

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 08/19/2024
NAME OF PROVIDER OR SUPPLIER Berlin Health & Rehab Ctr		STREET ADDRESS, CITY, STATE, ZIP CODE 98 Hospitality Drive Barre, VT 05641	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>29776</p> <p>Based on observation and interview, the facility failed to provide dignity and respect for 4 of 23 sampled residents (Residents #2, #6, #5, and #103) and residents on 1 of 2 units (Unit B). Findings include:</p> <p>1. Per observation on 8/5/24 at 3:12 PM, Res. #103 was observed being transferred by a Licensed Nurse's Aide [LNA] by pulling their wheelchair backwards from the dining room down the hallway to the resident's room. The resident's feet were dragging and 'bumping' along the floor, and the resident's urine drainage bag and tubing from the suprapubic catheter were also dragging on the floor during the transport.</p> <p>Per interview with the LNA on 8/5/24 at 3:15 PM, The LNA confirmed s/he had pulled the resident backwards in the wheelchair and that the resident's feet and catheter bag were dragging on the floor. The LNA stated [Res.#103] don't pick up [h/her] feet.</p> <p>43524</p> <p>2. During an interview with Resident #5 on 8/5/24 at approximately 3:15 PM, s/he stated that s/he is not taken to the bathroom by staff but is told use your pull up to pee or poop. When the Resident was asked how they feel about using her/his pullup s/he stated, I hate it - I don't like having to wet myself. When asked if s/he is offered a bed pan when s/he is in bed or rings to go to the bathroom, s/he stated, No they don't.</p> <p>Per record review a care plan focus revealed that Resident #5 .requires assistance with ADL's [activities of daily living] related to limited mobility, incontinence and CHARCOT'S ARTHROPATHY [Definition: A progressive condition of the musculoskeletal system that is characterized by joint dislocations, pathogenic fractures, and debilitating deformities . Interventions were listed as Begin weight bearing BLE [bilateral lower extremity], CAM [Controlled Ankle Movement - a type of orthopedic footwear used to immobilize the foot and ankle after an injury or surgery] for initial weight bearing when transferring; W/C [wheelchair] with footrest, used for mobility assistance as needed, and X1 [1 person] assist for toileting. This care plan was last revised on 7/2/24.</p> <p>Review of Orthopedic note dated 7/25/24 revealed the following plan:</p> <p>(continued on next page)</p>

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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>OK to begin weight bearing bilateral lower- ext. Consider using CAM boot for initial weight bearing maneuvers until more comfortable. Should have footwear on when transferring. Consider PT for general conditioning, strengthening.</p> <p>Per interview conducted during the survey, the resident's POA [Power of Attorney] stated that s/he has been telling the facility that s/he does not want the resident to just sit there and wet or mess her/himself, s/he wants the resident toileted. S/he stated that s/he has been telling the facility that s/he does not want the resident to just sit there and wet or mess herself, s/he wants the resident toileted. The residents POA stated that s/he has the orthopedic note that states the resident should be weight bearing with the boot but the facility won't bring the resident to the bathroom.</p> <p>During an interview on 8/7/24 at approximately 4:45 PM, the Nurse Practitioner (NP) stated that the staff have not been bringing the resident to the bathroom because s/he wanted to have the resident bone density testing done first to make sure it was safe to let s/he start ambulating. The NP confirmed that s/he had seen the orthopedic notes regarding the residents ability to weight bear with the CAM boot.</p> <p>46135</p> <p>3. Per observation on 8/5/24 at 10:52 AM until approximately 11:15 AM on Unit B, staff pushed three residents in their wheelchairs into the common area by the nurses' station and left them without saying anything to them. Staff did not interact with any of the 7 residents in the common area and talked over the residents to each other about work duties.</p> <p>Per observation on 8/5/24 at 2:05 PM, 9 residents are sitting in the common area on Unit B. No staff are seen interacting with the residents. The music on the television is very loud and staff are yelling over the loud music to talk about cleaning supplies, passing drinks, and other work duties. At 2:12 PM a staff member, who was around the corner from this surveyor, said something about kicking a coworker in the shin. It wasn't until 2:37 PM, that a staff member came into the common area and started to engage with the 9 residents sitting there by passing a balloon back and forth.</p> <p>Per observation on 8/6/24 at 7:50 AM, 6 residents were sitting in the common area on Unit B. From 7:50 AM until 8:12 AM, staff pushed two additional residents into the common area without talking to them. During this time, staff did not speak to the residents in the common area but staff did talk loudly to each other across the room, over the residents' heads.</p> <p>Per observation on 8/6/24 at 2:45 PM, Resident #103 was sitting in his/her wheelchair in the hall holding onto their catheter bag. His/her clothes were significantly wet. S/He was intermittently saying help. Even though s/he was quiet, s/he could be heard about 10 feet away. Multiple staff, including two aides and a nurse, walked within a foot of him/her and did not address his/her request for help or the fact that s/he was wet and holding his/her catheter bag on his/her lap. At 2:53 PM, the Activity Staff asked Resident #103 if s/he wanted a root beer float. The Activity Staff began to hand the root beer float to Resident # 103 without addressing the fact that s/he had a catheter bag in his/her hands and was visibly wet.</p> <p>50336</p> <p>(continued on next page)</p>		

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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>4. Per observation on 8/7/2024 at 11:30 AM, Resident #2 was being transferred via shower chair down the hall and into his/her room by a License Nursing Assistant (LNA). The resident had no clothes on and only a bath blanket partially covering her/his upper body. Exposed areas included his/her right leg, thigh, side of buttocks and abdomen.</p> <p>5. Per observation on 8/7/2024 at 9:25 AM, Resident #6 had been left outside the shower room in a shower chair with wet hair and a bath blanket over the front of him/her without clothes on. At 9:30 AM the Licensed Nursing Assistant (LNA) caring for Resident #6, approached and pushed him/her down the hall to their room. At 9:40 AM Resident #6 was heard hollering in his/her room Help, Help and the LNA entered the room. At 9:41 AM this writer entered the room and observed Resident #6 still sitting in the shower chair without clothes on. Resident #6 had been placed in the walkway of the room facing the entry door. S/he had a bath blanket covering part of his/her lap with his/her entire upper body exposed, the LNA was making the Resident's bed. At 9:45 AM the resident asked the LNA to return him/her to bed. Resident #6 stated s/he had pain in his/her legs, thighs and buttocks. Resident #6 stated I have been sitting here too long. At 9:48 AM the LNA finished making the Resident's bed, asked this Surveyor for assistance with transfer, then left the room to go get someone to help them transfer Resident #6. While the LNA was gone Resident #6 remained in the shower chair with only the lower half of his/her body covered. At 9:50 AM the two LNAs returned to the room and transferred Resident #6 to bed with a mechanical lift. At this time 25 minutes had passed since the first observation of Resident #6 in the shower chair in the hall.</p>

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.</p> <p>46135</p> <p>Based on observations and staff interview, the facility failed to provide necessary housekeeping and maintenance services to ensure residents have a safe, clean, comfortable, and homelike environment for 2 of 2 open resident units. Findings include:</p> <ol style="list-style-type: none"> 1. Per observation on 8/6/24 from approximately 11:00 AM to 2:00 PM, both nursing units (Units A and B) needed multiple functional and cosmetic repairs, and both unit's floors were generally messy in several resident rooms and common areas. <ol style="list-style-type: none"> a. Baseboard radiators were damaged in rooms A4, A7, A9, A17, A19, A22, B4, B7, B9, B14, B 15, B16, and the Unit A living room. Baseboard radiators were detaching from the wall in rooms A24 and B24. b. Wall had unrepaired holes or unpainted spackle in rooms A1, A5, A16, B4, B7, B9, B13, B15, B16, B18, B23, and the Unit B hallway near the nurses' station. c. Chair rails were damaged in rooms A24, B3, B4, and B24. d. Furniture, including dressers and side table, had peeled laminate exteriors and/or missing handles in rooms A10, A19, B8, B14, B15, and B25. e. Closets doors loose or missing handles and/or were unable to close properly in rooms A7, A9, A10, A12, B3, B4, B8, B9, B10, B12, B13, and B16. f. Ceiling tiles were stained and/or missing in rooms: A1, A9, A19, A22, B2, B3, B5, B10, B15, B22, B23, and the Unit B living room. g. Bugs were on the floor and/or inside light fixtures in rooms A7, A24, B3, B23, and B24. h. Blood and/or stool looking substances on toilets and sinks in rooms A5, B5, B7, and B23. i. Excessive urine odor in rooms A12, B8, and B9. j. Food and/or liquid splatter on walls in rooms A5, A11, A12, A13, A22, B5, B9, B11, B18, and the Unit B hallway near the nurses' station. k. Excessive dust on ceiling fixtures (vents or sprinklers) in rooms A1, A16, B1, all hallways, and the main dining room. l. Excessively dirty tray table legs in rooms B3, B13, B18, and B25. m. Generally dirty floors with debris that do not appear to be mopped and/or swept in rooms, especially under beds and around furniture, in addition to all uncarpeted floors having slight moisture, in rooms A1, A2, A5, A11, A12, A16, A17, A22, A23, A24, B1, B2, B3, B5, B7, B9, B10, B11, B13, B15, B18, and B22. <p>(continued on next page)</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>n. Unsafe environment issues, including a sharp door handle on closet in room B8, a sharp radiator in room A9, a broken window valance in room B23, a broken lampshade in room B13, exposed nails or screws in the walls below 5 feet in rooms A4, A13, and B2, no dome on the bath light, making the light extremely bright, in room B23, and unfinished renovation of a bariatric door in room A17.</p> <p>Per interview on 8/6/24 at 11:40 AM, Resident #12 explained that no one has cleaned his/her room in a while.</p> <p>Per interview on 8/6/24 at 1:30 PM, Resident #46 stated that no one cleans the tray table in his/her room and the floor keeps getting ants due to the mess that is left on the floor.</p> <p>Per interview on 8/6/24 at 1:45 PM, Resident #25 said that his/her floor has had a noticeable spill for a couple weeks and no one has cleaned it.</p> <p>Per interview on 8/6/24 at 2:03 PM, the Housekeeping Director explained that they do not have enough staff to do a detailed clean in each room every day. Since s/he has taken over as the Housekeeping Director at the beginning of the year, there has not been a deep clean to any area of the facility. The facility was supposed to hire an outside service for this job but it never happened. S/He also explained that s/he gets pulled from doing housekeeping duties to help with resident care, like helping with meals. S/He recently took a feeding assistant training to be able to help direct care staff feed residents.</p> <p>Per interview on 8/6/24 at 3:45 PM, the Market Operations Advisor explained that deep cleaning has not been done at the facility for a while. The facility has attempted to arrange for deep cleaning services but has yet to have a vendor provide the service. Following this interview, a walk through of the facility was conducted with the Market Operations Advisor and s/he confirmed the environmental observations listed above.</p> <p>40258</p> <p>2. During an interview with Resident # 4 on 8/7/2024 at 9:54 AM s/he was sitting in his/her wheelchair. There was a bath towel on the floor under the wheelchair soaked with urine. Resident #4 expressed several concerns related to the cleanliness of the facility stating that the housekeeping department is short staffed and s/he had been told by a housekeeper that they are now being asked to help out the nursing staff. Resident #4 also stated that s/he had been told last week by therapy that they could not take her/him down to the gym for therapy because there was mold.</p> <p>On 8/7/2024 at 10:15 AM observation of the gym revealed a large dehumidifier running. At this time therapy staff confirmed that the dehumidifier had been brought in after mold was discovered on gym equipment and wheelchairs that were located in the gym. Therapy staff reported that housekeeping staff had cleaned the areas of mold and removed the wheelchairs, but to their knowledge there had not been a complete over all cleaning of the gym.</p> <p>(continued on next page)</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>During a walk through and interview on 8/07/24 at 11:59 AM the Regional Environmental Services Director confirmed that the Rehab gym was damp due to humidity causing the mold to form. Observations of the social services office revealed that there was mold on a bin that is used to hold papers for shredding. The tub room off of A-Wing was also noted to have mold forming on the upper wall behind the tub. This was confirmed on 8/07/24 at 12:07 PM by the Regional Environmental Service Director and the Market Operations Advisor.</p> <p>43524</p> <p>3. Per observation on 8/6/24 at approximately 9:15 AM of Resident #59's room revealed the bathroom door casing to be down to the raw wood and drywall/mudding holding the door frame in/affixed to the wall. It appears as though the door frame was widened to allow better access to the bathroom with the residents electric wheelchair.</p> <p>Interview on 8/7/24 at approximately 10:15 AM with the Clinical Market Advisor and the Market Operations Advisor specific to the status of this doorway and the bare wood, the Clinical Market Advisor stated s/he would go to the residents room and take a look. The Clinical Market Advisor and the Market Operations Advisor confirmed that work had been started on this residents bathroom doorway to accommodate their electric wheelchair and they had run into issue with the contractor finishing the work.</p> <p>Interview on 8/7/24 at approximately 11:30 AM with Resident #59, they explained their bathroom door modifications/widening had been initiated but never finished. and the process that has taken place regarding the widening of the door. S/he explained that her/him electric wheelchair needs quite a bit of room as it is larger to meet their needs. S/he stated the contractor has been working on the door frame and that s/he knows the facility was having a hard time getting the contractor to come back and finish the doorway. During the interview with this resident, the Clinical Market Advisor came to this resident's room to look at the door frame and acknowledged that the door frame was down to the bare wood to the left of the door frame and the left of the header/top of the door frame. The Clinical Market Advisor agreed that this was an infection control issue since the bare wood could not effectively be cleaned. Upon the completion of the interview with the resident and exiting the room, a maintenance staff member came to the room with a gallon of paint and paint brush and stated s/he was going to finish painting the door frame.</p>		

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<p>F 0625</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43524</p> <p>Based on interview and record review, the facility failed to ensure that residents or resident representatives received written notification of the facility bed hold policy on residents' discharge to the hospital for 1 of 23 residents sampled. (Resident #5), Findings include:</p> <p>During an interview on 08/06/24 at approximately 8:26 AM Resident #5 stated they s/he had recently been to the hospital however s/he was not able to state the reason s/he was sent to the hospital or how long they s/he were there.</p> <p>Record review revealed that the resident had been sent to the ED [Emergency Department] on 8/1/24 for a potential UTI [urinary tract infection]. There was no evidence of a bed hold notice being sent to the POA [Power of Attorney] in the medical record.</p> <p>Per interview with the Clinical Market Advisor, on 8/7/24 at approximately 4:30 PM s/he could not find a bed hold notification for the resident's transfer to the ED on 8/1/24 but stated s/he would keep looking.</p> <p>On 8/7/24 at 4:45 PM the Clinical Market Advisor stated that s/he was unable to locate a bed hold notification to the POA and the resident.</p> <p>On 8/7/24 at 4:50 PM the Market Operations Advisor provided the facility Bed Hold Notice titled, Bed Hold Notice - Deliver Upon Transfer Eff [DATE] - Rev [DATE] stated under Process paragraph two Prior to a resident's transfer out of the center to a hospital or for therapeutic leave, the staff member conducting the transfer out will provide both the resident and representative, if applicable, with the Bed Hold Policy Notice & Authorization form (Smartworks form # GHC-4731) Notice must be given regardless of payer. Resident copy is given directly to the resident prior to transfer and noted in the medical record. Representative copy can be delivered electronically via email/secure fax or hard copy via mail if the representative is not present at the time of transfer. (Must be done within 24 hours.)</p> <p>The Market Operations Advisor provided at this time the Genesis Healthcare P&P AR102 Bed-Holds, effective date is listed as 03/15/00 and was last revised on 01/16/23 was provided. Under PURPOSE it stated, To provide written notice of the bed hold policy to the resident/resident representative at the time of transfer out of the service location - this applies to all payers.</p> <p>Under PROCESS it stated, 1. Providing Written Notice to All Residents at the Time of Transfer: 1:1 When it is known that a resident will be temporarily transferred out of the service location, staff involved with the resident's transfer out (e.g., Nursing, Admissions, Social Services, etc.) will: 1.1.1 Provide the Bed Hold Notice of Policy & Authorization form to the resident and representative, if applicable. 1.1.1.1 If the resident representative is not present to receive the written notice upon transfer, the notice will be delivered via e-mail, fax, or hard copy by mail within 24 hours. 1.1.2 Maintain a copy in the medical record. 1.1.3 Provide a copy to the Business Office Manager (BOM)/designee at the next interdisciplinary team meeting. 1.1.3.1 The BOM/designee will maintain a copy in the resident's financial file.</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>29776</p> <p>Based upon observation, interview, and record review, the facility failed to implement care plan interventions related to catheter care and monitoring for 1 [Res.#103] and failed to identify and implement interventions for an actual urinary tract infection and the use of antibiotic therapy for (Resident #5) for 2 of 2 sampled residents. Findings include:</p> <p>Per record review, Res.#103 medical conditions include a suprapubic catheter. [A suprapubic catheter is a medical device that helps drain urine from your bladder. It enters your body through a small incision in your abdomen.] (https://my.clevelandclinic.org/health/treatments/25028-suprapubic-catheter).</p> <p>Per observation on 8/5/24 at 3:12 PM, Res.#103 was observed being pulled backward in h/her wheelchair from the dining room to his/her room by a Licensed Nursing Aide [LNA]. The resident's urine drainage bag and tubing from the suprapubic catheter were dragging on the floor during the transport. Per interview, the LNA confirmed Res.#103's catheter bag and tubing were both touching the floor while the resident was being moved.</p> <p>Per review of Res.#103's Care Plan, the resident is identified as requires suprapubic catheter- resident is high risk for Urinary Tract Infection. Care Plan interventions include Keep catheter off floor and record output.</p> <p>Per observation on 8/5/24 at 5:20 PM, Res.#103 was sitting in h/her wheelchair in the facility's dining room. Res.#103's catheter bag and tubing again were observed touching the floor beneath the wheelchair while the resident ate. Per interview on 8/5/24 at 5:22 PM, two LNA's both confirmed the resident's catheter bag was hanging too low and the bag and tubing were touching the floor.</p> <p>An interview was conducted with a staff LNA on 8/6/24 at 2:20 PM. The LNA stated staff does not keep track of the resident's supra pubic tube [SPT] output because there is no order for it. The LNA confirmed that Res.#103's Care Plan includes record output, and confirmed during interview and per record review, there was no documentation in Res.#103's medical record of the resident's SPT output.</p> <p>An interview was conducted with the facility's Market Clinical Advisor [MCA] on 8/7/24 at 1:26 PM. The MCA confirmed that Res.#103's urine drainage tubing on the floor and being dragged during transport represented infection control risks for a resident susceptible to Urinary Tract Infections, and that Care Plan interventions included keep catheter off floor, and that infection control intervention was not being implemented. The MCA also confirmed that Res.#103's Care Plan regarding their SP tube included record output and this also was not being done.</p> <p>43524</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>2. Per reivev of Resident #5's record on 7/17/24 an order was received to obtain a urinalysis (UA) to determine if the resident had a Urinary Tract Infection (UTI). On 7/19/24 the UA came back as abnormal, indicating the resident was positive for a UTI. The culture and sensitivity (a test used to determine which antibiotics would work best to treat the infection based on the organism that caused the infection) was received back from the hospital on 7/24/24 and at that time the resident was placed on an antibiotic to treat the infection. Review of the resident Medication Administration Record for July 2024 revealed that resident had refused several doses of the antibiotic. On 8/1/24 the resident was transported to the ED (Emergency Department) for a suspected UTI (Urinary Tract Infection). The resident was seen by the ED providers and was diagnosed with a UTI. S/he was prescribed a one time antibiotic (one dose).</p> <p>Review of the resident's care plan did not include a care plan specific to the resident's diagnosis of an UTI or the use of an antibiotic.</p> <p>During an interview with the Clinical Market Advisor on 8/7/24 at approximately 3:20 PM, s/he could not provide a care plan specific to the resident's diagnosis of a UTI and/or the use of an antibiotic.</p>		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.</p> <p>50336</p> <p>Based on observation, interview, and record review the facility failed to revise the care plan for 1 of 23 residents sampled (Resident #16), related to significant medication error and symptomatic eye pain. Findings include:</p> <p>Per record review Resident #16 was admitted to the facility in November of 2023 with diagnoses that include, Pseudophakia OU (artificial lens in both eyes) mild retinopathy (bleeding in the small vessels in the eye), and dry eyes.</p> <p>During an interview with Resident #16 on 8/6/2024 at 2:00 PM s/he stated that s/he received drops for his/her ears to both of his/her eyes. Resident #16 stated It hurt like hell and burned.</p> <p>An emergency room Physician note written on 07/23/2024 states that Resident #16 was seen in the emergency department today for a recent chemical exposure to [his/her] eye . We flushed [his/her] eyes and have started [him/her] on some antibiotic eyedrops to prevent infection . If [she/he] experiences worsening symptoms, especially worsening pain, please return to the emergency room .</p> <p>Per the facility policy titled Person Centered Care Plan revised on 10/24/2022 states:</p> <p>7. Care plans will be:</p> <p>7.2 Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments, and as needed to reflect the response to care and changing needs and goals; and</p> <p>7.3 Documented on the Care Plan Evaluation Note.</p> <p>Review of Resident #16's care plan reveals there is no documented evidence that the facility revised the care plan to monitor Resident #16 for adverse effects related to a significant medication error which involved incorrectly administering ear drops into the resident's eyes.</p> <p>Per interview with the Clinical Market Lead (Registered Nurse) on 8/7/2024 at 8:30 AM s/he was unable to provide evidence or documentation that Resident #16 was monitored for pain, redness or burning in his/her eyes after returning from the hospital on 7/23/2024.</p> <p>Per interview on 8/7/2924 at 3:00 PM the Director of Nursing (DON) stated that the expectation would be to update the care plan and obtain a Physician's order to monitor both eyes and document findings in the facilities Medication/Treatment Record. The DON confirmed that there were no revisions made to the care plan after the significant medication error for Resident #16.</p>		

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 08/19/2024
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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>29776</p> <p>Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.</p> <p>Based upon observation, interview, and record review, the facility failed to implement infection control measures related to catheter care for 1 resident [Res.#103] of 2 sampled residents. Findings include:</p> <p>Per record review, Res.#103 medical conditions include a suprapubic catheter. [A suprapubic catheter is a medical device that helps drain urine from your bladder. It enters your body through a small incision in your abdomen.] (https://my.clevelandclinic.org/health/treatments/25028-suprapubic-catheter).</p> <p>Per observation on 8/5/24 at 3:12 PM, Res.#103 was observed being pulled backward in h/her wheelchair from the dining room to the resident's room by a Licensed Nursing Aide [LNA]. The resident's urine drainage bag and tubing from the suprapubic catheter were dragging on the floor during the transport. Per interview, the LNA confirmed Res.#103's catheter bag and tubing were both touching the floor while the resident was being moved.</p> <p>Per review of Res.#103's Care Plan, the resident is identified as requires suprapubic catheter- resident is high risk for Urinary Tract Infection.</p> <p>Per observation on 8/5/24 at 5:20 PM, Res.#103 was sitting in h/her wheelchair in the facility's dining room. Res.#103's catheter bag and tubing again were observed touching the floor beneath the wheelchair while the resident ate. Per interview, two LNA's both confirmed the resident's catheter bag was hanging too low and the bag and tubing were touching the floor.</p> <p>An interview was conducted with the facility's Market Clinical Advisor [MCA] on 8/7/24 at 1:26 PM. The MCA confirmed that Res.#103's urine drainage tubing on the floor and being dragged during transport represented infection control risks for a resident susceptible to Urinary Tract Infections.</p>		