



AGENCY OF HUMAN SERVICES
DEPARTMENT OF DISABILITIES, AGING AND INDEPENDENT LIVING

Division of Licensing and Protection
103 South Main Street, Ladd Hall
Waterbury VT 05671-2306
<http://www.dail.vermont.gov>
Voice/TTY (802) 241-2345
To Report Adult Abuse: (800) 564-1612
Fax (802) 241-2358

June 21, 2011

Phillip Condon, Administrator
Franklin County Rehab Center Llc
110 Fairfax Road
St Albans, VT 05478

Provider ID #:475047

Dear Mr. Condon:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **June 1, 2011.**

Follow-up may occur to verify that substantial compliance has been achieved and maintained.

Sincerely,

A handwritten signature in black ink that reads "Pamela M. Cota RN".

Pamela M. Cota, RN
Licensing Chief

PC:jl

Enclosure



DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/10/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 475047	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 06/01/2011
--	---	--	--

NAME OF PROVIDER OR SUPPLIER FRANKLIN COUNTY REHAB CENTER LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 110 FAIRFAX ROAD ST ALBANS, VT 05478
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 000}	INITIAL COMMENTS A follow-up to the recertification survey was conducted by the Division of Licensing and Protection on 6/1/11. The following regulatory violations were identified.	{F 000}	RECEIVED Division of JUN 17 11 Licensing and Protection	
{F 281} SS=E	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to assure that staff met professional standards of quality during medication administration for 4 of 5 residents in the total sample (Residents # 1, 2, 3, and 4). Findings include: 1. Per observation on 6/1/11 at 10:00 AM during a medication administration pass for Resident #1, the nurse administered an Alzheimer's medication, a vitamin, and a liquid dietary supplement scheduled to be administered at 8 AM. At 10:48 AM on 6/1/11, the nurse confirmed that the medications were administered more than one hour after the time indicated on the Medication Administration Record (MAR). 2. Per observation on 6/1/11 at 10:15 AM during a medication administration pass for Resident #2, the nurse administered 2 medications scheduled for 8:00 AM (heart medication and Alzheimer's medication), as well as 7 medications and 2 vitamins which were scheduled for 9:00 AM. At 10:48 AM on 6/1/11, the nurse confirmed that the	{F 281}	F 281 - F 332 Pass medication on time 1. Reviewed medication treatment sheets. A. Adjusted med time's to assure they would be able to be passed within the med pass parameters. B. Did medication review with the pharmacist and medical director. Discharged any unnecessary medications. C. Inserviced professional nurses on the importance of time management, with an emphasis on starting medication passes on time. D. Reviewed the medication administration preparation and general guidelines with nursing staff. Specifically highlighting the policy on opening capsules and crushing medications. E. Reviewed medications needing to be given with food or at meal time. Adjusted administration time to correspond with snacks or meal times. F. DNS will be auditing for compliance. (Per TC with DNS on 6/20/11) F281 POC Accepted 6/20/11 K. Campos RN Pincot RN	5/6/11 6/20/11 Per TC with DNS on 6/20/11.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *Philip H. Condon* 06/16/2011 TITLE: Administrator (X6) DATE

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.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/10/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 475047	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 06/01/2011
NAME OF PROVIDER OR SUPPLIER FRANKLIN COUNTY REHAB CENTER LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 110 FAIRFAX ROAD ST ALBANS, VT 05478		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 281}	<p>Continued From page 1</p> <p>medications were administered more than one hour after the time indicated on the MAR.</p> <p>3. Per observation on 6/1/11 at 10:15 AM during a medication administration pass for Resident #3, the nurse was observed opening a capsule of Detrol LA (Long Acting) 4 mg (milligrams) and emptying it into a cup with other crushed medications and contents of opened capsules to be given mixed with food. At this time the nurse called the pharmacy to check on the Ferrex 150 mg capsule to see if it could be opened, however did not ask the pharmacist if the Detrol LA could be administered safely in this manner. The medications were administered to the resident. Per interview on 6/1/11 at 10:25 AM, the nurse confirmed that the long acting capsule had been opened before administration. Per interview on 6/1/11 at 2:30 PM, the pharmacist confirmed that the Detrol LA should be swallowed whole, and there were alternative short acting forms of the medication available.</p> <p>4. On 6/1/11 at 9:50 AM during a medication administration pass for Resident #4, the nurse administered 8 medications that were scheduled on the MAR to be given at 8:00 AM. Per review of the MAR and physician orders, Glimeperide (Amaryl) 4 mg was ordered to be given with breakfast, and the Coreg 25 mg was to be given with meals. Per interview on 6/1/11 at 10:05 AM, the LNA (Licensed Nursing Assistant) stated that the resident ate breakfast at about 7:30 AM. Per interview on 6/1/11 at 10:10 AM, the nurse confirmed that the medications were administered more than an hour past the scheduled time, and not given with a meal.</p>	{F 281}		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/10/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 475047	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 06/01/2011
NAME OF PROVIDER OR SUPPLIER FRANKLIN COUNTY REHAB CENTER LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 110 FAIRFAX ROAD ST ALBANS, VT 05478		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 281}	Continued From page 2 On 6/1/11 at 3:15 PM during a Quality Assurance discussion and Exit Conference, the Administrator confirmed that facility policy (Granite Pharmacy Inc., Medication Administration-General Guidelines) directs that medications are administered within 60 minutes of scheduled time.	{F 281}		
{F 332} SS=E	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interview for the Medication Pass Observation(s) on 6/1/11, 4 of 5 sampled residents received medications out of the scheduled time frame or not in accordance with accepted standards of practice (Residents #1, 2, 3 and 4), which calculated to a 56% error rate. Findings include: 1. Per observation on 6/1/11 at 10:00 AM during a medication administration pass for Resident #1, the nurse administered an Alzheimer's medication, a vitamin, and a liquid dietary supplement scheduled to be administered at 8 AM. At 10:48 AM on 6/1/11, the nurse confirmed that the medications were administered more than one hour after the time written on the Medication Administration Record (MAR). 2. Per observation on 6/1/11 at 10:15 AM during a medication administration pass for Resident #2, the nurse administered 2 medications scheduled	{F 332}	incl. under F281 tag. F332 PDC accepted 6/20/11. K. Campos RN / AMcstarn	5/6/11 6/20/11 Per TC with DNS on 6/20/11.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/10/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 475047	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 06/01/2011
NAME OF PROVIDER OR SUPPLIER FRANKLIN COUNTY REHAB CENTER LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 110 FAIRFAX ROAD ST ALBANS, VT 05478		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
{F 332}	<p>Continued From page 3</p> <p>for 8:00 AM (heart and Alzheimer's), as well as 7 medications and 2 vitamins which were scheduled for 9:00 AM.</p> <p>At 10:48 AM on 6/1/11, the nurse confirmed that the medications were administered more than one hour after the time written on the Medication Administration Record (MAR).</p> <p>3. On 6/1/11 at 9:50 AM during a medication administration pass for Resident #4, the nurse administered 8 medications that were scheduled on the MAR to be given at 8:00 AM. Per review of the MAR and physician orders, Glimeperide (Amaryl) 4 mg (milligrams) was ordered to be given with breakfast, and the Coreg 25 mg was to be given with meals. Per interview on 6/1/11 at 10:05 AM, the LNA stated that the resident ate breakfast at about 7:30 AM. Per interview on 6/1/11 at 10:10 AM, the nurse confirmed that the medications were administered more than an hour past the scheduled time, and not given with a meal.</p> <p>4. Per observation on 6/1/11 at 10:15 AM during a medication administration pass for Resident #3, the nurse was observed opening a capsule of Detrol LA (Long Acting) 4 mg (milligrams) and emptying it into a cup with other crushed medications and contents of opened capsules to be given mixed with food. At this time the nurse called the pharmacy to check on the Ferrex 150 mg capsule to see if it could be opened, however did not ask the pharmacist if the Detrol LA could be administered safely in this manner. The medications were administered to the resident. Per interview on 6/1/11 at 10:25 AM, the nurse confirmed that the long acting capsule had been opened before administration. Per interview on</p>	{F 332}			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/10/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 475047	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 06/01/2011
NAME OF PROVIDER OR SUPPLIER FRANKLIN COUNTY REHAB CENTER LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 110 FAIRFAX ROAD ST ALBANS, VT 05478		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 332}	Continued From page 4 6/1/11 at 2:30 PM, the pharmacist confirmed that the Detrol LA should be swallowed whole, and there were alternative short acting forms of the medication available. On 6/1/11 at 3:15 PM during a Quality Assurance discussion and Exit Conference, the Administrator confirmed that facility policy (Granite Pharmacy Inc., Medication Administration-General Guidelines)directs that medications are administered within 60 minutes of scheduled time.	{F 332}		