

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

PRINTED: 04/27/2009
FORM APPROVED
OMB NO. 0938-0391

RECEIVED

MAY 8 2009

DIVISION OF LICENSING AND PROTECTION

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 475021	(X2) MULTIPLE CONSTRUCTION BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/08/2009
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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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(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 246 SS=D	<p>An unannounced onsite recertification survey was completed by the Division of Licensing and Protection from 4/6/09 to 4/8/09.</p> <p>483.15(e)(1) ACCOMMODATION OF NEEDS</p> <p>A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations and interviews, the facility failed to meet the needs of 1 applicable resident (Resident #24) when they placed the call bell out of reach of the resident. Findings include:</p> <p>1. Per observation on 4/7/09 at 11:30 a.m. Resident # 24, in his/her room, was calling for assistance. When this surveyor entered the resident's room he/she was sitting in a geri-chair, calling 'please help, I want to go to the annex', and said that they were unable to reach the call bell. Per observation, the call bell was fastened to the bed linens and was out of the resident's reach. The Surveyor informed a licensed nursing assistant (LNA) immediately that Resident # 24 required assistance. The LNA entered the resident's room to assist the resident, and confirmed that the call bell was out of reach.</p>	F 246	<p>F246 St. Albans Health & Rehabilitation 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>A mandatory in-service was conducted on 4/16/09 regarding resident's rights to reside and receive services with appropriate call systems within the resident's reach.</p> <p>Call light audits will be performed twice per week by the DNS and/or her designee. The corrective action will be monitored on a weekly basis x 6 months to ensure repetition of the deficient practice does not recur. The study will be presented during the quarterly QA meetings</p> <p>Corrective action completed by April 16, 2009. <i>P.O.C. Accepted 5/14/09. Pamela Cortali</i></p>	
F 280 SS=D	<p>483.20(d)(3), 483.10(k)(2) COMPREHENSIVE CARE PLANS</p> <p>The resident has the right, unless adjudged</p>	F 280		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE **NHA** (X6) DATE **5-6-09**

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.

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F 280 Continued From page 1
 incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.

A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.

This REQUIREMENT is not met as evidenced by:
 Based on interview and record review, staff failed to revise the care plan to reflect current needs for 2 of 17 residents in the sample (Residents #1,16)
 Findings include:

1. Per record review on 4/6/09, the care plan for Resident #1 was not revised to reflect a change in a pressure ulcer. Per review of the current plan of care addressing skin integrity, the care plan stated that Resident #1 "continues to have stage 2 (Left) buttocks." Per review of the treatment sheets and confirmed with the unit manager at 8:45 AM on 4/7/09, the pressure area was resolved on 3/3/09, and the care plan was not updated to reflect that change.

F 280

F280 All residents in the center who have a pressure ulcer or are incontinent have the potential to be affected by this deficient practice.

A mandatory in-service was conducted on 4/15/09 for all nurses regarding comprehensive care plans, revisions & updates to reflect the current needs of each individual resident.

The unit managers will review the care plans of their residents with a pressure ulcer and the residents who are incontinent to assure that the care plan reflects the resident's current status/needs. This will be completed by May 8, 2009.

The DNS and/or her designee will perform care audits weekly to assure that care plans are being updated to reflect the resident's needs x 3 months. The care plan study will be presented in the Quarterly QA meeting.

Corrective action will be completed by May 8, 2009.

P.O.C. Accepted 5/14/09. Pamela Motarn

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F 280 Continued From page 2
 2. Per record review on 4/7/09, the care plan for Resident #16 was not revised to reflect the current needs of the resident around incontinence. Per review of the LNA care sheet, identified to be part of the resident's plan of care, it states that Resident #16 is to be toileted using a bedside commode. Per observation on 4/8/09 at 9:45 AM, the resident did not have a commode present in his/her room or bathroom. Per review of the current plan of care around incontinence, there was no direction for staff on how to toilet this resident. Per observation of care on 4/7/09 at 12:43 PM, this resident is provided with incontinence care in bed and does not use a commode. On 4/8/09 at 10:15 AM, the Unit Manager confirmed that the care plan was not updated.

F 282 SS=D 483.20(k)(3)(ii) COMPREHENSIVE CARE PLANS

The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.

This REQUIREMENT is not met as evidenced by:
 Based on observations and interviews, the facility failed to follow the comprehensive care plan for 1 resident (Residents #24) in the applicable sample. Findings include:

1. Per review on 4/8/09 at 9 a.m. of the comprehensive care plan for Resident #24, the resident was identified as being at risk for falls and an intervention was listed on their care plan to "place a call bell within reach at all times." On 4/7/09 at 11:30 a.m., Resident # 24 was in her

F 280

F282 All residents in the center have the potential to be affected by this deficient practice.

F 282

The nursing staff was in-serviced on 4/15/09 & 4/16/09 regarding resident safety, appropriate placement of call bells, and following the comprehensive care plans to meet each resident's needs.

A call bell audit will be performed twice a week to assure that the resident's care plan is being followed to maintain the resident's safety. The corrective action will be monitored on a weekly basis x 6 months and presented quarterly in our QA meetings.

Corrective action completed by April 16, 2009.

P.O.C. Accepted 5/14/09. Pamela McArthur

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F 282 Continued From page 3
room calling out for assistance. Entering his/her room the resident told the surveyor that they could not reach their call bell because it was not fastened within reach. On 4/8/09 at 10:15 a.m. the Unit Manager confirmed that the care plan stated to have the call bell within reach at all times.

F 282

F 315 SS=D 483.25(d) URINARY INCONTINENCE
Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.

This REQUIREMENT is not met as evidenced by:
Based on interview, observation, and record review, the facility failed to assure that residents who are incontinent of bladder receive appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible for 1 applicable resident (Resident #16). Findings include:

1. Per record review on 4/7/09, the care plan for Resident #16, who has a diagnosis of recurrent UTI's, does not reflect the current needs of the resident around incontinence. Per review of the LNA care sheet, identified to be part of the resident's plan of care, it states that Resident #16 is to be toileted using a bedside commode. Per

F315 Resident #16's care plan was updated to reflect her individual plan of care around her toileting needs.

All residents have the potential to be affected by this deficient practice.

All nursing staff were in-serviced on the center's policy and procedure for bladder training, incontinent care, scheduled toileting, and updating care plans to reflect each individual resident's needs. This education will be completed by 05/08/2009.

The unit managers will review the care plans of their residents who are incontinent to assure that the care plan reflects the resident's current mode of toileting. This will be completed by May 8, 2009.

The DNS and/or her designee will perform care audits weekly to assure that care plans are being updated to reflect the resident's needs x 3 months. The care plan study will be presented in the Quarterly QA meeting.

Corrective action will be completed by May 8, 2009.

P.O.C. Accepted 5/11/09. Pamela Moran

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F 315 Continued From page 4
 observation on 4/8/09 at 9:45 AM, the resident did not have a commode present in his/her room or bathroom. Per review of the current plan of care around incontinence, there is no direction for staff on how to toilet this resident. Per observation of care on 4/7/09 at 12:43 PM, this resident is provided with incontinence care in bed and does not use a commode. On 4/8/09 at 10:15 AM, the Unit Manager confirmed that the care plan does not direct staff how to provide incontinence care and/or toileting.

F 315

F 329 SS=D 483.25(I) UNNECESSARY DRUGS
 Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.
 Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.

F 329

F329 The orders for resident #2 were revised to include medication dosages for the two orders in question.
 All new residents are at risk for this deficient practice. All new residents who receive a psychotropic medication are at risk for failure to receive an AIMS/Discus assessment upon admission to the center.
 Nursing Education was provided on 4/15/09 on the center's P&P for AIMS testing and proper transcription of physician orders.
 The DNS and/or her designee will monitor the corrective action for physician orders and AIMS testing to assure that admissions are completed per center P&P. New admission audits will be reviewed x 3 months and brought to the quarterly QA meeting.
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F 329 Continued From page 5
This REQUIREMENT is not met as evidenced by:
Based on interviews and record reviews, the facility failed to assure that medications were administered with adequate indications for use and with adequate monitoring for 2 of 17 residents in the sample (Resident #2, 9). Findings include:

1. Per record review on 4/6/09, Resident #2 has transcribed readmission orders containing 2 medications with no dose identified. The transcribed orders state "Bisacodyl suppository PR (per rectum) M-W-F" and "Vitamin C once a day via G-tube." At 11:40 AM on 4/7/09, the Unit Manager confirmed that these medications were missing dose amounts.
2. Per record review on 4/6/09 at 4 p.m. for Resident #9, who was admitted 1/19/09, and is administered psychotropic medication, received no initial assessment (AIMS or Discus) to establish a baseline and to monitor for side effects while using a psychotropic medication until 3/5/09. On 4/8/09 at 10:15 a.m. the Unit Manager confirmed that there was no initial AIMS/Discus assessment done for this resident and that one was completed after the March 3, 2009 pharmacist review recommending that one be completed.

F 329

F 431 483.60(b), (d), (e) PHARMACY SERVICES
SS=F
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

F 431

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F 431 Continued From page 6 reconciled.

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.

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.

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.

This REQUIREMENT is not met as evidenced by:
 Based on observation and interview, the facility failed to assure available medications are not expired. Findings include:

Per observation of medication storage rooms, there were expired or unlabeled medications present on all three units. On 4/6/09 at 4:15 PM, the following was found in the West medication storage room: 1 refrigerated opened multidose insulin vial with no open date, Cerovite liquid

F 431

F431 The outdated medications were discarded on 4/6/09. All OTC's were removed from the unit store rooms, and are to be stored in the medical supply room.

All resident's have the potential to be at affected by this deficient practice.

The Central Supply Clerk position has been filled. This position will be responsible for checking the OTC's monthly in the supply room to assure that medications have not expired. A Med Cart check list has been developed for nurses to verify medications have not expired and open meds are dated qshift.

The DNS and/or her designee will monitor this corrective action by performing audits twice a week x 3 months. Audits will be reviewed during the quarterly QA meetings.

Corrective action completed by May 8, 2009.

P.O.C. accepted 5/14/09. Pamela M. Starin

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F 431 Continued From page 7
 (expiration date 1/09), Maalox liquid (expiration date 2/09), and 10 containers of ear drops (expiration dates 8/07, 2/08, and 4/08). The above was confirmed with the nurse at the time of observation. On 4/6/09 at 3:50 PM, the following was found in the East medication storage room: 1 refrigerated opened multidose insulin vial with an open date of 3/5/09 and Cerovite liquid (expiration date 1/09). This was confirmed with the Unit Manager at the time of observation. At 3:57 PM, the following was found in the Center medication storage room: 2 refrigerated opened multidose insulin vials with no open date. This was confirmed with the Unit Manager at the time of observation.

F 454 483.70 PHYSICAL ENVIRONMENT
 SS=E
 The facility must be designed, constructed, equipped, and maintained to protect the health and safety of residents, personnel and the public.

 This REQUIREMENT is not met as evidenced by:
 Per observation and interview, the facility failed to maintain the physical building in a manner that protects the health and safety of residents. Findings include:

 1. Per observation during the environmental tour with the Maintenance Director on 4/7/09 from 3-4 PM, an Emergency Exit Door, located on the Special Care Unit at the resident dining / activity area, failed to alarm when opened by the Maintenance Director. Per interview at that time, the Maintenance Director confirmed that the alarm should engage when the door is opened.

 2. Per observation during the environmental tour

F 431

F454 On the evening of 4/7/09 the DNS and Maintenance man sat at the emergency door on the East Wing to assure the residents safety until the door was fixed that night by an outside vender.

F 4 The water damaged walls in both bathrooms on the West Wing have been repaired.

 All residents have the potential to be affected by these deficient practices.

 There has been a change in the Maintenance Dept. and a preventative maintenance plan is being completed to test emergency doors weekly. The staff have been educated on the proper procedure for a maintenance log located at each nursing station to ensure that the physical environment is kept in a manner that protects the health & safety of our residents.

 The corrective actions will be monitored weekly x 3 Months and reviewed during the quarterly QA meeting.

 Corrective Action completed by May 8, 2009.

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F 454 Continued From page 8
with the Maintenance Director on 4/7/09 from 3-4 PM, bathroom walls behind / beside the toilets in 2 rooms on West wing were in need of repair. The wall in the first room had an area behind the toilet tank that was blackened. The inner sheetrock was loose and falling from the wall to the floor (one piece observed on the floor) at and above the base cove trim. The wallboard covering was cracked in multiple places exposing the inner sheetrock material.

The wall in the second room had peeling / cracking covering, most significantly immediately above the base cove. The maintenance Director confirmed that the walls were damaged and that the rinse faucets directly above the toilet tanks were 'old' and had leaked causing water damage.

F9999 FINAL OBSERVATIONS

2.7 Special Care Units
2.7 (d)(1) Dementia units must provide initial training in addition to general facility training to include eight hours of classroom orientation for all employees assigned to the unit and an additional eight hours of clinical orientation to all nursing employees assigned to the unit. The eight hours of classroom work must include:

- (i) A general overview of Alzheimer's disease and related dementia;
- (ii) Communication basics;
- (iii) Creating a therapeutic environment;
- (iv) Activity focused care;
- (v) Dealing with difficult behaviors; and

F 454

F9999 The residents on the special care unit are at risk of being affected by this deficient practice.

F9999 The three nurses and one LNA in mention are traveling/agency staff . The required Dementia education for the specialty unit will be completed by May 8, 2009 for these staff members.

A new Staff Developer has been hired and will provide the eight hours of classroom orientation for all employees assigned to that unit and an additional eight hours of clinical orientation to all nursing employees assigned to the unit.

This corrective action will be reviewed by the Nurse Educator & DNS on a monthly basis X 3 months to assure education compliance and presented during the quarterly QA meeting.

Corrective action will be completed by May 8, 2009.

P.O.C. Accepted 5/14/09. Pamela Motaran

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F9999	<p>Continued From page 9 (vi) Family issues.</p> <p>This REQUIREMENT is not met as evidenced by: Per review of the staff education records, the facility failed to provide the required eight hours of initial training for three nurses and one LNA before they were assigned to work on the dementia unit. Findings include:</p> <p>During review of education records on 4/07/09, there was no evidence that the three nurses and one LNA had received the required training. Per interview on 4/07/09 at 3:30 PM, the DNS confirmed that the facility had not provided the training to this staff before they were assigned to the dementia unit.</p>	F9999		
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Saint Albans Healthcare And Rehabilitation Center
Resident Identifier
Health Survey April 8, 2009

Resident #1 Ann Sonski

Resident #2 Charles Barrett

Resident #9 Richard Branon

Resident #16 Alice Gagner

Resident #24 Margaret Bryce