

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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: Facility ID: 475020	If continuation sheet Page 1 of 27

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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 0554</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Allow residents to self-administer drugs if determined clinically appropriate.</p> <p>40258</p> <p>Based on observation, interview and record review the facility failed to assess a Resident for the ability to self-administer medications for 1 of 23 residents in the sample (Resident #18). Findings include:</p> <p>During an interview on 8/5/2024 at 4:00 PM Resident #18 pulled open his/her nightstand drawer revealing two topical medications, Nystatin powder (treatment for skin infections) and Bio Freeze (Pain relief cream that goes on the skin). When s/he was asked what the medications were, s/he explained that s/he had requested his/her family to bring in the Bio Freeze due to pain in his/her shoulder. Resident #18 stated that s/he has chronic pain in both shoulders, and s/he applies his/her own Bio Freeze. S/He also stated that s/he applies her/him own medicated powders to her/him skin and does not want his/her supplies stored outside his/her room. Resident #18 confirmed that s/he does not have a lockbox for his/her medications.</p> <p>During an interview on 8/6/2024 at 12:20 PM a Registered Nurse (RN) familiar with Resident #18's care confirmed that Resident #18 applies his/her own Nystatin and Bio freeze daily and keeps them both in his/her own room.</p> <p>Per facility policy titled NSG309 Medications Self- Administration, last revised on 3/1/22, Patients who request to self-administer medications will be evaluated for safe and clinically appropriate capability based on the patient's functionality and health condition. If it is determined that the patient is able to self-administer:</p> <ul style="list-style-type: none"> * A physician/advanced practice provider (APP) order is required. * Self-administration and medication storage must be care planned. * When applicable, patient must be provided with a secure, locked area to maintain medications. * Patient must be instructed in self-administration * Evaluation of capability must be performed initially, quarterly, and with any significant change in condition. <p>During an interview on 8/6/2024 at approximately 2:00 PM, the Clinical Market Lead confirmed there was no documented assessment for self -administration, there was no evidence of orders to self-administer, and self- administration of medication was not reflected on the Resident's care plan.</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 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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<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>		

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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</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>29776</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>

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<p>F 0711</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure the resident's doctor reviews the resident's care, writes, signs and dates progress notes and orders, at each required visit.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46135</p> <p>Per interview and record review, the facility failed to ensure that physicians sign and date all physician orders for 4 of 6 sampled residents (Residents # 403, #11, #103, and #35). Findings include:</p> <p>Record review reveals that Resident #403 was admitted to the facility on [DATE] and had a regulatory physician admission visit on 7/22/24. As of 8/19/24, 29 days after admission, Resident #403's admission orders, including medications, were not signed by a physician.</p> <p>Record review reveals that Resident #11 was admitted to the facility on [DATE] and had a regulatory physician admission visit on 7/8/24. As of 8/19/24, 62 days after admission, Resident #11's admission orders, including medications, were not signed by a physician.</p> <p>Record review reveals that Resident #103 was admitted to the facility on [DATE] and had a regulatory physician admission visit on 7/20/24. As of 8/19/24, 31 days after admission, Resident #103's admission orders, including medications, were not signed by a physician.</p> <p>Record review reveals that Resident #35 was admitted to the facility on [DATE] and had a regulatory physician admission visit on 7/22/24. As of 8/19/24, 39 days after admission, Resident #35's admission orders, including medications, were not signed by a physician.</p> <p>Per interview on 8/19/25 at 12:44 PM, the Market Clinical Lead confirmed that the Attending Physician did not sign admission orders for Residents # 403, #11, #103, and #35 and should have.</p>		

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46135</p> <p>Based on observation, resident and staff interviews, and record review, the facility failed to ensure there are a sufficient number of skilled licensed nurses, nurse aides, and other nursing personnel to provide care and respond to each resident's basic needs and individual needs as required by the resident's diagnoses, medical condition, or plan of care, potentially impacting all residents of the facility. Findings include:</p> <p>Per interview on 8/5/2024 at 4:00 PM, Resident #18 stated s/he feels there is not enough staff and sometimes his/her call light is on for 45 minutes before it is answered. Resident #18 stated that a few months ago s/he was left in his/her own urine overnight. S/He stated that the nurse on duty answered his/her call light and stated that s/he would get help to change him/her. The resident stated that no one came to help her, and s/he did not receive incontinent care until 7:30 in the morning.</p> <p>Per interview on 08/05/2024 at 11:30 AM, Resident #2 stated that it takes a long time for call bells to be answered. S/He stated that often the staff will turn off the call light and not return to assist him/her. S/He stated that recently s/he turned on his/her call light to use the bedpan, and when no one answered the call light s/he urinated in the bed.</p> <p>Per interview on 8/6/24 at 1:30 PM, Resident #46 explained that there are not enough staff to help him/her get other things to eat when s/he is served something that s/he does not like for meals, which happens frequently.</p> <p>Per interview on 8/6/2024 at approximately 10:00 AM, the Unit Nurse stated that they were promoted to Unit Manager but are unable to transition to the manager position for the unit due to not having enough staff to work the floor.</p> <p>Per interview on 8/7/24 at approximately 2:40 PM, an LNA stated that there are not enough staff to give residents a choice in what they would like to eat prior to meals being served. S/He explained that it is too much of a hassle to ask residents what they want to order for because they are short staffed, especially after 3:00 PM. S/He explained that s/he cannot do morning care for all residents on his/her assignment until after lunch when s/he works on Unit A. Unit A has residents are very needy because so many residents need a lot of assistance or two staff to help because there are a lot that require lifts. S/He stated that sometimes residents have to sit on bed pans or toilets for a long time because there are not enough staff to get to them right away.</p> <p>Per interview on 8/7/2924 at 3:00 PM, the Director of Nursing (DON) stated that s/he often is working the medication cart due to not enough staff at the facility. The DON further stated that s/he is often unable to update care plans or complete other manager related tasks due to working the medication cart. S/He also stated that s/he has been doing wound care because they currently do not have a wound nurse on staff.</p> <p>(continued on next page)</p>		

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Per joint interview with two Licensed Nursing Assistants on 8/7/24 at 3:54 PM LNA #1 explained that 5 residents (on Unit A) use a lift and the residents on the unit have high acuity and need a lot of help. LNA #2 explained that it takes a long time to do things with the residents not enough and there is not enough staff to provide quality care because the care is rushed. LNA #1 continued to explain that sometimes there is only one aide on the unit, which is hard because they need to do medications, so it can be hard to get to people, especially if they need two people to assist. LNA #2 said it is hard to get to someone that needs something during mealtimes because they have to pass the trays. They both explained that they are working around 80 hours a week sometimes and that they need more staff.</p> <p>Per review of direct care schedules from June 2024 through August 7th, 2024, there is only one week in June that has unit managers scheduled. Review of the Facility assessment dated active from 8/1/24 through 8/22/24 reveals on page 23 that the staff needed to provide care to the resident population include 2 full time unit managers and one full time skin health nurse and reads We have daily discussions on unit by unit staffing. The unit manager gives updates on patient needs [NAME] with nursing leadership involved the scheduler will make staffing adjustments.</p> <p>Per interview on 8/07/24 at 5:19 PM, the Scheduler explained that sometimes s/he has to work the floor as a LNA because there are not enough staff. S/He described that when s/he creates the direct care schedule, it is based in census, not on the acuity of the residents in the facility. The Scheduler confirmed that the facility has not had anyone to work as the Unit Manager for over a month now on either unit.</p>		

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<p>F 0730</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Observe each nurse aide's job performance and give regular training.</p> <p>46135</p> <p>Based on interview and employee files, the facility failed to ensure that Licensed Nursing Assistants (LNAs) received annual performance evaluations for 3 of 3 LNAs reviewed. Findings include:</p> <p>Per review of employee files for LNAs that have worked at the facility longer than a year, there were no nurse aide performance evaluations completed within the past year for LNA #1, hired on 5/31/18, LNA #2, hired on 3/28/22, and LNA #3, hired on 7/4/22.</p> <p>Per interview on 8/7/24 at 2:36 PM, the Market Operations Advisor confirmed that the facility did not have annual nurse aide performance evaluations for the above 3 LNAs.</p>

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<p>F 0760</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that residents are free from significant medication errors.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50336</p> <p>Based on interview and record review, the facility failed to ensure 1 out of 5 sampled residents (Resident #16) was free from significant medication errors related to the administration of medication by the wrong route, causing pain and requiring medical attention to Resident #16's eyes.</p> <p>Findings include:</p> <p>Per record review, Resident #16 was admitted to the facility with diagnoses that include, dry eyes, Pseudophakia OU (artificial lens in both eyes) and mild retinopathy (damage to the small vessels in the eye as defined by the American Academy of Ophthalmology, 2024).</p> <p>During an interview with Resident #16 on 08/06/2024 at 2:00 PM s/he stated that they received drops for his/her ears to both of his/her eyes. Resident #16 stated It hurt like hell and burned.</p> <p>Per review of Resident #16's medication orders written on 07/19/2024, the Advance Practice Registered Nurse (APRN) ordered Debrox Otic (ear) Solution 6.5% (Carbamide Peroxide) Instill 5 drop[s] both ears four times a day for ear wax for 5 Days. Per the Manufacturer, Debrox contains peroxide and oils that help break up the wax in the ear canal. (Drugs.com, 2024)</p> <p>The Advance Practice Registered Nurse telehealth provider, contacted by facility to assess Resident #16, wrote the following note on 07/22/2024 Nurse reports [AGE] year-old [Resident #16] received carbamide peroxide [Debrox] 1 drop into both eyes. Patient reports irritation .Diagnosis ocular pain, bilateral . condition is guarded. The following orders were received: Irrigate eyes and then apply artificial tear drops 2 drop in each eye [follow up] with primary care in the morning.</p> <p>A Follow up note written by the APRN dated 07/23/2024 reads [Resident #16] seen for an acute visit after [s/he] was given incorrect eye drops last night. Per patient [he/she] was given the drops which [he/she] stated burned. Per on call note, patient was given carbamide peroxide 1 drop in both eyes. [S/He] has been getting to [the] ear drops for wax build up. Patient states [his/her] eyes are irritated and itchy . Called the Northern New England Poison Center who recommended patient be sent to the ED [Emergency Department] for urgent follow up on context of extensive discomfort and redness and length of time since event occurred . Bilateral conjunctiva is red and excessively watery . Both eyes red, significant discomfort. Plan to send patient to ED for more urgent follow up.</p> <p>An Emergency Department note written on 07/23/2024 reads the following [Resident #16] seen in the emergency room today for recent chemical exposure to the eye. Thankfully his eye PH (acidity or alkalinity of fluid around the eye) is normal. We have flushed [his/her] eyes and started [him/her] on antibiotic eyedrops to prevent infection. I have placed a referral to the ophthalmology department.</p> <p>A Note written on 07/24/2024 by the APRN reads [Resident #16] seen for follow up eye irritation, [s/he] reports [his/her] eyes are still burning a little.</p> <p>(continued on next page)</p>

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<p>F 0760</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the facility policy Medication Errors, last revised 07/01/2024, reads Medication Error means the observed or identified preparation or administration of medications or biologicals which is not in accordance with the prescriber's order; manufacturer 's specifications (not recommendations) regarding the preparation and administration of the medication or biological . Significant Medication Error means one which causes the patient discomfort or jeopardizes their health and safety . The Center shall ensure medications will be administered as follows: 1.1 According to prescriber's orders . 2.1 Medication administered not in accordance with the prescriber's order. Examples include, but are not limited to: 2.1.1 Incorrect dose, route of administration, dosage form, time of administration safety To prevent medication errors and ensure safe medication administration, nurses should verify the following information: 5.1 Right medication, dose, route, and time of administration; 5.2 Right patient and right documentation.</p> <p>During an Interview with the Advance Practice Registered Nurse on 08/06/2024 at approximately 2:40 PM the APRN confirmed that Resident #16 did receive Debrox to his/her eyes in error. The APRN stated that during his/her assessment of Resident #16 on 07/23/2024 the Resident's eyes were very red, and s/he complained of pain and burning in both eyes. The APRN also stated that s/he was concerned that Resident #16 needed more flushing of his/her eyes, and s/he felt that Resident #16 needed fluoroscopy (imaging of the eye) to determine if there was damage to the eyes. The APRN contacted Poison control, and they recommended sending Resident #16 to the emergency room .</p> <p>Reference</p> <p>List of Cerumenolytics - Drugs.com</p> <p>Diabetic Retinopathy: Causes, Symptoms, Treatment - American Academy of Ophthalmology (aao.org)</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.</p> <p>50336</p> <p>Based on observation, interview, record review, and facility policy, the facility failed to ensure medications were properly stored for 1 of 23 residents (Resident #18) who had improperly stored medications in their room. Findings include:</p> <p>Per observation on 8/5/2024 at 4:00 PM Resident #18 pulled open his/her nightstand drawer revealing two topical medications. The medications included Nystatin powder (treatment for skin infections) and Bio Freeze (Pain relief cream that goes on the skin). When s/he was asked what the medications were, s/he explained that s/he requested his/her family to bring in the Bio Freeze due to pain in his/her shoulder. S/he has chronic pain in both shoulders, and s/he applies his/her own Bio Freeze. Resident #18 also stated that s/he does not have a lockbox to store his/her medications.</p> <p>Per facility policy titled NSG309 Medications Self- Administration, last revised 3/1/22, states Patients who request to self-administer medications will be evaluated for safe and clinically appropriate capability based on the patient's functionality and health condition. If it is determined that the patient is able to self-administer:</p> <ul style="list-style-type: none"> * A physician/advanced practice provider (APP) order is required. * Self-administration and medication storage must be care planned. * When applicable, patient must be provided with a secure, locked area to maintain medications. <p>Per interview on 8/6/2024 at approximately 2:00 PM, the Clinical Market Lead confirmed that Resident #18 had no evidence of orders to self-administer their own medications, and the facility had not provided a lockbox to the Resident because they did not know s/he was self-administering the medications. However, in a previous interview on 8/6/2024 at 12:20 PM a Registered Nurse (RN) familiar with Resident #18's care confirmed that Resident #18 applies his/her own Nystatin and Bio freeze daily and keeps them both in his/her own room.</p>

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<p>F 0791</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide or obtain dental services for each resident.</p> <p>46135</p> <p>Based on observation, interview, and record review, the facility failed to provide or obtain from an outside resource routine and emergency dental services to meet the needs of each resident for 1 of 23 sampled residents (Resident #25). Findings include:</p> <p>Per observation and interview on 8/5/24 at 12:22 PM, Resident #25 was grinding his/her teeth. S/He explained that s/he has been grinding his/her teeth for a while and can't help it, and s/he would like for the dentist to check it out. S/He would also like to wear his/her partial plate again but it is at his/her home. S/He has mentioned to staff that s/he would like to get this partial plate from home and see the dentist.</p> <p>Per record review, a dentist note dated 9/25/23 reveals that Resident #25 had requested a teeth cleaning. There is no evidence in his/her medical record that s/he had received a teeth cleaning or was provided any dental services since then. A 7/21/24 Nurse Practitioner note reveals that Resident #25 has a chronic issue with teeth grinding and discussed possibly a mouth guard at nighttime to help with nighttime symptoms. Resident #25's care plan reads [Resident #25 is at risk for oral health or dental care problems as evidenced by broken, carious teeth, revised on 4/3/23. The care plan does not include any interventions about obtaining or having a partial plate, providing dental services such as teeth cleaning, or any mention of his/her teeth grinding.</p> <p>Per interview on 8/7/24 at 1:06 PM, the Nurse Practitioner explained that s/he was aware that Resident #25 has been grinding his/her teeth for a while and knew about his/her partial plate at home but does not know how to get it. S/He was unsure of the process for residents to get their follow up cleanings, including Resident #25. S/He explained that there is a binder used to keep track of dentist referrals. S/He stated that s/he did not put Resident #25 on the list to be seen by the dentist regarding his/her teeth grinding and should have.</p> <p>Per interview on 8/7/24 at 1:36 PM, a Licensed Nursing Assistant, who had also coordinated scheduling resident dental appointment until June 2024, explained that s/he is not sure how Resident #25's cleaning was missed. S/He explained that there is a referral binder where nurses can put in referrals for the dentist for concerns such as teeth grinding.</p> <p>Per review of the referral binder for dentist appointments, there are no entries referring Resident #25 to be seen by the dentist for any reason including teeth grinding, a dental cleaning, or for a possible mouth guard.</p>		

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<p>F 0800</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Provide each resident with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs.</p> <p>29776</p> <p>Based upon observation, interview, and record review, the facility failed to ensure each resident was provided with scheduled food items to fulfill dietary requirements determined by the facility that meet each resident's daily nutritional and dietary needs and choices. Findings include:</p> <p>An interview was conducted on 8/6/27 at 10:15 AM with the facility's Dietary Manager. The Dietary Manager reported that facility's meal delivery system had been experiencing some difficulties in the past two weeks, and this has been reported to the facility's Administrator, the Market Clinical Advisor, and the Regional Market President-Operations. The Dietary Manger shared that carts with multiple meal trays are prepared in advance and delivered in each of the two residence hallways, to be available for residents who wish to remain in their rooms and have their meals there. In addition to the already prepared meal trays, the facility sets up a steam table in a central dining room, where residents can gather and sit at tables, and their meals are assembled there at the steam table after they arrive.</p> <p>The Dietary Manager reported that facility staff will bring residents who have already expressed their preference to remain in their rooms down into the dining room to eat. The Dietary Manager explained that those residents already have a meal tray waiting for them on one of the meal carts, and when they are brought down into the dining room, a second meal tray is prepared for them there, thereby creating two meal trays for one resident and leaving one meal to waste. The Dietary Manager explained that this contributes to food shortages at the facility. The Dietary Manager further explained that current produce deliveries contained amounts of unusable items, such as rotted lettuce and ripe bananas that quickly spoiled, which also contributed to the menu items shortages and substitutions. The Dietary Manager stated that the facility's food service is on a rigid budget, and any requests outside of the budgeted items are relayed to the facility's corporate entity by the Dietary Manager via a phone app [a type of software designed specifically for use on a mobile device] where they first must be approved. The Dietary Manager reported that sometimes items are not approved, or previous approved amounts are reduced.</p> <p>Observations were made of the facility's meal services on 8/5, & 8/6/24. Random residents were interviewed in resident rooms and in the facility's dining room during the meal services.</p> <p>Per review of the facility's posted Lunch menu for 8/5/24, as well as the individual printed menus handed to residents, Lunch meal items available included lettuce and tomato half slices, creamy Dill potato salad, watermelon, saltines, and egg salad on wheat bread. An observation was made of the facility's Lunch meal on 8/5/24. Random residents were interviewed in resident rooms and in the facility's dining room during Lunch on 8/5/24. Res. #39 reported h/her menu listed lettuce and tomato half slices, Creamy Dill Potato Salad, and Watermelon- none of which s/he received.</p> <p>Res.#7 reported h/her menu listed lettuce and tomato half slices, and saltines which s/he did not receive, along with an egg salad sandwich on white not wheat bread.</p> <p>(continued on next page)</p>		

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<p>F 0800</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Per review of the facility's posted menu for 8/5/24, as well as the individual printed menus handed to residents, the Dinner meal for 8/5/24 was posted as Beef Lasagna [1 square] with marinara sauce, along with tossed salad with Parmesan ranch dressing, and garlic bread. Observations were made of residents in their rooms during the Dinner service and in the dining room during the facility's Dinner meal on 8/5/24.</p> <p>Per observation, the main entree being served was penne pasta [a type of pasta with tubular pieces, with ends cut at an angle] with meat sauce and/or plain penne, accompanied by a cold cooked beet salad. No resident was observed received the scheduled Beef Lasagna with marinara sauce for the Dinner meal.</p> <p>Random residents were interviewed in resident rooms and in the facility's dining room during Dinner on 8/5/24.</p> <p>Res. #46 pointed to the penne entree on h/her plate and stated, this is not lasagna.</p> <p>Res.#35 reported in addition to not receiving the scheduled lasagna entree, h/her menu listed tossed salad with Parmesan ranch dressing, and s/he received no salad.</p> <p>Res.#38 reported in addition to not receiving the scheduled lasagna entree, h/her menu listed tossed salad with Parmesan ranch dressing, and s/he received no salad. Res.#38 stated Why didn't I get my salad? This happens all the time. The resident reported s/he requested salad with dinner and s/he received beets instead.</p> <p>Res.#4 reported in addition to not receiving the scheduled lasagna entree, h/her menu listed garlic bread and s/he did not receive any.</p> <p>During the Dinner meal service on 8/5/24, kitchen staff were interviewed and stated that they ran out of salad and served beets instead. The Kitchen staff stated that the residents receiving the substitutions were not notified in advance.</p> <p>An observation was made of the facility's Breakfast meal on 8/6/24. Per review of the facility's posted menu for 8/6/24, as well as the individual printed menus handed to residents, Breakfast meal items available included 1 banana per resident, yogurt, and oatmeal. Random residents were interviewed in resident rooms and in the facility's dining room during Breakfast on 8/6/24.</p> <p>Res.#33 reported s/he received no banana as listed on h/her menu.</p> <p>Res.#25 reported s/he received no yogurt or banana as listed on h/her menu.</p> <p>Res.#28 reported s/he received no oatmeal or banana as listed on h/her menu.</p> <p>Per Interview with Resident #34 on 8/5/2024 at 2:30 PM s/he stated that the facility runs out of several food items including ginger ale toward the end of the week. S/He stated the facility is sometimes out of items for several days. S/he stated, I look forward to the food truck delivery.</p> <p>Per interview with the Dietary Manager [DM] on 8/6/27 at 10:15 AM, the DM reported that</p> <p>(continued on next page)</p>		

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<p>F 0800</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>current produce deliveries contained amounts of unusable items, such as rotted lettuce and ripe bananas that quickly spoiled, which contributes to the menu items shortages and substitutions.</p> <p>The DM stated that menu changes and substitutions are relayed to Nursing staff in a daily 'morning meeting', with the changes to be passed on to the residents. An interview was conducted with a Staff Registered Nurse [RN] on 8/7/24 at 9:07 AM. The RN stated that no menu changes are communicated to nursing staff during the daily interdisciplinary team morning meeting. The RN stated, I don't want to rat anyone out, but that doesn't happen.</p> <p>Per interview with the Dietary Manager [DM] on 8/6/27, the DM reported residents should receive all items on their menu to ensure their dietary requirements are fulfilled. The DM stated that if an item is not available, an item of similar nutritional value should be substituted. The Dietary Manager stated that items missing from residents' meals shouldn't happen.</p>		

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<p>F 0801</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician.</p> <p>29776</p> <p>Based upon interview and record review, the facility failed to ensure that if a qualified dietitian or other clinically qualified nutrition professional is not employed full-time, the facility must designate a person to serve as the director of food and nutrition services, and that director must meet certain required qualifications. Findings include:</p> <p>Food safety certification is a formal recognition of an individual's knowledge and competency in food safety practices. It serves as proof that an individual has completed a recognized food safety training program and has demonstrated the necessary skills to handle food safely. Food safety certification is often required by regulatory authorities and can be a legal requirement for certain positions, such as food managers.</p> <p>Obtaining food safety certification enhances an individual's credibility and demonstrates the organization's commitment to food safety. Having trained managers in place helps to ensure that food safety practices are consistently followed, reducing the risk of foodborne illnesses and maintaining a safe workplace environment. (https://alwaysfoodsafes.com/en/benefits-food-safety-training)</p> <p>An interview was conducted with the facility's Dietitian on 8/7/24 at 2:20 PM. The Dietitian stated that s/he works at the facility on a part-time basis, along with several other facilities, and is present at the facility one day a week.</p> <p>An interview was conducted with a facility staff member on 8/5/24 at 10:30 AM. The staff member identified h/herself as the Dietary Manager and stated that h/she had been the Dietary Manager for the past year and was currently working on h/her certification for the position, which h/she reported they were halfway through. Per review of the facility's Department Heads phone list, the staff member interviewed is listed as the facility's Dietary Manager two times on the list. The phone list is marked as updated 8/1/24 by the Regional Market President-Operations. Per interview with the facility's Dietary Manager, s/he had not yet obtained the required certification and/or qualifications to ensure that food safety practices are consistently followed at the facility.</p>

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<p>F 0803</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>29776</p> <p>Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident.</p> <p>Based upon observation, interview, and record review, the facility failed to follow the Dinner Menu on 8/5/24 as posted, and the change was not noted or updated on the menu and residents were not notified of the change. Findings include:</p> <p>Per review of the facility's posted Dinner menu for 8/5/24, as well as the individual printed menus handed to residents, the Dinner meal for 8/5/24 was posted as Beef Lasagna [1 square] with marinara sauce.</p> <p>Observations were made of residents in their rooms during the dinner service and in the dining room during the facility's Dinner meal on 8/5/24.</p> <p>Per observation, the main entree being served was penne pasta [a type of pasta with tubular pieces, with ends cut at an angle] with meat sauce and/or plain penne. No resident was observed receiving the scheduled Beef Lasagna with marinara sauce for the Dinner meal.</p> <p>Random residents were interviewed in resident rooms and in the facility's dining room during Dinner on 8/5/24. Res. #46 pointed to the penne entree on h/her plate and stated, this is not lasagna. The resident stated s/he would have preferred lasagna and had not been notified that the lasagna would not be served.</p> <p>Per interview on 8/5/24, Residents #35, #38, & #4 reported they had anticipated lasagna for dinner, and had not been notified that the lasagna would not be served.</p> <p>An interview was conducted on 8/6/27 at 10:15 AM with the facility's Dietary Manager.</p> <p>The Dietary Manager confirmed that the posted Dinner menu for 8/5/24 was Beef Lasagna with marinara sauce. The Dietary Manager also confirmed the menu was changed prior to Dinner, and the change was not noted or updated on the menu and residents were not notified of the change.</p>		

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<p>F 0806</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options.</p> <p>29776</p> <p>Based upon observation, interview, and record review, the facility failed to effectively provide and communicate alternate food choices and appealing meal options to residents who choose not to eat food that is initially served. Additionally, the facility failed to provide options based on resident's food preferences. Findings include:</p> <p>Observations were made of the facility's meal services on 8/5, 8/6, & 8/7/24. Random residents were interviewed in resident rooms and in the facility's dining room during the meal services.</p> <p>Per interview with Resident #18 on 8/5/24 at 4:00 PM s/he stated the kitchen runs out of food items and salad sometime is just Lettuce. Resident #18 stated s/he is not offered a choice prior to the meal, and any alternative is only offered after s/he declines the meal served.</p> <p>An interview was conducted with Res. #33 on 8/6/24 at 8:45 AM. Per observation the resident was in bed eating breakfast. His/her roommate was eating scrambled eggs. Res.#33 said s/he wished s/he got eggs for breakfast. The resident stated 'no one ever asks' what s/he likes to eat.</p> <p>Per Interview with Resident #6 on 8/6/24 at 1:00 PM, S/He stated that s/he is only offered a grilled cheese as an alternative. Resident #6 stated I do not like grilled cheese. Per observation of Resident #6's lunch tray on 8/6/24, the resident did not consume food on his/her plate including the grilled cheese sandwich.</p> <p>Per interview with Res.#20 and Res. #47 on 8/7/24 at 9:50 AM, the roommates reported that they are not given any notice of upcoming meal options. Both residents stated there was no notice ahead of time about what was to be served and had no way of knowing what the alternatives were if they didn't like that meal's offering.</p> <p>An interview was conducted on 8/6/27 at 10:15 AM with the facility's Dietary Manager. The Dietary Manager stated that residents can request a meal option any time during the day. The Dietary Manager reported that residents can tell a Licensed Nurse's Aide [LNA] their order ahead of any meal. Per interview with a staff LNA on 8/7/24 at 2:40 PM, the LNA stated that 'it was too much of a hassle to ask residents what they want because we are short staffed', and there is not enough staff to ask residents what they want for meals.</p> <p>An interview was conducted with the facility's Dietitian on 8/7/24 at 2:20 PM. The Dietitian stated that the facility does not ask residents what they would like for meals or alternatives, the facility bases the meals choices on the resident's Preference List. [Per interview with the District Manager and confirmed by record review, the Preference List does not ask residents what foods they prefer: it asks what foods they dislike]. The Dietitian stated there is no formal process to ask residents if they want something other than what is posted as that day's meal item. The Dietitian stated that asking residents if they want something different is not what [the facility's corporate ownership] wants us to do.</p> <p>(continued on next page)</p>		

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<p>F 0806</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Per interview on 8/7/24 at approximately 2:40 PM, an LNA stated that there are not enough staff to give residents a choice in what they would like to eat prior to meals being served. S/He explained that it is too much of a hassle to ask residents what they want to order for because they are short staffed, especially after 3:00 PM.</p> <p>An interview was conducted with the facility's dietary District Manager on 8/7/24 at 3:03 PM. The District Manger stated that the facility does not print out or share with the residents the alternative menu: residents have to ask what they have as an option. The District Manager further stated that the facility serves residents food based on their dislikes, not their preferences.</p>		

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<p>F 0925</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Make sure there is a pest control program to prevent/deal with mice, insects, or other pests.</p> <p>29776</p> <p>Based upon observation and interview, the facility failed to ensure effective pest control was maintained related to an open window without a screen adjacent to food preparation areas. Findings include:</p> <p>During the initial tour of the kitchen on 8/5/24 at 10:30 AM, an open window was observed without a screen. The screenless window was adjacent to food preparation areas in the kitchen.</p> <p>An interview was conducted with the facility's Dietary Manager on 8/6/24 at 9:08 AM. The Dietary Manager confirmed that the window was without a screen and adjacent to food preparation areas. The Dietary Manager stated that the open window should have a screen as a preventative measure to inhibit insects and common pests from entering the kitchen and triggering infection control issues.</p>