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

February 23, 2024

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

Dear Ms. Dacosta:

Enclosed is a copy of your acceptable plans of correction for the complaint investigation conducted on **February 1, 2024.** 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 02/01/2024

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 onsite, unannounced investigation of 6 complaints (ACTS #22485, #22523, #22552, #22345, #22367, and #22370) on 1/22/2024 and 1/25/2024, with additional offsite record review and interviews that ensued through 2/1/2024, to determine compliance with 42 CFR Part 483 requirements for Long Term Care Facilities. The following regulatory deficiencies were 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 demostrate and maintain compliance.	
F 742 SS=D	Treatment/Srvcs Mental/Psychoscial Concerns CFR(s): 483.40(b)(1) §483.40(b) Based on the comprehensive assessment of a resident, the facility must ensure that- §483.40(b)(1) A resident who displays or is diagnosed with mental disorder or psychosocial adjustment difficulty, or who has a history of trauma and/or post-traumatic stress disorder, receives appropriate treatment and services to correct the assessed problem or to attain the highest practicable mental and psychosocial well-being; This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to provide mental health services and individualized care approaches that address the assessed needs of the resident for 1 applicable resident (Residents #1). Findings include: Per record review, Resident #1 was admitted to the facility on 10/2/2023 with diagnoses that include depression and anxiety disorder. A 10/2/2023 hospital discharge summary indicates Resident #2 was being treated for his/her anxiety and depression during his/her hospital stay. The	F 742	F742 Specific Corrective Action 1. Resident #1 was discharged on November 24, 2023. 2. To identify others at risk, an audit was completed for residents who display or are diagnosed with mental disorders or psychosocial adjustment difficulty or who have a history of trauma and post-traumatic stress disorder to ensure appropriate treatment and services to correct the assessed problem or to attain the highest practicable mental and psychosocial well-being inclusive of formulating a plan of care was provided with follow up as indicated.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
DaCosta	NHA	2/22/2024

...y deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that ...r 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 742	Continued From page 1 note explains that s/he was discharged on 75 mg sertraline daily and s/he "May ultimately benefit from continued increased dose of 150 mg daily [of sertraline; anti-depressant] due to combined anxiety/depression." Resident #1's care plan, created on 10/3/2023, states that s/he "'is at risk for distresses/fluctuating mood symptoms related to depression, anxiety, PTSD [post-traumatic stress disorder]." Per interview on 1/24/2024 at 11:19 AM, Resident #1's Representative explained that that s/he visited Resident #1 about 5 times a week while s/he was admitted to the facility. S/He explained that Resident #1 was displaying a significant increase in depressive symptoms after being admitted to the facility and that Resident #1 was undoubtedly exhibiting signs of depression with the staff. S/He stated that shortly after being admitted to the facility, Resident #1 was talking about wanting to die. Both Resident #1 and his/her Representative inquired of multiple staff about increasing the sertraline for managing depressive symptoms. The Representative explained that s/he was told that Resident #1 would have to be seen by psych to get an increase in dose because they are the only ones that can order a higher dose in the facility. S/He explained they had both asked multiple times about the psych referral and Resident #1 was never seen by psych once during his/her stay. A 10/2/2023 patient health questionnaire indicates that Resident #1 self-reported to have symptoms of feeling down, depressed, or hopeless 12-14 days over the past two weeks and feeling bad about themselves or that they are a failure 2-6 days over the past two weeks.	F 742	F742 continued... 3. The facility assures that a resident who displays or is diagnosed with a mental disorder or psychosocial adjustment difficulty or who has a history of trauma and post-traumatic stress disorder receives appropriate treatment and services to correct the assessed problem or to attain the highest practicable mental and psychosocial well-being. Social Services and Licensed staff will be re-educated on this process. 4. The DON/Designee will conduct audits of residents who display or are diagnosed with a mental disorder or psychosocial adjustment difficulty, or who have a history of trauma and post-traumatic stress disorder is receiving appropriate treatment and services to correct the assessed problem or to attain the highest practicable mental and psychosocial well-being. This audit will validate a care plan to address the residents' psychosocial needs. These audits will be weekly x 4 weeks, bi-weekly x 4 weeks, then monthly x 3 months. The results of these audits will be brought to the monthly QAPI Committee for further review and recommendations. Date of Compliance 3/7/2024	

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F 742	Continued From page 2 Record review reveals a 10/3/2024 Nurse Practitioner (NP) note stating, "While speaking with this writer[s/ he] expresses interest in a referral for psych services. . . Depression: Continue sertraline. Psych referral in place." Physician orders include a Psychiatrist Consult ordered on 10/3/23. There is no evidence that Resident #1 was seen by psych services during his/her stay at the facility and there is no evidence that any medical providers addressed the hospital recommendation and Resident #1 and their Representative's request to increase his/her sertraline. Per interview on 1/25/2024 at 4:04 PM, the Clinical Market Advisor confirmed that Resident #1 was not offered psych services as requested by Resident #1, their Representative, and as referred by the provider.	F 742	**Tag F 742 POC accepted on 2/23/24 by S. Stem/P. Cota**	
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility	F 755	F755 Specific Corrective Action 1. Resident #2 is receiving pharmaceutical services, including accurately acquiring, receiving, dispensing, and administering all drugs and biologics. 2. To identify others at risk, an audit of residents' records was completed to validate that residents are receiving pharmaceutical services, including accurate acquiring, receiving, dispensing, and administration of all drugs and biologics, inclusive of those medications requiring the Risk Evaluation and Mitigation Strategy (REMS) program with follow up as indicated.	

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F 755	Continued From page 3	F 755	F755 Continued...	

must employ or obtain the services of a licensed pharmacist who-

§483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility.

§483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and

§483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.
This REQUIREMENT is not met as evidenced by:
Based on interview and record review, the facility failed to provide pharmaceutical services to meet each resident's needs and the facility failed to collaborate with the pharmacist to assure that effective policies and procedures were established and implemented for one applicable resident (Resident #2). Findings include:

1. Per record review Resident #2 has diagnoses that include schizophrenia and physician order for "clozapine [antipsychotic] tablet 100 mg Give 1 tablet by mouth two times a day for schizophrenia," with a start date of 4/7/2023.

Per Resident #2's Medication Administration Record (MAR), Clozapine was last administered on 10/5/2023. Resident #2 did not receive pharmaceuticals to treat his/her schizophrenia until risperidone (an antipsychotic) was ordered and administered on 10/13/2023, 8 days after Resident #2 last received an antipsychotic for schizophrenia. The abrupt stop of Clozapine, with

3. The facility provides pharmaceutical services (including procedures that ensure the accurate acquisition, receipt, dispensation, and administration of all drugs and biologicals) to meet the needs of each resident. This includes having prescribers certified in REMS to prescribe certain medications to meet the needs of all residents. REMS is a drug safety program that the U.S. Food and Drug Administration (FDA) can require for certain medications with serious safety concerns to help ensure the benefits of the medication outweigh its risks. Prescribers and Licensed staff will be re-educated on this process.

4. The DON/Designee will complete audits of resident records to validate that medications are accurately acquired, received, dispensed, and administered. These audits will be weekly x 4 weeks, bi-weekly x 4 weeks, then monthly x 3 months. The results of these audits will be brought to the monthly QAPI Committee meeting for further review and recommendations.

Date of Compliance 3/7/2024

Tag F 755 POC accepted on 2/23/24 by S. Stem/P. Cota

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F 755	Continued From page 4	F 755		

no immediate replacement, put Resident #2 at risk for medical complications and increased behaviors. See F760 for more information.

Review of the manufacture's Clozapine safety information packet indicates that the medication is only available through a restricted program called the Clozapine Risk Evaluation and Mitigation Strategy (REMS) program run by the Food and Drug Administration (FDA). Requirements of this program include that healthcare professionals who prescribe Clozapine be certified with the program by enrolling and completing training and certified healthcare professionals are to complete and submit a Patient Status Form (PSF) monthly to the program in order for the pharmacy to fulfill Clozapine orders/refills.

Review of an email from the Pharmacist sent to the facility on 1/24/2024 at 9:54 AM reveals that the pharmacy had received a resupply request for Resident #2's Clozapine on 9/13/23 and the facility was made aware multiple times since 9/13/23 that the PSF needed to be filled out for a resupply. This is confirmed by a pharmacy conversation record, showing that the pharmacy had reached out to the facility on 9/13/23, 9/22/23, 9/26/23, 9/29/23, and 10/6/23 about the PSF requirement to receive refills.

A 10/5/2023 eMAR (electronic MAR) note states, "Awaiting pharmacy order, NP notified NP has to fill out REMS form (online patient status form) before medication will be filled. [S/he] will work on having it submitted."

A 10/12/23 Nurse Practitioner (NP) note states, "[Resident #2] is seen today for medications.

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F 755	Continued From page 5	F 755		

Patient ran out of [his/her] clozapine on 10/5 at which time [his/her] medication could not be refilled due to lack of proper paperwork. [S/He] has been taking clozapine for schizophrenia. Have been unable to get prescription refilled presently."

Per interview on 1/22/2024 at 1:48 PM, the Nurse Practitioner (NP) stated that Resident #2's order for Clozapine was discontinued because s/he was unable to refill it. S/He explained that s/he was not certified to authorize the Clozapine refill and there was no one providers in the facility able to refill it, including the Medical Director. The NP and the Medical Director decided that since there were no providers certified to refill Clozapine for the facility, and Resident #2 needed medication to manage his/her schizophrenia symptoms, they would start him/her on risperidone.

Per interview on 1/22/2024 at approximately 4:00 PM, the Administrator was unaware of the REMS requirements for ordering and refilling Clozapine and was unable to identify anyone at the facility who was certified to order and/or refill the medication.

On 1/23/2024 at 3:41 PM, the Medical Director explained that s/he was unable to: prescribe Clozapine, get certified in a timely manner to be able to prescribe Clozapine, and find another provider to prescribe Clozapine, so s/he, working with the NP, looked for an alternative medication for Resident #2. The Medical Director indicated that Resident #2's behaviors increased when they were working on finding an alternative medication to manage his/her schizophrenia symptoms.

Per interview on 1/23/2024 at 12:03 PM, the

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F 755	Continued From page 6 Market Clinical Lead was not aware of a facility provider that was able to complete and submit the monthly required patient status forms required order/refill Clozapine. 2. The facility was unable to produce policies or procedures that ensure residents receive Clozapine per physician orders related to the use of the REMS system and the role that provider and pharmacy have in meeting the requirements of the REMS system. Requests for these policies or procedures were made to the Administrator on 1/24/2024 and 1/25/2024. Per interview on 1/25/2024 at 4:04 PM, the Market Clinical Lead confirmed that they could not find any existing polices or procedures regarding Clozapine requirements. Review of a 1/25/24 email from the Pharmacist reveals that the facility had never been asked by the facility to create any policies surrounding Clozapine.	F 755		
F 760 SS=D	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure that residents are free of any significant medication errors for one applicable resident (Resident #2) related to the abrupt stop of a medication that should have been titrated down and the discontinuation of a medication due to the facility's inability to acquire the medication, putting Resident #2 at risk for medical	F 760	F760 Specific Corrective Action 1. Resident #2 is free from significant medication errors and is currently getting his medications as ordered. 2. To identify others at risk, an audit was completed of residents' Medication Administrator Records (MARs) to validate that medications are provided and administered as ordered and the physician (MD) is notified immediately of instances when the medication is not administered as ordered with follow-up as indicated.	

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F 760	Continued From page 7 complications and increased behaviors. Findings include: Per record review Resident #2 has diagnoses that include schizophrenia. Resident #2's care plan, created on 9/15/2022, states that s/he "is at risk for complications related to the use of psychotropic drugs, antipsychotic, anti-manic, anti-depressant." Record review reveals a physician order for "clozapine [antipsychotic] tablet 100 mg Give 1 tablet by mouth two times a day for schizophrenia," with a start date of 4/7/2023. Review of the manufacture's Clozapine safety information packet indicates that the medication is only available through a restricted program called the Clozapine Risk Evaluation and Mitigation Strategy (REMS) program run by the Food and Drug Administration (FDA). Requirements of this program include that healthcare professionals who prescribe Clozapine be certified with the program by enrolling and completing training and certified healthcare professionals are to complete and submit a Patient Status Form monthly to the program in order for the pharmacy to fulfill Clozapine orders/refills. Per Resident #2's Medication Administration Record (MAR), Clozapine was last administered on 10/5/2023. A 10/5/2023 eMAR (electronic MAR) note states, "Awaiting pharmacy order, NP notified NP has to fill out REMS form (online patient status form) before medication will be filled. [S/he] will work on having it submitted." Per a review of Resident #2's medical record, there were no care plan changes put into place for	F 760	3. The facility has the following procedure in place when medications ordered are not available, including when not available in the emergency medication Pyxis System or not available related to the REMS program: The nurse will evaluate the resident for adverse effects, report immediately to the Director of Nursing, notify physician/advanced practice provider, resident, and responsible party, obtain orders, if indicated, initiate orders, if any, and monitor the resident. Licensed staff will be re-educated on this process. 4. DON/Designee will complete audits, observations, and interviews to validate that the omission of the medication process is followed. These audits, observations, and interviews will be weekly x 4 weeks, then bi-weekly x 1 month, then monthly x 3 months. The results of these audits will be brought to the monthly QAPI Committee for further review and recommendations. Date of Compliance 3/7/2024 **Tag F 760 POC accepted on 2/23/24 by S. Stem/P. Cota**	

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F 760	Continued From page 8	F 760		

potential medical and behavioral side effects resulting from the abrupt discontinuation of the Clozapine on 10/5/2023.

Review of the Clozapine REMS website, updated 11/2/22 states, "Abrupt discontinuation of clozapine can result in significant complications for patient treatment."

On 1/24/2024 at 9:35 AM, the Consulting Pharmacist stated that there are side effects from abruptly stopping Clozapine and Resident #2 should have been tapered off the medication.

Per interview on 1/25/2024 at 12:50 PM, the Psychiatric Advanced Practice Registered Nurse (APRN) stated that Clozapine should not be suddenly discontinued; instead, residents should get tapered off the medication.

A 10/12/23 Nurse Practitioner (NP) note states, "[Resident #2] is seen today for medications. Patient ran out of [his/her] clozapine on 10/5 at which time [his/her] medication could not be refilled due to lack of proper paperwork. [S/He] has been taking clozapine for schizophrenia. Have been unable to get prescription refilled presently. At this time patient is alert but expresses repetitive behavior such as long periods of counting . . . After extensive discussion with medical director, will order, under MD direction and discretion, risperidone 2 mg daily."

Record review reveals a physician order for "risperidone [antipsychotic] oral tablet 2 MG Give 1 tablet by mouth one time a day for Schizophrenia," with a start date 10/13/2023. Per Resident #2's MAR, Resident #2 went 7 days without any antipsychotic medication treatments

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F 760	Continued From page 9 10/6/2023 through 10/12/2023. Per interview on 1/22/2024 at 1:48 PM, the Nurse Practitioner (NP) stated that Resident #2's order for Clozapine was discontinued because s/he was unable to refill it. S/He explained that s/he was not certified to authorize the Clozapine refill and there was no one providers in the facility able to refill it, including the Medical Director. The NP and the Medical Director decided that since there were no providers certified to refill Clozapine for the facility, and Resident #2 needed medication to manage his/her schizophrenia symptoms, they would start him/her on risperidone. Per interview on 1/23/2024 at 3:41 PM, the Medical Director explained that s/he was unable to: prescribe Clozapine, get certified in a timely manner to be able to prescribe Clozapine, and find another provider to prescribe Clozapine, so s/he, working with the NP, looked for an alternative medication for Resident #2. The Medical Director indicated that Resident #2's behaviors increased when they were working on finding an alternative medication to manage his/her schizophrenia symptoms. On 1/25/2024 at 2:20 PM, the Market Clinical Lead confirmed that there was no evidence that the facility made any revisions to Resident #2's care regarding monitoring for side effects related to the abrupt stop in the Clozapine or that the facility made any plans for managing a possible increase in schizophrenic behaviors related to Resident #2 not being on an antipsychotic for 7 days.	F 760		
F 770 SS=G	Laboratory Services CFR(s): 483.50(a)(1)(i)	F 770	F770 Specific Corrective Action	

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F 770	Continued From page 10 §483.50(a) Laboratory Services. §483.50(a)(1) The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. (i) If the facility provides its own laboratory services, the services must meet the applicable requirements for laboratories specified in part 493 of this chapter. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to obtain laboratory services to meet the needs of its residents for 2 of 2 sampled residents (Residents #1 and #2) related to obtaining urinalyses (UA) and culture and sensitivity [C&S; a test to determine if there is an infection, what germ is causing the infection, and what medication will work best to treat the infection] as requested by medical providers in a timely manner. As a result, Resident #1 and #2 suffered symptoms of urinary tract infections (UTI), a disease that can be diagnosed with a urinalysis and C&S, and were both transferred to the emergency department (ED) with sepsis [a life-threatening complication of an infection] caused by a UTI. Findings include: 1. Per record review, Resident #1 was admitted to the facility on 10/2/2023 with diagnoses that include benign prostatic hyperplasia (BPH; prostate gland enlargement that can cause urination difficulty), morbid obesity, and type 2 diabetes. A 10/2/2023 hospital discharge summary indicates that s/he has chronic colonization (high bacteria levels in urine) and had been treated for multiple catheter-associated urinary tract infections during their hospital stay.	F 770	F770 continued.... 1. Resident #1 was discharged on November 24, 2023. Resident #2 is currently receiving laboratory services as ordered by the provider. 2. To identify others at risk, an audit of resident records was completed going back 30 days to validate that laboratory service orders were obtained, with results communicated to the provider with follow-up as indicated. 3. The facility provides or obtains laboratory services to meet the needs of its residents, as ordered by the provider. The facility will inform the provider if laboratory services cannot be obtained as requested at the facility for further guidance. Licensed staff will be re-educated on this process. 4. DON/Designee will audit resident records to validate that orders for laboratory services are completed and communicated to the provider as ordered. These audits will be weekly x 4 weeks, Bi-weekly x 4 weeks, then monthly x 3 months. The results of these audits will be brought to the monthly QAPI Committee for further review and recommendations. Date of Compliance 3/7/2024	

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F 770	Continued From page 11 Resident #1's care plan, created on 10/2/2023, states that s/he requires a urinary catheter due to BPH and dysuria (pain or burning when urinating). Record review reveals that Resident #1 began having genitourinary (related to genital and urinary organs) pain starting 10/21/23. A 10/21/23 nursing note states that Resident #1 said they were "experiencing 'severe urethral' pain that lasted anywhere form 5-10 min [minutes], randomly throughout the day ... [S/He] states that [s/he] was previously on pyridium [phenazopyridine HCL; used to relieve the pain, burning, and discomfort caused by infection or irritation of the urinary tract] which helped." Per review of Resident #1's Medication Administration Record (MAR), s/he has the following physician order, "phenazopyridine HCL Oral Tablet 100 MG Give 1 tablet by mouth every 8 hours as needed for dysuria start date 10/2/2023." A 10/27/2024 Nurse Practitioner (NP) note states, "[S/He] is seen today for an acute visit regarding pain in [his/her] urethra. [S/He] is concerned for a possible UTI. [S/He] does have a chronic foley and the pain is described by [him/her] as 'screaming,' . . . Plan: Dysuria: At this time will not start any antibiotics due to indwelling catheter and lack of systemic symptoms. Will order a urine screen [urine sample test; UA] with C&S [culture and sensitivity; test to determine if there is an infection, what germ is causing the infection, and what medication will work best to treat the infection] and will follow up on ABX [antibiotic] is needed." Per review of Resident #1's Treatment Administration Record (TAR), s/he has the	F 770	**Tag F 770 POC accepted on 2/23/24 by S. Stem/P. Cota**	

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following physician order, "Urine screen, culture and sensitivity one time only for dysuria until 10/29/2023 start date 10/27/2023." The TAR does not show documentation that this was performed but rather to see nurse notes. A 10/28/23 nurse note indicates that the UA was not collected because Resident #1's urine was orange related to his/her medication. There is no evidence that the UA was reattempted at a different time or that the provider was notified that this test was not performed as ordered.

Per record review, Resident #1 continued to have genitourinary pain regularly after the initial onset of pain identified on 10/21/23. Resident #1's MAR reveals that Pyridium was administered for dysuria 19 times between 10/22/23 and 11/24/23.

A 11/24/2023 NP note states, "[Resident #1] is seen today for an acute visit after nursing staff noticed [s/he] was not at [his/her] baseline level of orientation. . . [S/He] endorses pain but is unable to clarify where [s/he] is feeling it as well as some SOB [shortness of breath]. . . Of note, a urine screen and culture was drawn 2 weeks ago, but no results ever came from this. . . Plan: AMS [altered mental status]: Acute, worsening. Plan to send patient to ED for further workup of acutely worsening cognition and orientation."

A 12/11/2023 Physician Assistant hospital note reveals that Resident #1 was seen at the ED for a catheter associated UTI resulting in severe sepsis on 11/24/2023. The note indicates that s/he was admitted to the hospital until 12/12/2023 due to complications (some indicated as likely caused by the UTI and sepsis) that include acute metabolic and toxic encephalopathy (brain disease that alters brain function or structure) and

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acute kidney injury.
Per interview on 1/22/2024 at 10:46 AM, Resident #1's Representative explained that Resident #1 was frequently in "screaming" pain related to his/her urinary tract system. The Representative explained that Resident #1's pain eventually became constant by mid-November and s/he was eventually so sick that s/he needed to be sent to the ED. S/He explained that the provider had ordered a UA at the end of October but it was never done. The Representative expressed concern about Resident #1's pain and the UA not being performed multiple times to both providers and nursing staff at the facility and the issue was not resolved.

Per interview on 1/24/2024 at 12:06 PM, the Director of Nursing confirmed that the UA was not obtained as ordered by the provider for Resident #1 and the facility failed to follow their process to follow up with the provider to ensure that the UA was reordered.

Per interview on 1/25/2024 at 4:04 PM, the Market Clinical Advisor confirmed that the Director of Nursing did notify the provider that the UA was not preformed and should have.

2. Per record review Resident #2 has diagnoses that include BPH, retention of urine, schizophrenia, bipolar disorder, and major depressive disorder. Resident #2's care plan, created on 9/15/2022, reveals that s/he requires extensive assistance for activities of daily living, has limited mobility, and has episodes of urinary incontinence.
A 10/27/2023 NP note states, "[S/He] is seen today for increased urinary frequency and nausea. [S/He] reports the nausea occurs

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randomly throughout the day. . . Regarding increased urinary frequency, [s/he] reports [s/he] has been going to the bathroom more than usual. [S/He] endorses mild discomfort with urination and the urine is a darker yellow in color. . . Plan: Dysuria: Plan to order clean catch urine for screen and C&S. Will hold off on ABX until urine results as patient does not have any systemic symptoms." Lab results reveal that at UA and C&S was performed on 10/27/2023 and there was no growth.

A 11/2/2023 Psychiatric Advanced Practice Registered Nurse (APRN) note states, "Recheck UA, pt [patient] has HX [history] of multiple UTIs with delirium and recent hospitalization with no recheck. UTI will alter the presentation of cognition, mood and psychosis."

Per record review, Resident #2 begins to display noticeable changes to his/her baseline in health and behavior, resulting in symptoms that are common in persons with UTIs, and continue to progress in severity until s/he is transferred to the ED on 11/17/2023.

A 11/11/23 nurse note indicates that Resident #2 does not feel well. Resident #2's MAR reveals that s/he starts to refuse some of their medications on this day.

A 11/14/2023 Psychiatric APRN notes indicates that Resident #2 is being seen for increased confusion and that staff reports that Resident #2 has "complained of abd [abdominal] pain, nausea and has been refusing food and medication for past several days." The Psychiatric APRN again requests a UA and C&S to be obtained. The treatment plan indicates the need to rule out a

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UTI in order to adjust psychiatric mediations to address behaviors.

A 11/14/2023 NP note states that Resident #2 is outside his/her baseline, s/he is staying in bed, reports hallucinations, has poor food and drink intake, is nauseous and has abdominal discomfort, is refusing medications, and has a flat affect. The NP indicates that his/her presentation is similar to previous episodes on an UTI and plans to order testing. Per Resident #2's TAR, a UA and C&S is ordered by the NP on 11/14/23 and performed on 11/15/23.

A 11/16/2023 NP note reveals that Resident #2 is "seen today for continued altered behaviors including refusing medications, not getting up out of bed, incontinence and accused this writer of 'Running experiments on everyone here.'" The NP indicates that Resident #2 is presumed to have a UTI and will order antibiotics, adjusting the regimen based on the results of the C&S performed on 11/15/2023.

Per 11/16/2023 nurse notes and confirmed by Resident #2's MAR, s/he is continuing to refuse all medications and care.

A 11/17/2023 NP note reveals that Resident #2 is continuing to decompensate and refusing to take medication, including the antibiotic to treat his/her UTI requiring a transfer to the emergency room for evaluation. A 11/17/23 transfer form states, "reason for transfer Abnormal Urinalysis or urine culture . . . Resident is refusing care and meds yesterday and today. Won't allow staff to come near [him/her],"

A 11/18/23 hospital note states that Resident #2

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was admitted "with a chief complaint of altered mental status and now with a principal diagnosis of sepsis in setting of UTI . . . Urine with gram neg and positive organisms [different types of bacteria that are sensitive to different medications] suggesting urinary tract [infection] and sepsis [a life-threatening complication of an infection] that were present on admission and drove metabolic encephalopathy and atrial fib [atrial fibrillation; irregular, often rapid heart rate] with RVR [rapid ventricular rate; a complication of atrial fib that disrupts blood supply to the body]." A 11/24/2023 hospital discharge summary indicates that Resident #2 was admitted to the hospital on 11/17/2023 and discharged 8 days later, on 11/24/2023.

Per interview on 1/22/2024 at 1:48 PM, the NP stated that s/he was unaware of the recommendation made by the Psychiatric APRN to collect a UA for Resident #2 on 11/2/2023 because s/he was unable to review the Psychiatric APRN's notes. The NP explained that there were a few weeks after the Psychiatric APRN started where notes were not being uploaded into residents' medical records and that would have been how s/he would have known about that request during the time period where communication systems were being established between the Psychiatric APRN and the facility.

Per interview on 1/25/2024 at 12:50 PM, the Psychiatric APRN confirmed that s/he had requested a UA to rule out a UTI for Resident #2 on 11/2/2023. S/He explained that this was not completed at his/her next visit with Resident #2 on 11/14/23. S/He explained that the decompensation of his behavioral symptoms (increase in hallucinations) was medical and

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F 770	Continued From page 17 related to his/her UTI. Per interview on 1/25/2024 at 2:20 PM, the Market Clinical Advisor stated that the Resident #1's provider was responsible for ordering the UA requested by the Psychiatric APRN on 11/2/2024 and confirmed this did not happen.	F 770		
F 776 SS=G	Radiology/Other Diagnostic Services CFR(s): 483.50(b)(1)(i)(ii) §483.50(b) Radiology and other diagnostic services. §483.50(b)(1) The facility must provide or obtain radiology and other diagnostic services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. (i) If the facility provides its own diagnostic services, the services must meet the applicable conditions of participation for hospitals contained in §482.26 of this subchapter. (ii) If the facility does not provide its own diagnostic services, it must have an agreement to obtain these services from a provider or supplier that is approved to provide these services under Medicare. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to obtain an EKG (electrocardiogram; a diagnostic test to evaluate heart function) to meet the needs of its residents for 1 applicable resident (Resident #2). As a result, Resident #2 was transferred to the Emergency Department (ED) and later to the ICU (intensive care unit) to manage the cardiac complications including atrial fibrillation (irregular, often rapid heart rate) with RVR (rapid ventricular response; abnormal	F 776	F776 Specific Corrective Action 1. Resident #2 is currently receiving diagnostic services as ordered by the provider. 2. To identify others at risk, an audit of resident records was completed, going back 30 days to validate orders for diagnostic services was obtained and communicated to the provider with follow-up as indicated. 3. The facility obtains diagnostic services to meet the needs of its residents, as ordered by the provider. The facility informs the provider if diagnostic services cannot be obtained as ordered at the facility for further guidance. Licensed staff will be re-educated on the process.	

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F 776	Continued From page 18 rhythm originating in the lower chambers of the heart) and NSTEMI Type II (a heart attack due to mismatched oxygen supply and demand to the heart muscle), both cardiac conditions can potentially be diagnosed with an EKG. Findings include: Per record review Resident #2 has diagnoses that include schizophrenia, hypertension (high blood pressure), and atrial fibrillation. Resident #2's care plan, created on 9/15/2022, states that s/he "is at risk for complications related to the use of psychotropic drugs, antipsychotic, anti-manic, anti-depressant." Record review reveals a physician order for "risperidone [antipsychotic] oral tablet 2 MG Give 1 tablet by mouth one time a day for Schizophrenia," with a start date 10/13/2023. A 11/2/2023 Psychiatric Advanced Practice Registered Nurse (APRN) note states, "Obtain 12 lead EKG to monitor QT [time it takes the heart to contact and refill with blood], [patient] on antipsychotic that causes QT prolongation [a heart rhythm disorder that can potentially cause fast, chaotic heartbeats]. Per interview on 1/24/2024 at 9:35 AM, the Consulting Pharmacist confirmed that Risperidone could potentially cause cardiac side effects. Per record review, an order for an EKG requested on 11/2/2023 was never placed and the test was never performed at the request of the facility. Per interview on 1/22/2024 at 1:48 PM, the Nurse Practitioner (NP) stated that s/he was unaware of the recommendation made by the Psychiatric APRN on 11/2/2023 to perform an EKG for Resident #2 because s/he was unable to review the Psychiatric APRN's notes. S/He confirmed	F 776	F776 continued..... 4. DON/Designee will audit resident records to validate that orders for diagnostic services are completed and communicated to the provider as ordered. These audits will be weekly x 4 weeks, Bi-weekly x 4 weeks, then monthly x 3 months. The results of these audits will be brought to the monthly QAPI Committee for further review and recommendations. Date of Compliance 3/7/2024 **Tag F 776 POC accepted on 2/23/24 by S. Stem/P. Cota**	

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that it was his/her responsibility for putting in an order for the EKG test recommended by the Psychiatric APRN and did not.

Per a 11/11/2023 Physician note, Resident #2 had a telemed (virtual) visit with the physician because s/he was tachycardic and hypertensive. The assessment/plan for both the tachycardia and hypertension revealed "Stat EKG ordered but cannot be obtained over the weekend."

Per record review, an order for an EKG requested on 11/11/2023 was never placed and the test was never performed at the request of the facility.

Per a 11/17/2023 progress note, Resident #2 was transferred to the Emergency Department for evaluation and treatment of his/her declining condition and urinary tract infection. A 11/18/2023 hospital progress note states that Resident #2 was admitted to the ICU for altered mental status and atrial fibrillation with RVR initially requiring a dilt drip (diltiazem; medicine to control rapid heartbeats or abnormal heart rhythms) overnight. Multiple cardiac complications occurred requiring Resident #2 to remain in the ICU. In addition to Resident #2's atrial fibrillation, other active problems included NSTEMI Type II. A 11/24/2023 progress note reveals that Resident #2 was readmitted to the facility on 11/24/23 after an 8 day hospital admission.

Per interview on 1/24/2024 at 10:00 AM, the Market Clinical Advisor confirmed that Resident #2 did not have an EKG in November until s/he was transferred to the Emergency Department on 11/17/2023 and confirmed it was the NP's responsibility to place the order for the EKG that was recommended by the Psychiatric APRN on

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F 776	Continued From page 20 11/2/2023. Per interview on 1/25/2024 at 12:50 PM, the Psychiatric APRN confirmed that s/he had requested an EKG for Resident #2 on 11/2/2023 and explained that this was not completed at his/her next visit with Resident #2 on 11/14/23. S/He explained that the decompensation of his/her behavioral symptoms (increase in hallucinations) was medical and related to his/her cardiac issues and urinary tract infection.	F 776		
F 887 SS=E	COVID-19 Immunization CFR(s): 483.80(d)(3)(i)-(vii) §483.80(d) (3) COVID-19 immunizations. The LTC facility must develop and implement policies and procedures to ensure all the following: (i) When COVID-19 vaccine is available to the facility, each resident and staff member is offered the COVID-19 vaccine unless the immunization is medically contraindicated or the resident or staff member has already been immunized; (ii) Before offering COVID-19 vaccine, all staff members are provided with education regarding the benefits and risks and potential side effects associated with the vaccine; (iii) Before offering COVID-19 vaccine, each resident or the resident representative receives education regarding the benefits and risks and potential side effects associated with the COVID-19 vaccine; (iv) In situations where COVID-19 vaccination requires multiple doses, the resident, resident representative, or staff member is provided with current information regarding those additional doses, including any changes in the benefits or risks and potential side effects	F 887	F887 Specific Corrective Action 1/2. An audit of resident records was completed to validate that those residents who had no previous documentation of receiving the most up-to-date COVID-19 vaccination had been offered, provided the opportunity to consent/decline, and obtained the covid 19 vaccination if consented. This included documentation of residents offered and declined f ollowing education on the benefits of receiving the most up-to-date COVID-19 vaccination.	

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associated with the COVID-19 vaccine, before requesting consent for administration of any additional doses;
(v) The resident, resident representative, or staff member has the opportunity to accept or refuse a COVID-19 vaccine, and change their decision;
(vi) The resident's medical record includes documentation that indicates, at a minimum, the following:
(A) That the resident or resident representative was provided education regarding the benefits and potential risks associated with COVID-19 vaccine; and
(B) Each dose of COVID-19 vaccine administered to the resident; or
(C) If the resident did not receive the COVID-19 vaccine due to medical contraindications or refusal; and
(vii) The facility maintains documentation related to staff COVID-19 vaccination that includes at a minimum, the following:
(A) That staff were provided education regarding the benefits and potential risks associated with COVID-19 vaccine;
(B) Staff were offered the COVID-19 vaccine or information on obtaining COVID-19 vaccine; and
(C) The COVID-19 vaccine status of staff and related information as indicated by the Centers for Disease Control and Prevention's National Healthcare Safety Network (NHSN).
This REQUIREMENT is not met as evidenced by:
Based on interview and record review, the faciliy failed to implement their policy regarding COVID-19 immunizations by failing to obtain vaccine supply and systematically provide education, obtain consents, and offer vaccines in a timely manner to all residents. Findings include:

3. The facility provides the opportunity to receive COVID-19 vaccinations following the Centers for Disease Control and Prevention (CDC) recommendations are subject to availability to residents unless the immunization is medically contraindicated or the individual has already been immunized. The facility will provide the same opportunity to employees, subject to the availability of COVID-19 vaccinations at the Center after the employee has attempted to obtain COVID-19 vaccination from their personal health provider, health department, or community health partner. The facility staff will also obtain residents' COVID-19 vaccination history, document the residents' COVID-19 status in the immunization record, and obtain consent or declination for COVID-19 vaccination. This will include obtaining a physician order for the vaccination for those residents who have consented and documenting the administration of the vaccination in both the electronic medication administration record and the immunization record. Licensed staff will be re-educated on 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 02/01/2024

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 887	Continued From page 22	F 887	F887 Continued	

1. On September 12, 2023, the Centers for Disease Control (CDC) announced the release of the new 2023-24 COVID vaccine and indicated the vaccine would be available later that week. Per facility policy, titled "COVID-19 Vaccination", the facility "will provide the opportunity to receive COVID-19 vaccinations following Centers for Disease Control and Prevention (CDC) recommendations subject to availability, to patients/residents...unless the immunization is medically contraindicated or the individual has already been immunized." The policy states this will be done under the Medical Director's authorization, with patient consent.

Per interview on 1/25/24 at 9:30 AM, the facility's designated Infection Preventionist (IP) stated that the first 2023-24 COVID vaccines were not ordered until the 3rd week of November, and not administered until 11/26/23. The facility only ordered 20 doses of COVID vaccine in November to begin their vaccination program, despite having approximately 65 residents at that time. During the months of September, October and November 2023, the facility did not systematically provide education and obtain consents or physician orders for residents in preparation for vaccination administration. On 11/26/23, the IP stated she prioritized alert and oriented residents to receive the vaccine first, due to the ability to obtain verbal consent, stating she went down the hallway of "A wing" and started asking residents if they wanted the vaccine. Of the 13 residents administered the vaccine that day, only 3 had evidence of completed consents prior to administration of the vaccine. Residents who were not alert and oriented were not given the opportunity to be vaccinated on 11/26/23, and no

4. DON/Designee will complete an audit of resident records to validate that those residents eligible for the most recent COVID-19 vaccination have been offered the vaccine, have obtained it, and staff have documented the most recent vaccination status in the immunization record. This will also include documentation of those residents who have declined following education on the benefits of receiving the most recent COVID-19 vaccination. These audits will be weekly x 4 weeks, bi-weekly x 4 weeks, and then monthly x 3 months. The results of these audits will be brought to the monthly QAPI Committee for further review and recommendations.

Date of Compliance 3/7/2024

Tag F 887 POC accepted on 2/23/24 by S. Stem/P. Cota

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F 887	Continued From page 23	F 887		

further vaccines were administered from 11/27-11/30/23.

The IP stated in the same interview that there were 2 residents (Residents #3 and #4) who experienced vaccine reactions, described as redness, swelling, pain and hardness at the injection site, so the facility's Nurse Practitioner (NP) directed them to stop vaccinating residents on 11/30/23. The IP stated it was an intended 3-5 day "pause" in their vaccination program. There was no documentation of this decision at the time, nor were residents or families educated regarding this delay in the offering of the updated vaccine.

Per review of Resident #3 and Resident #4's record, there was no evidence of severe reactions, there is no evidence of the NP's assessment of the vaccine reactions, and no evidence of close monitoring by nursing of the affected arms. The documented redness, swelling, pain and hardness at the injection site are all expected side effects, listed on the facility's own educational material the IP stated she used for educating residents and obtaining consents for this vaccine. Per interview with the NP on 1/25/24 at 1:04 PM, no severe reactions were reported to the Vaccine Adverse Event Reporting System (VAERS), and the NP stated she did not assess the residents after 11/30/23 to monitor the reactions which caused the vaccination program to be stopped. The NP stated that the "pause" was only intended to last 3-5 days, but when asked about the plan to resume vaccinations, they did not have a plan to resume promptly on day 3-5. The facility did not order further vaccines to be ready to continue to implement their immunization policy the week of 12/4/23.

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They stated that due to certain staff not being around on weekends, they would have had to wait until Monday, 12/11/23 to begin vaccinating residents again.

The NP and IP stated that they didn't resume vaccinations due to 2 staff testing positive for COVID-19 on 12/6/23 and 12/9/23 and then they went into a "full outbreak". Vaccinations did not resume until 1/25/24, due to a widespread COVID-19 outbreak in the facility, which infected 36 residents in December 2023. However, the first resident positive case was not identified until 12/17/23, leaving ample time to continue the facility's vaccination effort after the 3-5 day pause, prior to the outbreak affecting residents. The IP stated on 1/25/24 at 2:06 PM that they couldn't vaccinate residents after a contracted staff person tested positive on 12/6/23 because the residents may have been exposed to COVID.

Per the CDC, there is no contraindication for giving the COVID-19 vaccine if someone may have been exposed to a person with a COVID-19 infection. No materials for vaccination, including consent forms, education and FAQ's state that vaccinations shouldn't be given if there was a chance of exposure.

Per interview on 1/25/24 at 3:15 PM, the facility's Medical Director (MD) stated he was not involved in the decision to stop vaccinations on 11/30/23, and when asked about his role in ensuring the facility's COVID-19 Vaccination Policy was being implemented, he stated he had not read the policy and did not know what the policy said.