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	01/20/2022

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. 29776 Based upon observation and interview, the facility failed to provide a safe, clean, comfortable, and homelike environment for 4 residents [Res. #6, #7, #8 & #9] of 12 sampled residents. Findings include: 1.) An observation of the bathroom for Res. #6 & #7 was conducted on 1/4/22 at 10:08 AM. Per observation, the bathroom did not contain a toilet. A white circular plastic disc was observed on the floor, covering the opening where a toilet would be attached. Next to the white plastic disc were crumbled paper towels and/or toilet tissue. In place of the toilet, above the white circular disc was a gray plastic and metal bedside commode. Inside the commode urine and feces were visible. Crumbled paper towels and/or toilet tissue were hanging from the right front leg of the commode. To the left of the commode on the wall was an empty toilet tissue dispenser. In the right corner of the bathroom inside the doorway was a small mound of crumbled paper towels and/or toilet tissue on the floor. There was no trash receptacle in the bathroom. Above the sink, attached to the right wall was a paper towel dispenser. On top of the dispenser was an empty clear plastic cup lying sideways, and a crumbled paper towel. An interview was conducted with the facility's Director of Nursing [DON] and the facility's Corporate Clinical Director [CCD] on 1/4/22 at 10:17 AM. Both the DON and CCD viewed and confirmed the observation of the condition of the residents' bathroom. 2.) An observation was conducted of Res. #8's room on 1/4/22 at 10:27 AM. From the doorway of the resident's room, liquid was visible on the floor underneath the resident's bed. The room had a strong urine odor. Upon entering the room, yellow liquid was visible on the floor on the right side of the resident's bed, stretching from below the foot of the bed to head of the bed, reaching from the far wall of the room to underneath the bed, approximately 3 feet in width and 7 feet in length. A large wet area was visible on the fitted bed sheet on the right side of the resident's bed. The resident was awake, lying in bed, with no shirt on and his lower body covered by a bed sheet. On the resident's bedside table was a tray with a dirty empty plate. When questioned the resident was confused but able to answer appropriately. The resident could not state what had happened regarding the yellow liquid on the floor. The resident reported staff had come into his room and delivered his breakfast tray and did not say anything about the liquid on the floor. (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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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview was conducted with a Staff Licensed Nurses Aide [LNA] on 1/4/22 at 10:35 AM. The LNA reported that Res. #8 urinates on the floor, stating Unfortunately, he just does that. Per observation, there were no housekeeping staff present on the unit at the time of the observation. 3.) An observation was conducted of Res. #9's room on 1/4/22 at 9:58 AM. The resident's bedside table was observed to have an area of dried spilled liquid, with paper straw wrappers stuck to the surface. On the floor next to the resident's bed was a small basket of artificial flowers. Next to the basket on the floor was a blue surgical mask, and the resident's call bell and wires. Per observation on 1/4/22 at 4:57 PM, the basket, surgical mask, and resident's call bell remained on the floor as first observed 7 hours earlier.

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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 0656 Level of Harm - Actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 29776 Based upon interview and record review, the facility failed to implement a comprehensive person-centered care plan to meet a resident's medical, nursing, and mental and psychosocial needs for 1 resident [Res. #10] of 12 sampled residents. Findings include: Review of Res. #10's medical record reveals the resident's extensive diagnoses include Multiple Sclerosis, quadriplegia, neuromuscular dysfunction of the bladder, pressure ulcer of the left hip, chronic pain, major depressive disorder, Atherosclerotic vascular disease, and anemia. Per review of Res. #10's Care Plan, the resident is identified as 'at risk for Pain related to Diagnosis of Multiple Sclerosis, with interventions that include 'Complete pain assessment per protocol' and 'Administer pain medication as per MD orders and note the effectiveness'. Review of Physician Orders for Res. #10 reveals a medication order for 'Morphine Sulfate tablet by mouth two times a day related to Chronic Pain.' The pain medication administration was ordered to begin on 12/22/21 at 9:00 PM. For the next 9 days, the pain medication was to be administered 17 times: per record review, the morphine was administered as ordered only twice. The Medication Administration Record [MAR] reveals a numeric code ['16'] entered for the 15 times the morphine was not given, directing to Hold/See Nurses Notes. Review of Nurses Notes for the 15 times the morphine was not given reveal either no note, notes that simply repeat the order, or entries including ordered, on order, not available, not sent by pharmacy, and not received from pharmacy- there is no documentation that the physician was notified that the medication for Chronic Pain was not received and not administered as ordered. On 12/27/21, 6 days after the medication was to have been started, a Nurses Note reads not available from pharmacy, will contact doctor today for new RX. The next time the morphine is due, the medication is again not given and is noted as ordered with no further explanation. Further review of Res. #10's MAR reveals the resident's pain level ordered to be monitored, on a scale of 0 to 10, with 0=no pain, and 10=worst pain. During the time the resident was ordered to be receiving Morphine for pain but received none, the resident's pain level on 12/23 was measured as '9 out of 10', on 12/24 a '6' two times, and on 12/25 '7 out of 10'. Per review of Physician Orders for Res. #10, orders include 'Monitor for pain every shift'. Per review of the resident's Medication Administration Record [MAR] for December 2021, there are spaces on 12/23, 12/24, 12/29, 12/30, 12/31/21 where nursing would initial that the monitoring and assessment was completed as ordered but are left blank. Physician orders also include 'Lidocaine Gel 2 % Apply to buttocks topically every shift for pain'. Per review of the resident's Medication Administration Record [MAR] for December 2021, there are spaces on 12/6, 12/14, 12/15/21 where nursing would initial that the medication or treatment was administered as ordered but are left blank. (continued on next page)

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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 0656 Level of Harm - Actual harm Residents Affected - Few	Per review of Res. #10's Care Plan, the resident is identified as 'requires indwelling catheter related to: Neurogenic bladder', with interventions that include 'Provide Catheter care as per physician order'. Per review of Physician Orders for Res. #10, orders include 'Foley Catheter Care every shift for Urinary Elimination'. Per review of the resident's Treatment Administration Record [TAR] for December 2021, there are spaces on 12/3, 12/6, 12/10, 12/12, 12/14, 12/15, 12/19, 12/24, 12/25, 12/26, 12/27, 12/28, 12/29, 12/30, 12/31/21 where nursing would initial that the treatment was completed as ordered but are left blank. Per review of Res. #10's Care Plan, the resident is identified as 'at risk for altered cardiovascular status related to Hypertension, Atherosclerotic vascular disease' with interventions that include 'Administer oxygen as ordered by the physician.' Per review of Physician Orders for Res. #10, orders include 'Oxygen @ 2 Liters continuous per nasal cannula every shift related to Acute and Chronic Respiratory Failure with Hypoxia.' Per review of the resident's Medication Administration Record [MAR] for December 2021, there are spaces on 12/6, 12/14, 12/15/21 where nursing would initial that the medication or treatment was administered as ordered but are left blank. Per review of Res. #10's Care Plan, the resident is identified as having 'a Stage 3 pressure ulcer on Left ischial tuberosity [hip] related to Immobility related to diagnoses of Multiple Sclerosis and Functional Quadriplegia and Chronic pain', with interventions that include 'Administer treatments as ordered'. Per review of Physician Orders for Res. #10, orders include 'Wound care: for left hip wound- cleanse with wound cleanser and use q tip to dry inside of wound. skin prep outside skin around the wound. Pack wound with collagen rope with silver (Ag) and cover with a bordered adhesive foam daily.' Per review of the resident's Treatment Administration Record [TAR] for December 2021, there are spaces on 12/1, 12/4, 12/5, 12/6, 12/7/21 where nursing would initial that the treatment was completed as ordered but are left blank. Further review reveals the wound care was advanced to two times a day, with spaces on the TAR for 12/10, 12/14, 12/15, 12/23, 12/24, 12/25, 12/26, 12/27, 12/28, 12/29, 12/30, 12/31/21 where nursing would initial that the treatment was completed as ordered but are left blank. Additionally, Physician Orders for Res. #10 include 'For skin damage on scrotum, buttocks, and sacrum, please mix together equal parts lidocaine 2% jelly, barrier cream, and collagen crystals, and apply to affected areas. every shift'. Per review of the resident's Treatment Administration Record [TAR] for December 2021, there are spaces on 12/3, 12/6, 12/10, 12/12, 12/14, 12/15, 12/19, 12/24, 12/25, 12/26, 12/27, 12/28, 12/29, 12/30, 12/31/21 where nursing would initial that the treatment was completed as ordered but are left blank. Further record review reveals no documentation regarding why any of the medications and/or treatments listed above were not administered as ordered and per the resident's plan of care. (continued on next page)

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F 0656 Level of Harm - Actual harm Residents Affected - Few	An interview was conducted with the Staff Nurse on Res. #10's unit on 1/4/22 at 1:37 PM. The Staff Nurse confirmed the blank spaces in Res. #10's treatment record and the absence of documentation regarding completion of treatment and implementation of physician orders. The Staff Nurse confirmed there should be no blanks spaces on any resident's TAR. The Staff Nurse confirmed the TAR should be initialed if the treatment or assessment was completed, or there should be documentation as to whether the treatment and assessments were not completed as ordered, but there was none.

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F 0658 Level of Harm - Actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. 29776 Based upon observation, interview, and record review, the facility failed to ensure services provided met professional standards of quality regarding resident medications administered as ordered, treatments administered as ordered, and assessments completed as ordered for 1 resident [Res.# 10] of 12 sampled residents. Findings include: Review of the American Nurses Association's Standards of Professional Nursing Practice (Nursing: Scope and Standards of Practice (wordpress.com)) reveals: The Standards of Professional Nursing Practice are authoritative statements of the duties that all registered nurses, regardless of role, population, or specialty, are expected to perform competently. Under 'Standard 5. Implementation: -The registered nurse implements the identified plan. - Implements the plan in a timely manner in accordance with patient safety goals. -Documents implementation and any modifications, including changes or omissions, of the identified plan'. Review of Res. #10's medical record reveals the resident's extensive diagnoses include Multiple Sclerosis, quadriplegia, neuromuscular dysfunction of the bladder, pressure ulcer of the left hip, chronic pain, major depressive disorder, Atherosclerotic vascular disease, and anemia. Per review of Res. #10's Care Plan, the resident is identified as 'at risk for Pain related to Diagnosis of Multiple Sclerosis, with interventions that include 'Complete pain assessment per protocol' and 'Administer pain medication as per MD orders and note the effectiveness'. (continued on next page)

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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 0658 Level of Harm - Actual harm Residents Affected - Few	Review of Physician Orders for Res. #10 reveals a medication order for 'Morphine Sulfate tablet by mouth two times a day related to Chronic Pain.' The pain medication administration was ordered to begin on 12/22/21 at 9:00 PM. For the next 9 days, the pain medication was to be administered 17 times: per record review, the morphine was administered as ordered only twice. The Medication Administration Record [MAR] reveals a numeric code ['16'] entered for the 15 times the morphine was not given, directing to Hold/See Nurses Notes. Review of Nurses Notes for the 15 times the morphine was not given reveal either no note, notes that simply repeat the order, or entries including ordered, on order, not available, not sent by pharmacy, and not received from pharmacy- there is no documentation that the physician was notified that the medication for Chronic Pain was not received and not administered as ordered. On 12/27/21, 6 days after the medication was to have been started, a Nurses Note reads not available from pharmacy, will contact doctor today for new RX. The next time the morphine is due, the medication is again not given and is noted as ordered with no further explanation. Further review of Res. #10's MAR reveals the resident's pain level ordered to be monitored, on a scale of 0 to 10, with 0=no pain, and 10=worst pain. During the time the resident was ordered to be receiving Morphine for pain but received none, the resident's pain level on 12/23 was measured as '9 out of 10', on 12/24 a '6' two times, and on 12/25 '7 out of 10'. Per review of Physician Orders for Res. #10, orders include 'Monitor for pain every shift'. Per review of the resident's Medication Administration Record [MAR] for December 2021, there are spaces on 12/23, 12/24, 12/29, 12/30, 12/31/21 where nursing would initial that the monitoring and assessment was completed as ordered but are left blank. Physician orders also include 'Lidocaine Gel 2 % Apply to buttocks topically every shift for pain'. Per review of the resident's Medication Administration Record [MAR] for December 2021, there are spaces on 12/6, 12/14, 12/15/21 where nursing would initial that the medication or treatment was administered as ordered but are left blank. Per review of Res. #10's Care Plan, the resident is identified as 'requires indwelling catheter related to: Neurogenic bladder', with interventions that include 'Provide Catheter care as per physician order'. Per review of Physician Orders for Res. #10, orders include 'Foley Catheter Care every shift for Urinary Elimination'. Per review of the resident's Treatment Administration Record [TAR] for December 2021, there are spaces on 12/3, 12/6, 12/10, 12/12, 12/14, 12/15, 12/19, 12/24, 12/25, 12/26, 12/27, 12/28, 12/29, 12/30, 12/31/21 where nursing would initial that the treatment was completed as ordered but are left blank. Per review of Res. #10's Care Plan, the resident is identified as 'at risk for altered cardiovascular status related to Hypertension, Atherosclerotic vascular disease' with interventions that include 'Administer oxygen as ordered by the physician.' (continued on next page)

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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 0658 Level of Harm - Actual harm Residents Affected - Few	Per review of Physician Orders for Res. #10, orders include 'Oxygen @ 2 Liters continuous per nasal cannula every shift related to Acute and Chronic Respiratory Failure with Hypoxia.' Per review of the resident's Medication Administration Record [MAR] for December 2021, there are spaces on 12/6, 12/14, 12/15/21 where nursing would initial that the medication or treatment was administered as ordered but are left blank. Per review of Res. #10's Care Plan, the resident is identified as having 'a Stage 3 pressure ulcer on Left ischial tuberosity [hip] related to Immobility related to diagnoses of Multiple Sclerosis and Functional Quadriplegia and Chronic pain', with interventions that include 'Administer treatments as ordered'. Per review of Physician Orders for Res. #10, orders include 'Wound care: for left hip wound- cleanse with wound cleanser and use q tip to dry inside of wound. skin prep outside skin around the wound. Pack wound with collagen rope with silver (Ag) and cover with a bordered adhesive foam daily.' Per review of the resident's Treatment Administration Record [TAR] for December 2021, there are spaces on 12/1, 12/4, 12/5, 12/6, 12/7/21 where nursing would initial that the treatment was completed as ordered but are left blank. Further review reveals the wound care was advanced to two times a day, with spaces on the TAR for 12/10, 12/14, 12/15, 12/23, 12/24, 12/25, 12/26, 12/27, 12/28, 12/29, 12/30, 12/31/21 where nursing would initial that the treatment was completed as ordered but are left blank. Additionally, Physician Orders for Res. #10 include 'For skin damage on scrotum, buttocks, and sacrum, please mix together equal parts lidocaine 2% jelly, barrier cream, and collagen crystals, and apply to affected areas. every shift'. Per review of the resident's Treatment Administration Record [TAR] for December 2021, there are spaces on 12/3, 12/6, 12/10, 12/12, 12/14, 12/15, 12/19, 12/24, 12/25, 12/26, 12/27, 12/28, 12/29, 12/30, 12/31/21 where nursing would initial that the treatment was completed as ordered but are left blank. Per record review, Nurses Notes include only sporadic references to treatments e.g. 12/25/21 Did not occur. Further record review reveals no explanation regarding why any of the medications and/or treatments listed above were not administered as ordered and per the resident's plan of care, or of the physician being notified that medications and treatments were never received.

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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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. 40258 Based on observations, resident and staff interview, and record review the facility failed to provide sufficient nursing staff to ensure 4 of 4 residents in the applicable sample (Residents #1, #2, # 3, and #4) received timely administration of medications and needed nursing and personal care as directed by physician orders and resident care plans. Findings include: 1. Per review of four residents' time stamped medication administration record (MAR) there are 610 occasions that reflect untimely medication administration. During interview with the UM on 12/3/2021 at 9:30 PM s/he confirmed that medications are not administered timely and that the lack of staff contributes to the untimely medication pass. Per interview with Resident #1 on 1/3/2022 at 11:30 PM there is not enough staff and the staff that do work, work over shifts. When they are short staffed they close the dining room, and take from the activities department for care. That just leaves nothing to do and makes things worse. The residents have to wait a long time for things like medications and care. The resident stated My dressing change was not done for days a while back. Per record review Resident #1 has a wound on her/his left ankle. A physicians order dated 12/9/2021 states cleanse with wound cleanser and pat dry with gauze. Apply honey-infused gauze, and cover with nonadherent superabsorbent dressing, ABD pad and wrap with roller gauze QD (every day) and PRN (as needed). Review of Resident #1's December 2021 treatment record (TAR) reveals that there is no documentation on 12/9, 12/16, 12/20, 2/22, 12/24 , 12/25, 12/26, 12/27, and 12/29/2021 that the dressing was changed. Resident #1 also stated during this interview that medication errors are a big thing. I don't always get my morning pills till afternoon because they are just too busy. This is not good because I take Sinemet (a drug used to treat symptoms of Parkinson's disease, such as slowness, stiffness, shakiness, and imbalance) five times a day for my Parkinson's and when I miss a dose or get it late, I have trouble moving. Then I'm taking it so close together. Per review of Resident #1's time stamped Medication Administration Record (MAR), there were 312 documented occasions that scheduled medications were administered outside the administration parameters in December. 2. Per review of Resident #2's time stamped MAR, there were 79 documented occasions that scheduled medications were administered outside the administration parameters in December 2021. 3. Per interview with Resident #3's family member on 1/6/2022 at 12:30 PM the family had concerns that medications are not always administered timely and sometimes they are given close together. Per review of Resident #3's time stamped MAR, there were 157 documented occasions that scheduled medications were administered outside the administration parameters in December 2021. 4. Per review of Resident #4's time stamped MAR, there were 62 documented occasions that scheduled medications were administered outside the administration parameters in December 2021. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Per interview with the Unit Manager on 1/3/2022 at 9:30 PM due to staff shortages s/he has been filling in on the medication cart over the past few weeks. When asked if s/he has difficultly getting the medications to the residents timely s/he stated that the medication pass is challenging, and confirmed that medications are not always administered timely. Per interview with the A wing nurse on duty on 1/3/2022 at 9:15 PM staffing for the shift consisted of three LNAs until 7:00 PM and then two Aides and her/himself after 7:00 PM. It is impossible to get everything done when it is supposed to get done, and the residents complain that their meds are late and that they have to wait for care. One nurse can't do all the meds and treatments and take care of issues when they happen. Per interview with the Regional Nurse Consultant and Interim Director of Nursing on 12/3/2021 at 9:45 PM the facility has been having difficulty throughout December and especially over the holidays. Several Agency staff's contracts have ended recently and they have not been able to replace them. The week leading up to the holiday was especially bad. Staff did double shifts, the dining room was closed, and the staff from other departments that are also Licensed Nursing Asssistants, including the activity staff was providing care to the residents. The following is a list of medication classes that were listed in this report as having been administered late: Blood Thinners Blood Pressure medications Narcotics Anti-Arrhythmics (heart medications) Allergy Medications Anti-depressants Analgesics both Opioid and non-opioid (Pain medications) Bladder selective muscarinic antagonist (bladder control) Antihypertensives Dietary Supplements Anti-seizure medications Neuropathic pain medications Diuretic medication (to treat excess fluid) Anti-Anxiety medications (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Nutritional Supplements Cholesterol medication (for Hyperlipidemia/high cholesterol) Ammonia Reducer (liver disease) Lidocaine patches Anti-Parkinson medications Glaucoma medications Review of the facility Medication Administration policy and procedure, titled, NSG305 Medication Administration: General revealed the following: Page 1 Purpose To provide a safe, effective medication administration process. Under PRACTICE STANDARDS, #5 Doses will be administered within one hour of the prescribed time unless otherwise indicated by the prescriber. During interview on 1/4/22 at approximately 5:20 PM with the Interim Director of Nursing and Regional Nurse Consultant confirmation was made that it is the policy that all medications will be administered per the facility policy and procedure. Confirmation was also made that the parameters for administering medications is 1 hour before, and no later than 1 hour after the scheduled dose and medications administered outside of these parameters would be considered late.

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F 0760 Level of Harm - Actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. 40258 Based on resident, family, and staff interviews and record review, the facility failed to ensure that three of four resident in the applicable sample were free from significant medication errors. Findings include: Per interview with the Licensed Practical Nurse (LPN) on duty on 1/3/2022 at 9:15 PM It is impossible to get everything done when it is supposed to get done, the residents complain that their meds are late and that they have to wait for care. One nurse can't do all the meds and treatments and take care of issues when they happen. Per interview with the Unit Manager (UM) on 1/3/2022 at 9:30 PM due to staff shortages s/he has been filling in on the medication cart over the past few weeks. The nurse who is responsible for administering medications is also responsible to do treatments including wound care. When asked if it is difficult getting the medications to the residents timely s/he stated the medication pass is challenging. Sometimes they are late. The UM also stated that there needs to be medication reviews done for medication reduction and changes in administration times. Because there have been so many changes in managers and staffing issues it has made it hard to find time to review the meds. 1. During interview on 1/3/2022 at 11:30 PM Resident #1 stated Medication errors are a big thing. Last weekend the nurse almost gave me too much morphine. I watch what they are giving me, like not the right pills. I don't always get my morning pills till afternoon because they are just too busy. This is not good because I take Sinemet (a drug used to treat symptoms of Parkinson's disease, such as slowness, stiffness, shakiness, and imbalance) five times a day for my Parkinson's and when I miss a dose or get it late, I have trouble moving. Then I'm taking it so close together. Per record review Resident #1 has a diagnosis of Parkinson's Disease. A Physicians order for Carbidopa-Levodopa (Sinemet) 25-100 give 2 tablets orally five times a day related to Parkinson's disease that is scheduled to be administered at 6:00 AM, 10:00 AM, 2:00 PM, 6:00 PM, and 8:00 PM. Review of Resident #1's time stamped medication administration record (MAR) revealed that on 12/22/2022 the dose of Carbidopa-Levodopa scheduled to be administered at 10:00 AM was not administered until 1:14 PM. The dose scheduled for 2:00 PM was administered at 2:15 PM one hour after the 10:00 AM dose was administered. The December MAR also reflected that Residnet #1's Sinemet was administered over an hour past the scheduled time 13 times between 12/1- 12/31/2021. 2. Per record review Resident #2 has a diagnosis of Alcoholic Cirrhosis of Liver with Ascites with a physician order for Cholestyramine Packet 4 gm give 2 packets by mouth two times a day for loose stools please remind resident not to take this med at the same time as other meds. The doses are scheduled for 9:00 AM and 9:00 PM. Medications scheduled and administered at the same time as the 9:00 AM and 9:00 PM Cholestyramine include; Carvedilol Tablet 3.125 MG Give 1 tablet by mouth two times a day related to Hypertension (continued on next page)

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	01/20/2022

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 0760 Level of Harm - Actual harm Residents Affected - Few	Gabapentin Tablet 600 MG Give 1 tablet by mouth three times a day for pain Methocarbamol Tablet 500 MG Give 2 tablet by mouth two times a day for muscle spasms Lactulose Solution 20 GM/30 ML Give 67.5 ml by mouth four times a day related to Alcoholic Cirrhosis of the Liver Potassium Chloride ER Tablet Extended Release 20 MEQ Give 2 tablet by mouth one time a day for supplement Cymbalta Capsule Delayed Release Particles 60 MG (DULoxetine HCl) Give 1 capsule by mouth one time a day related to Major Depressive Disorder Magnesium Oxide Tablet 400 MG Give 2 tablet by mouth three times a day for supplement Sodium Bicarbonate Tablet 650 MG Give 1 tablet by mouth three times a day for supplement Administration of Cholestyramine with other medications can interfere with their absorption. It is recommended that Cholestryramine be administered 1 hour prior to or 4 hours after other medications. Resident #2 also has Physician orders for Gabapentin 600 mg by mouth three times a day scheduled for 9:00 AM, 2:00 PM, and 9:00 PM, Enulose Solution 10 gm/15 ml give 68 ml by mouth four times a day 9:00 AM, 12:00 PM, 5:00 PM, and 9:00 PM, and Magnesium Oxide Tablet 400 mg 2 tablets by mouth three times a day 9:00 AM, 2:00 PM, and 8:00 PM Review of the December 2021 time stamped MAR revealed that on 12/21/2021 at 9:16 AM Resident #2 received both 8:00 AM and 12:00 PM doses of Enulose, and both 8:00 AM and 2:00 PM doses of Gabapentin and Magnesium. On 12/22/2021 at 8:03 AM Resident #2 received both 8:00 AM and 12:00 PM doses of Enulose, and both 8:00 AM and 2:00 PM doses of Gabapentin and Magnesium. 3. Per interview with Resident #3's family member on 1/6/2022 at 1:00 PM s/he stated that on 12/26/2021 at 10:00 AM during a visit, s/he noticed that Resident #3 appeared anxious. S/he was told by staff that the resident had been up since 8:00 AM and had not received the scheduled 8:00 AM medications including a scheduled Ativan. The medications were not administered until 11:00AM and the resident received the 1:00 PM dose. The family member also reports that the resident was very agitated and took some time to calm down then became zombie like in the afternoon. Per record review Resident # 3 has diagnoses that include dementia and anxiety. A physician orders dated 11/9/2021 reflects Lorazepam [Ativan] 0.75 mg two times a day for anxiety at 8:00 AM and 12:00 PM, and Lorazepam 0.5 mg at 9:00 PM. The December 26, 2021, time stamped MAR reflects that Resident #3 received the 8:00 AM dose at 10:40 AM. S/he then recieved the 12:00 PM dose at 1:06 PM, with only two hours and 26 minutes between doses. Per the December 2021 time stamped MAR other documented late administration of the physician ordered Ativan is as follows: (continued on next page)

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	01/20/2022

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 0760 Level of Harm - Actual harm Residents Affected - Few	12/6 the dose scheduled for 12:00 PM was administered at 2:12 PM 12/7 the dose scheduled for 12:00 PM was administered at 1:35 PM 12/8 the dose scheduled for 8:00 AM was administered at 10:24 PM 12/11 the dose scheduled for 8:00 AM was administered at 10:10 AM and the 12:00 PM dose was administered at 1:44 PM 12/16 the dose scheduled for 8:00 AM was administered at 10:38 AM and the 12:00 PM dose was administered at 2:08 PM 12/17 the dose scheduled for 8:00 AM was administered at 12:16 PM and the 12:00 PM dose was administered at 2:35 PM 12/21 the dose scheduled for 12:00 PM was administered at 2:30 PM 12/22 the dose scheduled for 8:00 AM was administered at 11:19 AM and the 12:00 PM dose was administered at 2:40 PM 12/23 the dose scheduled for 12:00 PM was administered at 2:00 PM 12/24 the dose scheduled for 12:00 PM was administered at 3:28 PM 12/25 the dose scheduled for 8:00 AM was administered at 10:29 AM and the 12:00 dose was administered at 2:06 PM Review of the facility Medication Administration policy and procedure, titled, NSG305 Medication Administration: General revealed the following: Page 1 Purpose To provide a safe, effective medication administration process. Under PRACTICE STANDARDS, #5. Doses will be administered within one hour of the prescribed time unless otherwise indicated by the prescriber. 5.1.4 If unable to provide the medication9s0 or substitution(s) within one hour of prescribed time, refer to Medication Errors ploicy. Per interview with the Interim Director of Nursing and Regional Nurse Consultant the on 1/4/2022 at Medication Administration policy provided by the facility reflects that medications are to be administered between one hour prior to and one hour after the prescribed scheduled times. Confirmation that medications given outside the hour parameters are considered medication errors was made.