

Division of Licensing and Protection

HC 2 South, 280 State Drive

Waterbury, VT 05671-2060

<http://www.dail.vermont.gov>

Survey and Certification Voice/TTY (802) 241-0480

Survey and Certification Fax (802) 241-0343

Survey and Certification Reporting Line: (888) 700-5330

To Report Adult Abuse: (800) 564-1612

October 18, 2016

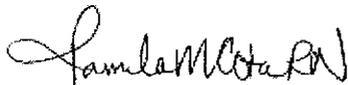
Ms. Jessica Jennings, Administrator  
Saint Albans Healthcare And Rehabilitation Center  
596 Sheldon Road  
Saint Albans, VT 05478-8011

Dear Ms. Jennings:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **September 13, 2016**. Please post this document in a prominent place in your facility.

We may follow-up to verify that substantial compliance has been achieved and maintained. If we find that your facility has failed to achieve or maintain substantial compliance, remedies may be imposed.

Sincerely,



Pamela M. Cota, RN  
Licensing Chief

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

PRINTED: 09/28/2016  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>476021</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>09/13/2016</b>
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NAME OF PROVIDER OR SUPPLIER  <b>SAINT ALBANS HEALTHCARE AND REHABILITATION CENTER</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>596 SHELDON ROAD SAINT ALBANS, VT 05478</b>
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(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
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F 000	INITIAL COMMENTS	F 000		
F 157 SS=D	<p>483 10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC)</p> <p>A facility must Immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an Interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).</p> <p>The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.</p> <p>The facility must record and periodically update</p>	F 157		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *[Signature]* TITLE *Executive Director* (X5) DATE *10/3/16*

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.

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NAME OF PROVIDER OR SUPPLIER  <b>SAINT ALBANS HEALTHCARE AND REHABILITATION CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>596 SHELDON ROAD</b> <b>SAINT ALBANS, VT 05478</b>		
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F 157	Continued From page 1 the address and phone number of the resident's legal representative or interested family member.  This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to inform the resident's legal guardian and representative of a significant change in psychotropic medications for 1 of 3 residents (Resident #1) prior to implementing the medication changes. Findings include: Per record review, Resident #1 was seen for a tele-psychiatric consult on 6/23/16 for evaluation of dementia with physical and verbal aggression. The psychiatrist recommended that the resident's Quetiapine (an antipsychotic medication) be stopped and the resident be started on Risperidone 0.5 mg twice daily (another antipsychotic medication) to increase by 0.5 mg increments every 5 days to a maximum dose of 2 mg. The psychiatrist also recommended that the resident's order for Lorazepam (an anti-anxiety medication) be discontinued; that Trazodone 50 mg (an antidepressant/antianxiety medication) be offered three times daily as needed for moderate emergent agitation; that Risperdal 0.25 mg be offered twice daily as needed for severe emergent agitation; and that Lexapro (an anti-depressant medication) be started after 1 week on the scheduled Risperidone. On 6/23/16 at 12:38 PM, a staff nurse documented in the progress notes that, "new orders obtained, message left for [responsible party] to call facility for update." On 6/23/16 the facility Nurse Practitioner (NP) documented that new orders were written based on the	F 157	Past noncompliance: no plan of correction required.		

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F 157	Continued From page 2 psychiatrist's recommendations. Per review of the MAR (Medication Administration Record) for June 2016, the orders for the new psychotropic medications were implemented on 6/24/16. On 9/13/16 at 1:20 PM, the Nurse UM (Unit Manager) reported that prior to starting a new medication or psychotropic medication, a resident's family/responsible party is to be notified and a verbal consent given; a signed consent is to be obtained as soon as able. The UM confirmed that there was no evidence that Resident #1's [responsible party] was notified of the psychotropic medication changes or signed an informed consent for the medication changes prior to their administration. During the 9/12-9/13/16 survey, the facility administrator reported that following an internal review, the administrative team had identified that nursing staff needed additional training regarding the process for notification of family, guardians and responsible parties for resident's changes in condition and changes in medications and treatment as well as for the process of obtaining signed consents prior to the initiation of psychotropic medications. The facility scheduled an in-service on 7/27/16 for nursing staff that included education on updating family/responsible parties on all new orders; documenting conversations with families; the process to obtain signed consents before tele-psychiatric consults and starting psychotropic medications; and the notification of family and MD for medication refusals. The Director of Nursing (DNS) provided evidence of record audits to determine that notifications had occurred and reported that record audits would continue for 3-4 months to assure that compliance is maintained. Per interviews with	F 157			

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F 157	Continued From page 3	F 157			
F 281 SS=G	<p>483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS</p> <p>The services provided or arranged by the facility must meet professional standards of quality.</p> <p>This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility failed to ensure that nurses met professional standards of nursing practice regarding failure to follow physician orders for medication administration and for the failure to obtain orders for wound treatment once the current orders ended for 1 resident (Residents #2) Findings include: 1. Per record review, due to a transcription error, Resident #2 was not administered physician ordered Lasix for 5 days and experienced physical symptoms of increased edema, weight gain, shortness of breath and lethargy that impacted his/her health and safety (Lasix is a diuretic medication that helps the body get rid of excess fluid). Resident #2 had diagnoses of Diabetes, Chronic Kidney Disease, Stage III, Atherosclerotic Heart disease, a non-healing ulcer on the left plantar foot with associated Osteomyelitis (infection going into the bone) along with other chronic medical conditions. On 8/18/16 the Resident's physician ordered an increase in Lasix from 40 mg daily to 40 mg twice daily for 5 days and then was to resume</p>	F 281	<p><b>F281 St. Albans Health and Rehabilitation Center Provides this plan of correction without admitting or denying the validity or existence of the alleged deficiencies. This plan of correction is prepared and executed solely because it is required by federal and state law.</b></p> <p><b>Resident #2 was discharged to home prior to the Survey completed on September 13, 2016.</b></p> <p><b>All residents have the potential to be affected by this deficient practice.</b></p> <p><b>Education will be provided to RN's/LPN's Regarding following physician's orders for Medication administration and for obtaining Wound orders once the current order ends. Education will be completed by October 10, 2016.</b></p> <p><b>Audits will be conducted by the Director of Nursing and/or her designee to ensure that Nursing is following physician orders for medication Administration and obtaining orders for wound Treatment once current orders are completed. This will be completed weekly x 4 and then Monthly x 3.</b></p> <p><b>Results of the audits will be reviewed for further recommendations at the Quality Assurance Meeting for a minimum of three months.</b></p> <p><b>Corrective action will be completed by October 13, 2016.</b></p>		

*F281 Poc accepted 10/17/16 Mckay*

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NAME OF PROVIDER OR SUPPLIER  SAINT ALBANS HEALTHCARE AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 596 SHELDON ROAD SAINT ALBANS, VT 05478		
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F 281	Continued From page 4 Lasix 40 mg daily. Per review of the MAR (Medication Administration Record), the resident received the increased dose of Lasix from 8/18/16 -8/22/16. On 8/23/16 the resident received 1 dose of Lasix 40 mg and then did not receive the medication from 8/24-8/28/16 (5 days) until the error was discovered on 8/29/16. Per interview on 9/13/16 beginning at approximately 9:00 AM, the nursing UM (Unit Manager) stated that there was a transcription error made in the MAR so it was not clear that nursing staff were to continue to administer Lasix 40 mg daily after 8/23/16. S/he confirmed during the interview that the physician orders were not followed for the administration of Lasix and that a medication error had occurred; record review indicated that the resident experienced significant weight gain, edema, lethargy and shortness of breath following the error. 2. Per record review, Resident #2 did not receive his/her physician ordered IV (intravenous) infusions of Ampicillin/Sulbactam (antibiotic) to treat osteomyelitis (infection into the bone of the left foot) as ordered. Per record review, Resident #2 was admitted to the facility for IV antibiotic treatment of an infection (osteomyelitis) on the bottom of the left foot. The orders stated to give Ampicillin/Sulbactam 3 gm every 8 hours IV through a PICC line (peripherally inserted central catheter). Per review of the infusion medication administration record (MAR), there is no evidence that the resident received the antibiotic on 7 of the ordered administrations from 8/15/16- 8/31/16 (8/10 at 2 PM; 8/15 at 6 AM and 10 PM; 8/19 at 2 PM; 8/29 at 2 PM and 10 PM; 8/31 at 6 AM). Per interview with the UM (Unit Manager) on 9/13/16 at approximately 9:00 AM, s/he reported that on	F 281			

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F 281	Continued From page 5 some of the days, the resident had medical appointments and left the facility at about 5- 5:30 AM and returned at about 6:00 PM; the UM also reported that on some of the other days, s/he thought there could be a documentation error and thinks the resident could have been administered the antibiotic. The UM confirmed that the prescribing physician was not contacted to see if the antibiotic could be held for medical appointments or administered on a different time schedule or given at the medical appointment for the days that the antibiotic was not administered due to medical appointments. 3. Per record review, nursing staff failed to obtain new orders for wound care for Resident #2 after the 8/23/16 order for wound cleansing and wet to dry dressings ended on 8/29/16. Per record review, there was no evidence that the wound had healed as a nursing skin assessment on 9/1/16 documented that the resident had a wound on the bottom of the left foot. A discharge summary by the facility nurse practitioner dated 9/2/16 documented that the resident had a small residual wound on the plantar aspect of the left foot. On 9/13/16 at an interview beginning at approximately 9:00 AM, the Unit Manager (UM) confirmed that nursing staff had not obtained an order for wound care after the treatment order ended on 8/29/16. Per review of the TAR (Treatment Administration Record), a nurse signed that wound care was provided on 8/31/16 and on 9/2/16 a nurse documented in the progress notes that a dressing change had been done on foot; however, there was no current physician order to provide a wound treatment and no evidence that a new order was obtained. Additionally, the UM confirmed that there was no	F 281			

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F 281  F 282 SS=D	<p>Continued From page 6</p> <p>evidence that the wound was assessed or measured after 8/22/16 and that an assessment and measurement should have been obtained weekly per policy (the resident was discharged from the facility on 9/6/16). (Refer to F 282, 333, 514)</p> <p><b>483.20(k)(3)(II) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</b></p> <p>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility failed to provide services in accordance with the plan of care for 1 of 3 residents (Resident # 2) related to wound care. Findings include:</p> <p>Per record review, the facility failed to follow Resident # 2's care plan related to the evaluation and monitoring of a left foot ulcer. Resident # 2's care plan for "actual skin breakdown related to vascular disease and diabetes, left foot ulcer" states that the staff are to: Provide wound treatment as ordered. Provide weekly wound assessment to include measurements and description of wound status.</p> <p>Per review of Resident # 2's medical record, nursing staff failed to obtain new orders for wound care after the 8/23/16 order for wound cleansing and wet to dry dressings ended on 8/29/16. A nurse signed on the TAR (Treatment</p>	F 281  F 282	<p><b>F282 Resident #2 was discharged to home prior to the Survey completed September 13, 2016.</b></p> <p><b>Residents with wounds have the potential to be affected by this deficient practice.</b></p> <p><b>Education will be provided to RN's/LPN's regarding implementation of the care plan related to wound care. Education will be completed by October 10, 2016.</b></p> <p><b>Audits will be conducted by the Director of Nursing and/or her designee to ensure that Nursing is providing wound care per the residents care Plan. This will be completed weekly x 4 and then Monthly x 3.</b></p> <p><b>Results of the audits will be reviewed for further recommendations at the Quality Assurance Meeting for a minimum of three months.</b></p> <p><b>Corrective action will be completed by October 13, 2016.</b></p> <p><i>Faba POC accepted 10/17/16 Pmedarw</i></p>	

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F 282	Continued From page 7 Administration Record) that wound care was provided on 8/31/16; on 9/2/16 a nurse documented in the progress notes that "dressing changed on foot;" however, there was no current physician order to provide a treatment to the wound and no evidence that a new order was obtained and followed.  On 9/13/16 at an interview beginning at approximately 9:00 AM, the Unit Manager (UM) confirmed that the last skin integrity report that included a description of the resident's left foot wound and measurements was completed on 8/22/16. The resident was discharged from the facility on 9/6/16; per care plan, weekly wound assessment and measurements were due on 8/29/16 and 9/5/16. On 9/13/16 at approximately 1:00 PM, the UM confirmed that the resident's care plan for the treatment of Resident #2's foot wound was not followed. (Refer to 281, 514)	F 282			
F 333 SS=G	483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS  The facility must ensure that residents are free of any significant medication errors.  This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to assure that residents are free of any significant medication errors for 1 of 3 residents (Resident #2). Findings include:  Per record review, due to a medication error of omission, Resident #2 experienced physical symptoms of increased edema, weight gain,	F 333			

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F 333	<p>Continued From page 8</p> <p>shortness of breath and lethargy that impacted his/her health and safety. Resident #2 had diagnoses of Diabetes, Chronic Kidney Disease, Stage III, Atherosclerotic Heart disease, a non-healing ulcer on the left plantar foot with associated Osteomyelitis (infection going into the bone) along with other chronic medical conditions.</p> <p>On 8/18/16 the Resident's physician ordered an increase in Lasix from 40 mg daily to 40 mg twice daily for 5 days and then to resume Lasix 40 mg daily (Lasix is a diuretic medication that helps the body get rid of excess fluid). Per review of the MAR (Medication Administration Record), the resident received the increased dose of Lasix from 8/16/16 -8/22/16. On 8/23/16 the resident received 1 dose of Lasix 40 mg and then did not receive the medication from 8/24-8/28/16 (5 days) until the error was discovered on 8/29/16.</p> <p>Per review of Nurse Practitioner (NP) notes, on 8/29/16 Resident #2 was seen in follow up for edema and shortness of breath. The resident "states [s/he] is feeling very fatigued and having a hard time catching [his/her] breath." The NP reported meeting with "nursing and according to [the resident's] MAR, [s/he] had not received [his/her] Lasix since 8/23/16. In that time frame [the resident] has had an 18 pound weight gain. [His/her] baseline weight is about 226 to 231. Today [his/her] weight is 249." Per the exam, the resident was noted to have +2 to +3 edema to bilateral lower extremities. "[The resident] was restarted on [his/her] Lasix today." "...In early afternoon, I reassessed [the resident] and [s/he] had not voided much and still feels symptomatic.</p>	F 333	<p>F333 Resident #2 was discharged to home prior to the Survey completed on September 13, 2016.</p> <p>All residents have the potential to be affected by this Deficient practice.</p> <p>Education will be provided to RN's/LPN's regarding Administration of Medication. Education will be completed by October 10, 2016.</p> <p>Audits will be conducted by the Director of Nursing and/or her designee to ensure that Residents are free of any significant medication Errors. This will be completed weekly x 4 and then Monthly x 3.</p> <p>Results of the audits will be reviewed for further recommendations at the Quality Assurance Meeting for a minimum of three months.</p> <p>Corrective action will be completed by October 13, 2016.</p> <p><i>F333 POC accepted 10/17/16 meeturn</i></p>		

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F 333	Continued From page 9 I ordered an additional 40 mg of Lasix. Nursing is aware that [s/he] bears close monitoring." Per nurses progress notes on 8/30/16, Resident #2 was reported to be edematous throughout extremities and torso. On exam on 9/1/16, the NP documented that the resident was switched to Torsemide [another diuretic] and has started to void more with weight down to 251.2 from 256 yesterday. "[The resident] states [his/her] abdomen still feels big and [s/he] has some SOB [shortness of breath] with exertion." On a 9/2/16 exam, the NP documented that weights had improved as did shortness of breath.  Per interview on 9/13/16 beginning at approximately 9:00 AM, the nursing UM (Unit Manager) stated that there was a transcription error made in the MAR so it was not clear that nursing staff were to continue to administer Lasix 40 mg daily after 8/23/16. S/he confirmed during the interview that the physician orders were not followed for the administration of Lasix and that a medication error had occurred; evidence in the medical record documented that the medication omission resulted in the resident experiencing symptoms of edema, weight gain, lethargy and shortness of breath. (Refer to F281, 514)	F 333			
F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE  The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.	F 514			

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>475021</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>09/13/2016</b>
NAME OF PROVIDER OR SUPPLIER  <b>SAINT ALBANS HEALTHCARE AND REHABILITATION CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>686 SHELDON ROAD SAINT ALBANS, VT 05478</b>		
(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 514	<p>Continued From page 10</p> <p>The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.</p> <p>This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility failed to maintain complete and accurately documented medical records for the administration of medication and treatments for 1 of 3 residents (Resident #2)</p> <p>Per record review, the MAR (medication administration record) and TAR (treatment administration record) for Resident #2 had incomplete documentation that medications were administered and dressing treatments were performed per orders. Per review, Resident #2 had diagnoses of Diabetes, Chronic Kidney Disease, Stage III, Atherosclerotic Heart disease, a non-healing ulcer on the left plantar foot with associated Osteomyelitis (Infection going into the bone) along with other chronic medical conditions.</p> <p>Per record review, there is no documentation on the infusion medication administration record or nurses progress notes to explain why Resident #2 did not receive his/her physician ordered IV (intravenous) infusions of Ampicillin/Sulbactam (antibiotic) to treat osteomyelitis (infection into the bone of the left foot) as ordered. Per record review, physician orders stated to give Ampicillin/Sulbactam 3 gm every 8 hours IV</p>	F 514	<p>F514 Resident #2 was discharged to home prior to the Survey completed on September 13, 2016.</p> <p>All residents have the potential to be affected by this Deficient practice.</p> <p>Education will be conducted on accurate and complete resident medication and treatment documentation to RN's/LPN's. Completion date will be October 10, 2016.</p> <p>Audits will be conducted by the Director of Nursing and/or her designee to ensure that the center is Maintaining complete and accurate medication and Treatment records. This will be completed weekly x 4 and then Monthly x 3.</p> <p>Results of the audits will be reviewed for recommendations at the Quality Assurance Meeting for a minimum of three months.</p> <p>Corrective action will be completed by October 13, 2016.</p>		
<p><i>F514 pcc accepted 10/11/16 ANCOTARW</i></p>					

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NAME OF PROVIDER OR SUPPLIER  SAINT ALBANS HEALTHCARE AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 586 SHELDON ROAD SAINT ALBANS, VT 05478		
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F 514	<p>Continued From page 11</p> <p>through a PICC line (peripherally inserted central catheter). Per review of the infusion medication administration record (MAR), there is no documentation that the resident received the antibiotic on 7 of the ordered administrations from 8/15/16- 8/31/16 (8/10 at 2 PM; 8/15 at 6 AM and 10 PM; 8/19 at 2 PM; 8/29 at 2 PM and 10 PM; 8/31 at 6 AM). Per interview with the UM (Unit Manager) on 9/13/16 at approximately 9:00 AM, s/he reported that on some of the days, the resident had medical appointments and left the facility at about 5- 5:30 AM and returned at about 6:00 PM; the UM also reported that on some of the other days, s/he thought there could be a documentation error and thinks the resident could have been administered the antibiotic.</p> <p>On 8/18/16 the Resident #2's physician ordered an increase in Lasix from 40 mg daily to 40 mg twice daily for 5 days and then was to resume Lasix 40 mg daily. Per review of the MAR (Medication Administration Record), the resident received the increased dose of Lasix from 8/18/16 -8/22/16. On 8/23/16 the resident received 1 dose of Lasix 40 mg and then did not receive the medication from 8/24-8/28/16 (5 days) until the error was discovered on 8/29/16. Per interview on 9/13/18 beginning at approximately 9:00 AM, the nursing UM (Unit Manager) stated that there was a transcription error made in the MAR so it was not clear that nursing staff were to continue to administer Lasix 40 mg daily after 8/23/16 resulting in a medication error; record review indicated that the resident experienced significant weight gain, edema, lethargy and shortness of breath following the error.</p>	F 514			

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NAME OF PROVIDER OR SUPPLIER  SAINT ALBANS HEALTHCARE AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 686 SHELDON ROAD SAINT 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 514	Continued From page 12 Per record review, there is no documentation in the TAR that orders for a wet to dry dressing of Resident #2's left foot wound was performed on 8/26 and 8/27/16 per orders.  Per review, the facility policy, Clinical Record: Charting and Documentation (revision date 1/1/13) states under Process, step 7 "Document treatments, medications, vital signs, and weights as required/requested." The facility policy, Nursing Documentation (review date 3/1/16) states that documentation will follow the guidelines of good communication and be concise, clear, pertinent and accurate. (Refer to 281, 282, 333)	F 514			