

Division of Licensing and Protection
103 South Main Street
Waterbury, VT 05671-2306
<http://www.dail.vermont.gov>
Voice/TTY (802) 871-3317
To Report Adult Abuse: (800) 564-1612
Fax (802) 871-3318

October 23, 2014

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 October 6, 2014. 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

PC:kc

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

PRINTED: 10/09/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 475021	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 10/08/2014
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NAME OF PROVIDER OR SUPPLIER SAINT ALBANS HEALTHCARE AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 606 SHELDON ROAD SAINT ALBANS, VT. 05478
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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)	(X6) COMPLETION DATE
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F 000	INITIAL COMMENTS An unannounced on-site complaint investigation concerning care and services was conducted by the Division of Licensing and Protection on 10/08/14. The following regulatory violations were identified:	F 000	St Albans Health and Rehab Center provides this plan of correction without admitting or denying the validity or existence of the alleged deficiency. The plan of correction is prepared and executed solely because it is required by federal and state law.	
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 upon staff interview and record review, the facility failed to assure that physician orders were followed and that the medical records of 4 of 4 residents in the survey sample were maintained according to professional standards of quality (Residents #1, #2, #3, & #4). Findings include: 1). Per 10/6/14 record review, Resident #1 had Physician Orders dated for the period 8/1-8/31/14 for facility nursing staff to administer Acetaminophen 325 mg 2 tablets twice daily, once at 6 AM and again at 8 PM. Per review of the MAR (Medication Administration Record), there is no documentation that the medication was administered on 8/2/14 at 8 PM or 8/5/14 at 8 AM. There were orders for Atorvastatin 40 mg (a cholesterol lowering medication) to be administered at bedtime; per review of the MAR, there is no documentation that the medication was administered on 8/2/14 or 8/20/14. Donepezil 10 mg (a medication for dementia/Alzheimer's disease) was ordered at bedtime; per review of the MAR, there is no documentation that the medication was	F 281	F-281 Entries for resident # 1,2,3,4 were reported as omissions. Nursing staff will be educated regarding Medication Documentation and following MD orders. Other residents with have the potential to be affected by this alleged deficient practice. Audits will be performed to ensure Current Medications and treatments are signed for when completed. Audits will be done weekly X 4 weeks and then monthly x 3 to ensure that the center is compliant with documenting medications and treatments per doctor's order. Results of the audit will be discussed at CQI for further evaluation and Recommendations. Corrective action will be completed by November 7, 2014. F281 POC accepted 10/23/14 <i>Amsturn</i>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *[Signature]* TITLE *NHA* DATE *10/22/2014* (X8)

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 patient. (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 SAINT ALBANS HEALTHCARE AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 596 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 CRD98-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 281	<p>Continued From page 1</p> <p>administered on 8/2, 8/19, 8/20, 8/21, 8/23 and 8/28/14. Orders call for Senna-S (3) tablets (for constipation) to be administered at 10 AM and 8 PM; per review of the MAR, there is no documentation that they were administered on 8/20/14 at 6 PM. Namenda 10 mg (a medication for the treatment of Alzheimer's) was ordered twice daily; per review of the MAR, there is no documentation that it was administered on 8/20/14 at 6 PM. The medical orders also called for Resident #1 to have his/her code alert bracelet (an elopement security bracelet) checked for function on each shift and for placement on each shift. There is no documentation on the TAR (Treatment Record) that the bracelet was checked for function on 8/14/14 or for placement on 8/20/14.</p> <p>2). For Resident #2, there were Physician Orders for the period 8/1-8/31/14 and 9/1/14- 9/30/14 for the nursing staff to administer Vitamin D2 50,000 units (a vitamin supplement) every week; per review of the MAR, there is no documentation that it was given on 8/22/14. The orders called for Aspirin 81 mg to be administered daily; there is no documentation in the MAR that it was administered on 8/27/14. The orders called for Atenolol 25 mg (a Blood pressure medication) to be administered daily at 8 PM; there is no documentation that the medication was given on 8/27, 9/1, 9/12, 9/18 or 9/24/14. Simvastatin 20 mg (a cholesterol lowering medication) was ordered daily at bedtime; there is no documentation on the MAR that it was administered on 8/19, 8/21, 8/23 or 8/27, 9/19, or 9/24/14. Trazodone 25 mg was ordered at bedtime; there is no documentation that the medication was administered on 8/27 or 9/24/14.</p> <p>3). Per review of Resident #3's medical record, Physician Orders dated for the period 9/1-9/30/14</p>	F 281			

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NAME OF PROVIDER OR SUPPLIER SAINT ALBANS HEALTHCARE AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 698 SHELDON ROAD SAINT ALBANS, VT 05478
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F 281	<p>Continued From page 2 .</p> <p>call for nursing staff to administer Risperdal 0.5 mg at bedtime (an antipsychotic medication); per review of the MAR, there is no documentation that it was administered on 9/27/14. The resident also had orders for Refresh Liquigal 1% drops (for the treatment of dry eyes) to be administered at bedtime in each eye. There is no documentation in the MAR that the drops were administered on 9/8, 9/9, 9/11, or 9/27/14.</p> <p>4). Resident #4 had Physician Orders dated for the period 10/1-10/31/14 for Lumigan 0.01% drops (used to treat glaucoma), 1 drop in the right eye at bedtime; per review of the MAR, there is no documentation that the medication was administered on 10/5/14. There are also orders for Tylenol 325 mg 2 tablets three times per day; per the MAR, there is no documentation that the resident was administered the medication on 10/5 or 10/6 at 8 AM. There is no documentation on the resident's behavior monitoring sheet that the resident refused medications on these dates. Per review of the facility policy Medication Administration; General (revised 1/2/14), under the heading Practice Standards, subsection 9 states, "Document: 9.1 Administration of medication on Medication Administration Record (MAR) ... 9.3 For medication refused by patient, circle your initials in the date and time space where that medication is ordered, and document patient's refusal of medication on the back of the MAR ..."</p> <p>On 10/6/14 in an interview concluding at approximately 2:48 PM, the Unit Manager (UM) confirmed the above findings and agreed that based on the lack of documentation, it could not be determined whether the above medications were administered to the residents. S/he stated that it was a facility expectation that nursing staff should fill out the MAR/TAR completely and notify</p>	F 281		
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F 281	Continued From page 3 both the physician and the family representative when a medication was not administered; s/he confirmed that there was no documentation on the back of the MAR to explain the omissions [as per policy]. S/ha reported meeting with nursing staff to address medication administration and documentation expectations in September and October and confirmed it was an area that needed more attention. (See F514) *Reference: Lippincott Manual of Nursing Practice (9th ed.). Wolters Kluwer Health/Lippincott Williams & Wilkins. 483.75(l)(1) RES	F 281		
F 514 SS=E	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. 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. This REQUIREMENT is not met as evidenced by: Based upon staff interview and record review, the facility failed to maintain complete and accurate clinical records in accordance with accepted professional standards of practice for 4 of 4 residents in the sample group (Residents	F 514	F-514 The medical record for resident# 1,2,3,4 has been reviewed and report completed for Omission of medication and or treatment. Nursing staff will be educated regarding the importance of ensuring a complete and accurate medical record. All residents have the potential to be affected by this alleged deficient practice. Audits will be done weekly x 4 weeks then monthly x 3 to ensure that that the center is compliant with care plan interventions. Results of the audits will be discussed at CQI For further evaluation and recommendations Corrective action will be completed by November 6, 2014.	

F514 PDC accepted 10/23/14 p.m.coturn

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F 514	Continued From page 4 #1, #2, #3, & #4). Findings include: 1). Per 10/6/14 record review, Resident #1 had Physician Orders dated for the period 8/1-8/31/14 for facility nursing staff to administer Acetaminophen 325 mg 2 tablets twice daily, once at 6 AM and again at 6 PM. Per review of the MAR (Medication Administration Record), there is no documentation that the medication was administered on 8/2/14 at 6 PM or 8/5/14 at 6 AM. There were orders for Atorvastatin 40 mg (a cholesterol lowering medication) to be administered at bedtime; per review of the MAR, there is no documentation that the medication was administered on 8/2/14 or 8/20/14. Donepezil 10 mg (a medication for dementia/Alzheimer's disease) was ordered at bedtime; per review of the MAR, there is no documentation that the medication was administered on 8/2, 8/18, 8/20, 8/21, 8/23 and 8/26/14. Orders call for Senna S (3) tablets (for constipation) to be administered at 10 AM and 6 PM; per review of the MAR, there is no documentation that they were administered on 8/20/14 at 6 PM. Namenda 10 mg (a medication for the treatment of Alzheimer's) was ordered twice daily; per review of the MAR, there is no documentation that it was administered on 8/20/14 at 6 PM. The medical orders also called for Resident #1 to have his/her code alert bracelet (an elopement security bracelet) checked for function on each shift and for placement on each shift. There is no documentation on the TAR (Treatment Record) that the bracelet was checked for function on 8/14/14 or for placement on 8/20/14. 2). For Resident #2, there were Physician Orders for the period 8/1-8/31/14 and 9/1/14- 9/30/14 for the nursing staff to administer Vitamin D2 50,000 units (a vitamin supplement) every week; per	F 514		

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F 514	Continued From page 5 review of the MAR, there is no documentation that it was given on 8/22/14. The orders called for Aspirin 81 mg to be administered daily; there is no documentation in the MAR that it was administered on 8/27/14. The orders called for Atenolol 25 mg (a Blood pressure medication) to be administered daily at 8 PM; there is no documentation that the medication was given on 8/27, 9/1, 9/12, 9/18 or 9/24/14. Simvastatin 20 mg (a cholesterol lowering medication) was ordered daily at bedtime; there is no documentation on the MAR that it was administered on 8/19, 8/21, 8/23 or 8/27, 9/19, or 9/24/14. Trazodone 25 mg was ordered at bedtime; there is no documentation that the medication was administered on 8/27 or 9/24/14. 3). Per review of Resident #3's medical record, Physician Orders dated for the period 9/1-9/30/14 call for nursing staff to administer Risperdal 0.5 mg at bedtime (an antipsychotic medication); per review of the MAR, there is no documentation that it was administered on 9/27/14. The resident also had orders for Refresh Liquigel 1% drops (for the treatment of dry eyes) to be administered at bedtime in each eye. There is no documentation in the MAR that the drops were administered on 9/8, 9/9, 9/11, or 9/27/14. 4). Resident #4 had Physician Orders dated for the period 10/1-10/31/14 for Lumigan 0.01% drops (used to treat glaucoma), 1 drop in the right eye at bedtime; per review of the MAR, there is no documentation that the medication was administered on 10/5/14. There are also orders for Tylenol 325 mg 2 tablets three times per day; per the MAR, there is no documentation that the resident was administered the medication on 10/5 or 10/8 at 6 AM. There is no documentation on the resident's behavior monitoring sheet that the resident refused medications on these dates.	F 614			

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F 514	<p>Continued From page 6</p> <p>Per review of the facility policy Medication Administration: General (revised 1/2/14), under the heading Practice Standards, subsection 9 states, "Document: 9.1 Administration of medication on Medication Administration Record (MAR) ... 9.3 For medication refused by patient, circle your initials in the date and time space where that medication is ordered, and document patient's refusal of medication on the back of the MAR ..."</p> <p>On 10/6/14 in an interview concluding at approximately 2:48 PM, the Unit Manager (UM) confirmed the above findings and agreed that based on the lack of documentation, it could not be determined whether the above medications were administered to the residents. S/he stated that it was a facility expectation that nursing staff should fill out the MAR/TAR completely and notify both the physician and the family representative when a medication was not administered; s/he confirmed that there was no documentation on the back of the MAR to explain the omissions (as per policy). S/he reported meeting with nursing staff to address medication administration and documentation expectations in September and October and confirmed it was an area that needed more attention. (See F281)</p>	F 514			