STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	475020	A. Building B. Wing	03/01/2024

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46135 Based on interview and record review, the facility failed to protect the residents' right to be free from sexual abuse by a resident for 2 applicable residents (Resident #31 and #38). Findings include: Per record review, Resident #28 was admitted to the facility on [DATE] with diagnoses that include chronic pain, epilepsy, depression, and anxiety. Resident #28's care plan states s/he has the potential to demonstrate verbal behaviors related to: History of verbal outbursts directed toward others (e.g., use of abusive language, pattern of challenging/confrontational verbal behavior), Ineffective coping skills, i.e., poor anger management, revised 2/11/24, with an intervention to monitor and report any of the following behaviors; verbal outbursts directed toward others (e.g., use of abusive language, pattern of challenging/confrontational verbal behavior), Ineffective coping skills, i.e., poor anger management, revised on 8/8/23. Per a 2/10/24 progress note, Resident #28 was having abnormal behaviors. 2/12/24 behavior notes reveals At 04:45am resident noted storming up and down the hall and between both units exit seeking, going into another residents room yelling vulgar language, attempted to redirect resident, however resident continue to yell and use profanity toward the staff on the hall. A 2/12/24 Nurse Practitioner (NP) note that s/he is seen for acute behaviors and Early this morning [s/he] was seen ambulating the hallways, yelling profanities at staff, and going into other residents' rooms. The following day, 2/13/24, the NP wrote, [S/he] is seen for an acute visit for continued behaviors. This morning it was reported that patient was found in a [gender omitted] resident's room with his/her pants down and was touching himself/herself inappropriately. This weekend [s/he] was also wandering in rooms, yelling at staff (names and racial slurs) and being difficult to redirect. [S/he] was also seen touching another resident's face . Based on this escalation and concern for safety of residents and [himself/herself] will send patient to emergency department for further workup. There is no documentation in Resident #28's medical record from the nurse that witnessed Resident #28's inappropriate sexual behavior. (continued on next page)

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Per interview on 3/1/24 at 10:38 PM, Licensed Nurse #1, the nurse that was working on Resident #28's unit on the 2/12/24-2/13/24 night shift, explained that when s/he came on for his/her shift, there were no new interventions in place for Resident #28's newly increased behavior. S/He explained that while working this shift, Resident #28 had taken their pants down in the middle of the hall a few times. S/He explained that Resident #28 should have been on 1 to 1 supervision at that point because the resident 's behaviors had increased and s/he was unable to supervise Resident #28 when s/he was providing care for other residents. When asked about Resident #28's sexually inappropriate behaviors, Licensed Nurse #1 explained that around 3 am in the morning s/he was helping another resident when s/he heard the door across the hall close. About 5 minutes later, s/he walked into the hall and heard Resident #38 yell get out, get out. She opened Resident #38's door and found Resident #28 laying on the floor masturbating. She was unable to determine what Resident #38 or his/her roommate Resident #31 saw, or if either of them were touched by Resident #28. S/He explained that s/he reported this event to the Unit Manager, the Nurse Educator, and Licensed Nurse #2. Per interview on 3/1/24 at 9:35 AM, the Administrator explained that the above event was reported to the team while investigating a separate resident to resident altercation involving Resident #28 but did not investigate it. See F 609 for more information.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. 46135 Based on interview and record review, the facility failed to ensure that allegations involving abuse are reported no later than 2 hours to the Administrator of the facility and the State Survey Agency for 2 applicable residents (Resident #31 and #38). Findings include: Per interview on 3/1/24 at 10:38 PM, Licensed Nurse #1, explained that s/he witnessed Resident #28 masturbating in Resident #31 and #38's room around 3:00 AM on 2/13/23. See F600 for more information. S/He explained that s/he reported this event to the Unit Manager, the Nurse Educator, and Licensed Nurse #2 (Licensed Nurse #1's replacement at change of shift). Per interview on 3/1/24 at 9:10 AM, the Administrator explained that s/he became aware of Resident #28's sexually inappropriate behavior while investigating while investigating a separate resident to resident altercation involving Resident #28. This statement, taken by Licensed Nurse #2 on 2/13/23, states When I came in this morning to take report form the night nurse, I was told that [Resident #28] was found in another [gender omitted] resident's room masturbating on the floor between the bed and the window. That [gender omitted] patient did not appear to be aware that [s/he] was in the room according to the night nurse. At 9:35 AM, the Administrator stated s/he did not believe the facility investigated or reported this event because they did not believe it to be a reportable event. When asked if a statement was ever taken from the nurse that witnessed this event, s/he did not believe so but would have to check with the Director of Nursing. Per interview on 3/1/24 at 9:40 AM, The DON confirmed that s/he did not interview anyone else about Resident #28's sexually inappropriate behavior. On 3/1/24 at 11:50 AM, the Administrator confirmed that neither the Nurse Educator nor the Unit Manager had reported his event to him/her.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. 46135 Based on interview and record review, the facility failed to initiate and investigate an investigation of an alleged violation of sexual abuse for 2 applicable residents (Resident #31 and #38). Findings include: Per record review of a facility investigation of an allegation of resident to resident physical abuse, a statement taken on 2/13/23 from Licensed Nurse #2 states When I came in this morning to take report form the night nurse, I was told that [Resident #28] was found in another [gender omitted] resident's room masturbating on the floor between the bed and the window. That [gender omitted] patient did not appear to be aware that [s/he] was in the room according to the night nurse. Per interview on 3/1/24 at 10:38 PM, Licensed Nurse #1 confirmed that s/he found Resident #28 in Resident #31 and #38's room masturbating around 3:00 AM on 2/13/24. S/He explained that while s/he did not know how much Residents #31 or #38 saw of Resident #28's behavior or if Resident #28 had other inappropriate behaviors, s/he is sure that at least Resident #38 was upset and yelling get out, get out. S/He indicated that no facility staff ever followed up with her about witnessing this event. See F600 for more information. Per interview on 3/1/24 at 9:40 AM, The DON confirmed that s/he did not interview anyone else about Resident #28's sexually inappropriate behavior and did not investigate this event further. On 3/1/24 at 11:50 AM, the Administrator confirmed that there were no nursing notes about this event in Resident #28, #31, or #38's medical record. S/He also confirmed that neither Residents #31 nor #38 were assessed, evaluated, or monitored regarding the event.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 29776 Based upon observation, interview, and record review, the facility failed to ensure the environment was free of accident hazards for 1 resident [Res.#11] of 34 sampled residents. Findings include: Per record review, Res.#11 was admitted to the facility on [DATE] with diagnoses that include 'Hemiplegia and Hemiparesis following Cerebral Infarction affecting Right dominant side' [complete paralysis and partial weakness after a stroke affecting the right side of the body]. Per review of Progress Notes for Res.#11, on 11/5/23, Res.#11 was evaluated for a blister after burn from coffee spillage on left inner thigh area. Blister is now broken, 2 by 2 centimeters and patient is in burning pain. Res.#11's Care Plan identified the resident as requires assistance/is dependent for Activities of Daily Living care related to: generalized weakness, impaired mobility. After the blistering burn from the coffee spill, the intervention Ensure resident is provided with coffee cup with secured lid was added to the Care Plan to prevent future burns. Per observation on 2/26/24, Res.#11 was observed eating dinner in their room. On their dinner tray was a cup of coffee with no lid. There was no lid visible on the tray or table. Next to the cup of coffee was the resident's dinner menu, which included the note in capital letters ALL DRINKS MUST HAVE A LID. Per observation on 2/27/24 and on 2/28/24, Res.#11 was again served hot coffee without a secured lid. An interview was conducted with 3 Licensed Nurses' Aides [LNAs] on 2/28/24. The first LNA was serving hot drinks to residents in their rooms, including Res.#11, and the other 2 LNAs were serving hot drinks to residents in the main dining area. All 3 LNAs stated that the facility's coffee mugs did not have lids and there were no such lids available. An interview was conducted with the facility's Corporate Clinical Specialist on 2/28/24 at 9:02 AM. The Corporate Clinical Specialist confirmed the resident had a history of burns from spilled coffee and due to their stroke was at risk for future burns during meals. The Corporate Clinical Specialist confirmed Res. #11's Care Plan included the intervention to provide a secured lid to the resident's coffee to prevent burns, and that the intervention was not being followed. At 9:24 AM on 2/28/24, the Corporate Clinical Specialist reported that lids had been available for the resident's coffee but had not been used.

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care or services that was trauma informed and/or culturally competent. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46135 Based on interview and record review, the facility failed to Identify a resident's past history of trauma, and/or triggers which may cause re-traumatization for 3 applicable residents (Residents #22, #31, and #28). Findings include: 1. Per record review, Resident #22, age 93, was admitted to the facility on [DATE] with diagnoses that include dementia, anxiety, and depression. Per interview on 2/26/24 at 11:12 AM, Resident #22 said that s/he is very sad. S/He explained that his/her past was hard and at one point was held against his/her will and pressured into religion and became teary. Later in the interview Resident #22 expressed frustration and anger that the facility will not let him/her go outside and said it feels like they keep him/her in his/her room all the time. S/He stated, people here don't give a [explicative] about me. All I do is go to the bathroom, eat, and watch TV. Per review of Resident #22's transfer of care note, his/her active problem list, which was signed by a physician on 9/30/23, includes a diagnosis of post-traumatic stress disorder (PTSD) since 6/25/1999. The first mention of Resident #22 having PTSD in his/her medical record is in a 12/22/23 physician note. Resident #22 does not have a care plan for PTSD and does not have any triggers identified in his/her care plan or medical record. Per interview on 2/27/24 at 12:54 PM, the Social Service Specialist (SSS) explained that s/he was unaware of Resident #22's diagnosis for PTSD. 2. Record review reveals that Resident #31 has diagnoses that include dementia with agitation, PTSD, dysphagia (difficulty swallowing), ataxia (poor muscle control that can affect speech) and bipolar. Resident #31's care plan states, [Resident #31] reports past experience of trauma as evidenced by: [diagnosis] of PTSD, revised 5/21/23, but does not have any triggers identified within the care plan. Per interview on 2/28/24 at approximately 3:30 the Market Clinical Lead confirmed that Resident #31 does not have adequate, person centered care plan interventions related to trauma. 3. Per record review, Resident #28 was admitted to the facility on [DATE] with diagnoses that include chronic pain, epilepsy, depression, and anxiety. Per interview on 3/1/24 at 11:50 AM, Resident #28 indicated that s/he had some bad things happen in her past and then quickly changed the subject. Being cautious, this surveyor did not ask follow up questions, to prevent the conversations from becoming triggering. A social service assessment used to screen for PTSD was completed on 8/1/23, 8/31/23, and 10/27/23. All three assessments coded Resident #28 as negative for trauma. The screening tool used is a two question assessment that asks the resident if they have experienced any consequences from trauma in the past month. It does not ask the resident if they have experienced trauma at any point in their past. (continued on next page)

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Per interview on 2/27/24 at 12:54 PM, the SSS confirmed that the only screening that s/he did for trauma was ask the two questions above. S/He explained that there are no other screening tools that s/he uses to assess for trauma and s/he does not ask resident's family's directly about trauma. S/He explained that s/he usually will know if a resident has trauma because it is in their medical record or nursing staff will inform him/her. S/He explained that this is the system because s/he is not a licensed social worker; the facility did not have a social worker after August 2023.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46135 Based on observation, interview, and record review, the facility failed to ensure that records are complete, accurately documented, readily accessible, and systematically organized related to dental records for all residents and medication reviews for 3 of 5 sampled residents (Residents #16, #32, and #31). Findings include: 1. Per interview on 2/26/24 at 10:39 AM, Resident #28, admitted to the facility on [DATE], explained that they had been seen at the facility by a dentist in regard to getting him/her bottom dentures. Per review of Resident #28's medical record, there were no dentist notes that documented that s/he had been seen by a dentist or that a plan was made to get him/her bottom dentures. On 2/28/24 at 3:22 PM, the Administrator showed this surveyor a large binder that contained notes for all the residents seen by the dentist. S/He explained that the Dentist had asked that notes all be kept in the same spot. The Administrator confirmed that all residents' dental records, including Resident #28, were not kept in their medical record and should be. 2. Record review reveals that monthly pharmacist medication reviews with identified irregularities and medication recommendations and documentation that the attending physician has reviewed the recommendation and their action based on the recommendation, were not included in Resident #16, #32, and #31's medical record. The following were missing: Resident #16's medical record was missing pharmacist recommendations and physician reviews of these recommendations on 7/19/23, 11/15/23, and 12/12/23. Resident #32's medical record was missing pharmacist recommendations and physician reviews of these recommendations on 7/18/23, 8/21/23, and 12/21/23. Resident #31's medical record was missing pharmacist recommendations and physician reviews of these recommendations 9/19/23, 12/21/23, and 2/5/24. Per observation on 02/28/24 at 8:45 AM, the Director of Nursing was heard talking to other staff about reaching out to the pharmacy for the pharmacist reviews because they do not have them all in the facility. Per interview on 2/28/24 at approximately 5:00 PM, the Administrator confirmed that the above reviews were not in the resident's medical record.