

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

December 4, 2014

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 **November 13, 2014**. 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: 11/20/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 475020	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/13/2014
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NAME OF PROVIDER OR SUPPLIER BERLIN HEALTH & REHAB CTR	STREET ADDRESS, CITY, STATE, ZIP CODE 98 HOSPITALITY DRIVE BARRE, VT 05641
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F 000	INITIAL COMMENTS	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.	
F 279 SS=D	<p>483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS</p> <p>A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</p> <p>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility failed to assure that a comprehensive plan of care was developed to meet the post-surgical needs for one applicable resident in the survey sample (Resident #2). Findings include:</p>	F 279	<p>F279 483.20(d), 483.20(k)(1)</p> <ol style="list-style-type: none"> 1. Resident #2 no longer resides in this facility and had no negative effects related to this alleged deficient practice. 2. Residents admitted to the facility with specific care needs have the potential to be affected by this alleged deficient practice. 3. Education will be provided to licensed nurses regarding the requirement to develop a plan of care for residents admitted with specific care needs. 4. Random audits will be conducted 3x weekly by the DNS or designee to monitor the effectiveness of the plan. 5. Results of the audits will be brought to the QAA committee monthly x3 months as which time the QAA committee with determine further frequency of the audits. 6. Corrective action will be complete by December 5, 2014. 	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE **11-28-14**

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 279	Continued From page 1 Per 11/13/14 medical record review, Resident #2 was admitted to the facility on 9/4/14 for post-surgical care and rehab following a cystoprostatectomy and ileal conduit urinary diversion procedure (surgical removal of the prostate and bladder necessitating a urinary diversion and collection system). His/her hospital discharge summary which was sent to the facility, detailed that the resident was "discharged with stents in place, drain in place and staples in [his/her] midline incision" and to "Please ensure that this dressing is changed with a 4 x 4 [gauze] twice daily." On 11/13/14 at approximately 3:30 PM, the DON (Director of Nursing) reported that when residents are admitted to the facility, nursing staff are expected to review the residents' hospital discharge orders, the facility's admission assessment and the [Minimum Data Set] Care Area Assessments (CAA) to determine resident needs that require the development of a care plan. On 11/13/14 at approximately 4:05 PM, the DON confirmed that Resident #2 had been admitted to the facility specifically for post-surgical care and that a care plan was not developed to address those specific care needs.	F 279	<i>F279 POC accepted 12/4/14 SDennisAPPN/PMC</i>		
F 281 SS=E	(Refer to F281) 483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced	F 281			

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F 281	<p>Continued From page 2</p> <p>by:</p> <p>Based on staff interview and record review, the facility failed to assure that nurses met professional standards of nursing practice regarding obtaining and/or following physician orders for treatments and monitoring of medical symptoms for 1 of 3 residents in survey sample. (Residents #2) Findings include:</p> <p>1. Per 11/13/14 medical record review, Resident #2 was admitted to the facility on 9/4/14 for post-surgical care and rehab following a cystoprostatectomy and ileal conduit urinary diversion procedure (surgical removal of the prostate and bladder necessitating a urinary diversion and collection system). His/her hospital discharge summary which was sent to the facility, detailed that the resident was "discharged with stents in place, drain in place and staples in [his/her] midline incision" and to "Please ensure that this dressing is changed with a 4 x 4 [gauze] twice daily."</p> <p>Per 11/13/14 review of the TAR (Treatment Administration Record), although Resident #2 was admitted on 9/4/14, there is no evidence that the dressing on the resident's surgical site was changed until 9/6/14. On 11/13/14 at 3:15 PM Staff Nurse #1 reported that on 9/4/14 and 9/5/14, s/he lifted the resident's dressing to inspect the incision site, but placed the same dressing back on the incision as there was no order to change the dressing at the time. S/he reported that another nurse was responsible for getting the order for the dressing.</p> <p>On 11/13/14 at approximately 3:30 PM, the DON reported that when a resident is admitted to the facility, nursing staff are expected to review the</p>	F 281	<p>F281 483.20(k)(3)(i)</p> <ol style="list-style-type: none"> 1. Resident #2 no longer resides in the facility and had no negative effects related to the alleged deficient practice. 2. Residents requiring treatments and monitoring of medical symptoms have the potential to be affected by this alleged deficient practice. 3. Education will be provided to licensed nurses regarding the requirements for obtaining and following physician orders. 4. Random audits will be completed 3x weekly by the DNS or designee to monitor effectiveness of the plan. 5. Results of the audits will be submitted to the QAA committee monthly x3 months at which time the QAA committee will determine further frequency of the audits. 6. Corrective action will be complete by December 5, 2014. <p><i>F281 POC accepted 12/4/14 SDennisrd/pmc</i></p>	
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F 281	<p>Continued From page 3</p> <p>hospital orders and enter them into the EMAR (Electronic medical record). S/he reported that one nurse enters the orders and a second nurse verifies that the orders are correct and then the completed orders are sent to the attending physician for signature or changes. The DON confirmed that the orders for Resident #2's dressing changes were missed on admission and that the first documented dressing change occurred 2 days after his/her admission.</p> <p>2. Per 11/13/14 medical record review of the same resident as above, on 9/6/14 Staff Nurse #2 documented in a nursing progress note regarding Resident #2: "Wound repacked and dressed with a NS [normal saline solution] wet-to-dry dressing as ordered..." Per 11/13/14 interview at approximately 3:15 PM, Staff Nurse #2 reported that she was told by another staff nurse (who is no longer employed by the facility) that orders had been obtained for a wet-to-dry dressing and s/he followed the verbal order from the nurse to provide care. On 11/13/14 at approximately 3:30 PM, the DON confirmed that there was no physician order for a wet-to-dry dressing in the medical record. Per medical record review, on 9/6/14 at 1500, an order was obtained for Resident #2 to have a 4 x 4 dressing change to the midline incision for post op care.</p> <p>3. Per 11/13/14 medical record review of the same resident, Resident #2, on 9/4/14, the physician orders stated to "Monitor for pain status every shift (pain scale 0-10: pain scale 1-3 mild pain; 3-7 moderate pain; 8-10 severe pain)." Per review of the medical record, there is no evidence that pain was monitored on each shift as ordered. On 11/13/14 in an interview starting at approximately 3:30 PM, the DON confirmed the</p>	F 281		

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F 281	Continued From page 4 above information and confirmed that there is no evidence that pain was monitored on each shift for Resident #2. *Reference: Lippincott Manual of Nursing Practice (9th ed.). Wolters Kluwer Health/Lippincott Williams & Wilkins. (Refer to F279)	F 281			
F 514 SS=D	483.75(I)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review the facility failed to assure that the clinical record for 1 of 3 residents in the survey sample was complete and accurate (Resident #1). Findings include: Per 11/13/14 medical record review, Resident #1 was admitted to the facility on 10/31/14 for a short term admission for the administration of Meropenem IV (an antibiotic administered	F 514	F514 483.75(I)(1) 1. Resident #1 had no negative effect related to the alleged deficient practice. 2. Residents requiring documentation in the medical record have the potential to be affected by the alleged deficient practice. 3. Education will be provided to licensed nurses regarding the requirement to document accurately in the medical record and correct any incorrect documentation. 4. Random audits will be done 3x weekly by the DNS or designee to monitor effectiveness of the plan. 5. Results of the audits will be submitted to the QAA committee monthly x3 months at which time the QAA committee will determine further frequency of the audits. 6. Corrective action will be complete by December 5, 2014.		

F514 POC accepted 12/4/14 SDennis/APPA/PME

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F 514	Continued From page 5 intravenously) for a resistant UTI (urinary tract infection). On 11/2/14, Staff Nurse #1 documented in the nursing progress notes that, "Resident did not receive 1400 antibiotic. Called [MD #1] re: this issue. (on call for [MD #2]) No new orders at this time." However, per review of the MAR (Medication Administration Record), Staff Nurse #2 documented that s/he administered Meropenem IV on 11/2/14 at 1430. On 11/13/14 at approximately 11:55 AM, the DON (Director of Nursing Services) reported that Staff Nurse #2 confirmed that s/he administered Merppenem to Resident #1 on 11/2/14 at 1430 and that Staff Nurse #1 documented in the wrong resident record that the antibiotic was not given. The facility was not aware of the error until the time of the survey and no correction had been made to the medical record.	F 514			