Resident #1 confirmed, during interview with the Administrator, that the episode of personal care caused them pain in their shoulder but that they felt safe in the facility and did not have concerns about LNA 1 or wish to no longer be cared for by LNA 1.

Per interview on 8/22/23 at approximately 10:30 AM, Resident #1 confirmed that LNA 1 pulled their right arm in a painful way during personal care during the night shift of 8/8/23.

2. Per record review, Resident #2 has diagnoses that include pain in right leg and pain in left leg, as well as pain in right hip and other chronic pain. Per skin check documentation, Resident #2 had a skin check on 8/5/23 where no skin issues were identified. On 8/9/23, new bruising on the left knee and lower extremities was found during the skin check of Resident #2. Per a nursing progress note from 8/9/23, the note reads, "LNA reported bruising on resident's bilateral legs."

Per review of the facility reported incident investigation documentation, Resident #3 (resident #2's roommate) reported to LNA 3 that Resident #2 was crying out while LNA 1 was assisting Resident #2 with personal care during the 8/8/23 night shift. LNA 3 reported this to the Administrator and LNA 3 and LNA 4 were interviewed about Resident #2. Both LNAs confirmed that Resident #2 cries out regularly

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F 557	Continued From page 2	F 557		

during personal care. LNA 4 went on to state that the frequency of Resident #2 crying out during personal care has increased recently. The Administrator also interviewed Resident #3, who confirmed that Resident #2 regularly cries out during personal care.

Per interview on 8/22/23 at approximately 10:40 AM, Resident #3 stated that they hear Resident #2 crying out during personal care sometimes and that they "don't like the way people twist [Resident #2's] legs." Resident #3 says they "feel bad" for Resident #2.

Per interview on 8/22/23 at approximately 10:45 AM, Resident #2 cannot recall a specific incident when a staff member provided them with personal care that caused them pain or discomfort, but that some staff "could be more gentle." Resident #2 stated that some staff put too much pressure on their legs and that they will "holler if it hurts." Resident #2 denied feeling unsafe in the facility.

3. Per record review, Resident #3 has Moisture Associated Skin Damage of the right lower abdomen and had a stage 2 pressure ulcer of the left gluteus that was resolved approximately 2 months ago.

Per interview on 8/22/23 at approximately 10:45 AM, Resident #3 stated that they have had to tell various staff members to be gentler when cleaning their lower abdomen and pressure ulcer area. Resident #3 stated that they "scratch" too hard at the sore skin with washcloths.

Per interview on 8/22/23 at approximately 11:30 AM, the Market Clinical Lead and the

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F 557	Continued From page 3 Administrator confirmed that there is a pattern of undignified handling of residents during personal care.	F 557		