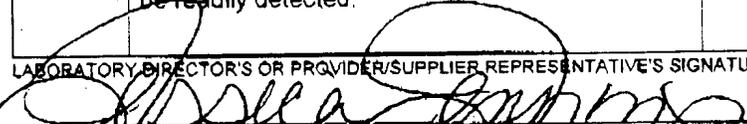


STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 475021	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 05/29/2009
NAME OF PROVIDER OR SUPPLIER SAINT ALBANS HEALTHCARE AND REHABILITATION CENTER			STREET ADDRESS, 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 CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
{F 000}	INITIAL COMMENTS	{F 000}			
{F 431}	<p>The Division of Licensing and Protection conducted a revisit recertification survey to the facility on 5/29/09. The following deficiency remained out of compliance.</p> <p>483.60(b), (d), (e) PHARMACY SERVICES</p> <p>The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.</p> <p>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p>	F 431	<p>St. Albans Health & Rehab center provides this plan of correction without admitting or denying the validity or existence of the alleged deficiencies. The plan of correction is prepared and executed solely because it is required by federal and state law.</p> <p>All residents in the center have the potential to be affected by this deficient practice.</p> <p>On 6/1/09 the refrigerators from the East Wing and the West Wing were removed and a central refrigerator has remained on the Center Wing. Refrigerated meds for all three units are kept in one location.</p> <p>The nursing staff has received education on Tag F431 in relation to labeling of drugs in the center and disposing of drugs that have expired. Education will be completed by 6/18/09.</p> <p>A daily medication refrigerator checklist has been implemented and is checked twice a day by the center night nurse and the day nurse.</p> <p>This corrective action will be reviewed by the DNS and/or her designee on a weekly basis x 3 months to assure compliance and will be presented during the quarterly QA Meeting.</p> <p>Corrective Action will be completed by June 18, 2009.</p>	SS=F	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE
 NHA 6-17-09

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

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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 R 05/29/2009	
NAME OF PROVIDER OR SUPPLIER SAINT ALBANS HEALTHCARE AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 586 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 431}	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on observations, the facility failed to assure that medications/biologicals available on 2 of 3 units in the facility were not expired. Findings include: 1. Per observation of the medication refrigerator located on East Wing on 5/29/09 at 10:22 AM, a partially used vial of Tuberculin injectable medication dated as opened 1/17/09 was found. Per manufacturer's instructions on the bottle label, the medication is to be discarded 30 days after opening / accessing the vial. Per interview with a unit nurse at this time, the access date of 1/17/09 was confirmed, the manufacturer discard recommendation was verified, and the solution was confirmed "outdated". 2. Per observation of the medication refrigerator on the West Wing on 5/29/09 at 10:45 AM, an open multi-dose vial of 2007-2008 influenza vaccine with a manufacturers expiration date of June 2008 was found. During interview at the time of the observation, the Unit Manager confirmed that the influenza vaccine was expired and discarded the vial.	{F 431}		

Daily Medication Refrigerator Checklist

Month _____

Date	Nursing Signature 11-7	Nursing Signature 7-3
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MUST CHECK THAT ALL OPEN BOTTLES ARE DATED AND THAT THERE ARE NO EXPIRED MEDICATIONS