

Division of Licensing and Protection  
103 South Main Street  
Waterbury, VT 05671-2306  
<http://www.dail.vermont.gov>  
Voice/TTY (802) 871-3317  
To Report Adult Abuse: (800) 564-1612  
Fax (802) 871-3318

June 18, 2015

Mr. John O'Donnell, Administrator  
Berlin Health & Rehab Ctr  
98 Hospitality Drive  
Barre, VT 05641-5360

Dear Mr. O'Donnell:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **May 27, 2015**. 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



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

PRINTED: 06/04/2015  
FORM APPROVED  
OMB NO. 0938-0391

05/17/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>475020</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>05/27/2015</b>
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NAME OF PROVIDER OR SUPPLIER  <b>BERLIN HEALTH &amp; REHAB CTR</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>98 HOSPITALITY DRIVE BARRE, VT 05641</b>
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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F 000	<b>INITIAL COMMENTS</b>  The Division of Licensing and Protection conducted four complaint investigations during an unannounced onsite survey on May 26 - 27, 2015. The following regulatory violations were cited as a result.	F 000	Preparation and/or execution of this Plan of Correction does not constitute the Providers admission of /or agreement with the alleged violations or conclusions set forth in this statement of deficiencies. This Plan of Correction is prepared and/or executed as required by State and Federal law.	
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F 281 SS=D	<b>483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS</b>  The services provided or arranged by the facility must meet professional standards of quality.  This REQUIREMENT is not met as evidenced by: Based on staff interview and record review the facility failed to adhere to professional standards regarding following physician orders for 1 of 3 residents (Resident #1). Findings include:  Per record review the facility failed to provide home oxygen for Resident # 1 per physician orders/discharge instructions. Physician order for 2/6/15 is as follows: May discharge home via ambulance with home health and current medications. As evidenced by Patient Care Referral Form to Home Health, the physician orders state; oxygen 0.5-1.0 liter via nasal cannula to keep saturation above 93-96%. Per interview with Unit Manager on C-Wing on 5/26/15 at 1:11 PM, he/she confirmed that resident was not discharged home with oxygen as per physician order. *Lippincott Manual of Nursing Practice (9th ed.). Wolters Kluwer Health/Lippincott Williams & Wilkins.	F 281	F281 483.20(k)(3)(i)  1. Resident # 1 no longer resides in the facility. 2. Residents discharging home with orders for oxygen have potential to be effected by the alleged deficient practice. 3. Education provided to RN's and LPN's regarding resident discharge process. 4. Random audits to be done at least weekly by the DNS or designee to monitor the effectiveness of the plan. 5. Results of the audits will be reported to the QA committee by the DNS or designee for a minimum of 3 months at which time the QA committee will determine further frequency of the audits to be done. 6. Corrective action to be completed by 6/27/15.	
F 282 SS=D	<b>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</b>	F 282	F281 POC accepted 6/18/15 RTremblay RN/pme	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  <i>John Deane</i>	TITLE <b>ADMINISTRATOR</b> DATE <b>6/11/15</b>
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An asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that 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 2B2	Continued From page 1  The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.	F 282	F282 483.20 (k)(3)(ii)  1. Resident # 3 no longer resides in the facility. 2. Residents at risk for Altered Nutritional Status have the potential to be effected by the	
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F 441 SS=D	This REQUIREMENT is not met as evidenced by: Based on staff interview and record review the facility failed to implement the plan of care for 1 out of 3 residents (Resident # 3). Findings include:  Per record review the facility failed to weigh Resident # 3 according to the care plan. The resident's care plan states resident is at risk for Altered Nutritional Status. A listed goal was that the resident will not experience a significant weight change from admission weight of 146 pounds. Resident will be weighed per facility protocol. 2/6/15 weight recorded in electronic medical record as 163.2 pounds; this documented weight is the last recorded weight for resident in the clinical record. Per interview with Corporate Clinical Coordinator on 5/27/15 at 09:20 AM he/she stated the facility protocol for monitoring resident weights is to weigh residents monthly, if not otherwise ordered specifically by physician. He/she confirmed that weights for the resident had not been done since 2/6/15.	F 441	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS  The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission  1. Resident # 3 had no negative effect as a result of the alleged deficient practice.	
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*F282 POC accepted 6/18/15 RTreview/RN/PME*

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F 441	Continued From page 2 of disease and infection.  (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility;	F 441	2. Residents requiring assistance with continence care/toileting have the potential to be effected by the alleged deficient practice.  3. Education provided to Licensed Nursing Assistants regarding proper continence care with	
	(2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.  (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.  (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.  This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and record review the facility failed to help prevent the development and transmission of disease and infection as evidenced by staff failing to wash		competencies completed.  4. Random observation audits at a minimum of weekly to be done by the DNS or designee to monitor the effectiveness of the plan.  5. Results of the audits will be reported to the QA committee by the DNS or designee for a minimum of 3 months at which time the committee will determine further frequency of the audits.  6. Corrective action will be completed by 6/27/15.  <i>F441 POL accepted 6/18/15 RTremblay RN/PME</i>	

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F 441	Continued From page 3 hands between dirty and clean procedures during continence care for 1 out of 3 residents (Resident #2). Findings include:  Per observation on 5/26/15 at 1:35 PM, a Licensed Nursing Assistant (LNA) toileted Resident #2 on the commode. The LNA used	F 441		
	his/her right gloved hand to wipe the resident's genital area after the resident urinated. The LNA then proceeded to touch the resident's and his/her own clothing, gait belt, wheelchair, rolling walker, bedside table, wipe container, and pager with soiled right hand. The LNA then emptied the commode in the bathroom toilet, rinsed commode with water, then wiped the inside of the commode that had contained urine, with the same gloved right hand. The LNA then removed soiled gloves and without sanitizing hands touched multiple items in the room. Per interview on 5/26/15 at 1:45 PM, Unit Manager confirmed that the LNA should have changed his/her gloves and sanitized hands between dirty and clean procedures.			