

Division of Licensing and Protection
103 South Main Street, Ladd Hall
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

April 21, 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 **March 12, 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:jl

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

RECEIVED
Division of

PRINTED: 03/27/2014
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 _____ APR - 0 14 Licensing and Protection	(X3) DATE SURVEY COMPLETED C 03/12/2014
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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 000	<p>INITIAL COMMENTS</p> <p>An unannounced onsite recertification survey and complaint investigation were conducted on 3/10-3/12/14 by the Division of Licensing & Protection. The following regulatory deficiencies were identified as a result of the survey:</p> <p>483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS</p> <p>A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</p> <p>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview, the facility failed to develop a plan of care for an identified risk area for 1 of 25 residents sampled (Resident #84). Findings include:</p>	F 000	<p>Saint Albans Health and Rehab</p> <p>The filing of this plan of correction does not constitute an admission of the allegations set forth in the statement of deficiencies. The plan of correction is prepared and executed as evidence of the facility's continued compliance with applicable law.</p> <p>Request for IDR has been Submitted for F279 and F314</p> <p>F-279 Resident #1, a care plan for risk for skin breakdown was added 3/12/14. No residents were negatively impacted by the alleged deficient practice. All residents have the potential to be affected by the alleged deficient practice. An audit has been conducted on all current residents care plans for to ensure a risk for skin break down has been identified if clinically indicated. Center licensed nursing staff, will be re-educated on process developing a comprehensive care plan for residents.</p>	
F 279 SS=G		F 279		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE NHA	(X6) DATE 4.03.14
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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.

pmc

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F 279	<p>Continued From page 1</p> <p>Per record review on 3/11/14, Resident #84 was admitted on 9/13/13 with a diagnosis of dementia. Per review of the admission MDS dated 9/26/13, the area of pressure ulcer risk was triggered by the assessment to be an identified risk for Resident #84. The decision to proceed to care planning was marked as "Yes" on the MDS, however there was no plan of care developed to include the prevention interventions for a resident at risk of developing a pressure ulcer. At the beginning of February 2014, Resident #84 became very ill, ceased to ambulate, became more incontinent, and was not eating or drinking well. On 2/11/14, nursing noted a pressure ulcer had developed on the resident's coccyx, and was evaluated to be a stage 3. Treatment was initiated, and a plan of care also initiated to include the recently developed Stage 3 ulcer. The plan of care was incomplete for interventions related to off-loading pressure through a positioning schedule, or mention of a gel cushion that was placed in the resident's recliner. Per interview on 2/12/14 at 9:10 AM, the Unit Manager confirmed that the initial plan of care did not include the identified risk of developing a pressure ulcer for Resident #84, and that the care plan created when the resident developed an actual pressure ulcer on 2/11/14 did not include all the appropriate interventions such as a repositioning schedule or pressure-relieving devices being utilized. Per interview on 3/12/14 at 10:00 AM, the MDS coordinator confirmed that the area of pressure ulcer risk was triggered by the admission MDS on 9/26/13, and that this was an oversight of the care planning team to not include the identified risk in the plan of care.</p> <p>Refer also to F314.</p>	F 279	<p>Administrator or designee will conduct weekly audits x3 then monthly x3 with results to be reviewed at QA meeting for further review and recommendations.</p> <p>Date of compliance: 4/10/2014</p> <p><i>F279 POC accepted 4/10/14</i> <i>SDennis APRN / PML</i></p>	
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F 282 SS=D	<p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</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 record review and staff interviews the facility failed to assure that care was provided according to the plan of care for 1 of 25 residents sampled. (Resident #114). Findings include:</p> <p>Per record review on 3/10/14, the plan of care for Resident #114 stated "Resident exhibits or is at risk for alterations in comfort related to colon/ liver cancer." One of the listed interventions is: "Complete Pain assessment per protocol;" a second intervention was "Evaluate pain characteristics: quality, severity, location, precipitating/ relieving factors". In a review of the facility policy, the Pain management policy states that "At a minimum of daily, patients will be evaluated for the presence of pain by making an inquiry of the patient or by observing for the presence of pain."</p> <p>In Nurses notes there are shifts where it is recorded that the resident received pain medication for stomach pain with good effect but no evidence of regular pain assessments and no evidence of evaluation of pain characteristics. In the PRN (as needed) comments section of the MAR (Medication Administration Record), Tramadol was given 7 times for various "complaints" of pain usually "stomach". There is no evidence of pain evaluation, including level</p>	F 282	<p>F-282 Resident #114 no longer resides at the center. All residents have the potential to be affected by the alleged deficient practice. An audit was conducted of Current residents to ensure That a pain monitor is present And that when PRN pain meds are given pain is assessed before and after the med is given.</p> <p>Center licensed nursing staff will be re-educated on the policies and procedures for assessing pain medication administration. Administrator or designee will Conduct weekly audits x 3 then Monthly x 3. With results to be reviewed at QA For further evaluation and for any other recommendations. Date of compliance: 4/10/2014</p> <p><i>F282 POC accepted 4/10/14 SDennis APRN/pmc</i></p>	
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F 282	Continued From page 3 and severity of pain, in the MAR. At 11:23 AM on 3/12/14 the Director of Nurses confirmed that there is no evidence in the record of daily pain evaluations.	F 282		
F 314 SS=G	<p>483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES</p> <p>Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview, the facility failed to ensure that a resident did not develop a potentially preventable pressure ulcer for 1 of 25 residents sampled (Resident #84). Findings include:</p> <p>Per record review on 3/11/14, Resident #84 was admitted on 9/13/13 with a diagnosis of dementia. Per review of the admission MDS dated 9/26/13, the area of pressure ulcer risk was triggered by the assessment to be an identified risk for Resident #84. The decision to proceed to care planning was marked as "Yes" on the MDS, however there was no plan of care developed to include the prevention interventions for a resident at risk of developing a pressure ulcer. At the beginning of February 2014, Resident #84 became very ill, ceased to ambulate, became</p>	F 314	<p>F-314 Resident #84 continues to receive treatment as directed by the physician. All residents have the potential to be affected by the alleged deficient practice. All care plans of current residents were checked to ensure the presence of a risk for skin breakdown care plan if clinically indicated. Center licensed staff will be educated On the process of the comprehensive Assessment related to identifying risk for skin breakdown and what appropriate Preventive techniques may be instituted. Administrator or designee will conduct weekly audits x3 and then monthly x3 with results to be reviewed at QA meeting for further review and recommendations. Date of compliance: 4/10/2014</p> <p><i>F314 POC accepted 4/18/14 SDennis APRN/PMU</i></p>	

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F 314	Continued From page 4 more incontinent, and was not eating or drinking well. The plan of care was not altered to address the new risk of developing skin breakdown until the actual pressure ulcer was discovered. On 2/11/14, nursing noted a pressure ulcer had developed on the resident's coccyx, and was evaluated to be a stage 3. Treatment was initiated, and a plan of care also initiated to include the recently developed Stage 3 ulcer. The plan of care was incomplete for interventions related to off-loading pressure through a positioning schedule, or mention of a gel cushion that was placed in the resident's recliner. Per interview on 2/12/14 at 9:10 AM, the Unit Manager confirmed that the initial plan of care did not include the identified risk of developing a pressure ulcer for Resident #84, and that the care plan created when the resident developed an actual pressure ulcer on 2/11/14 did not include all the appropriate interventions such as a repositioning schedule or pressure-relieving devices being utilized. Per interview on 3/12/14 at 10:00 AM, the MDS coordinator confirmed that the area of pressure ulcer risk was triggered by the admission MDS on 9/26/13, and that this was an oversight of the care planning team to not include the identified risk in the plan of care.	F 314		
F 441 SS=D	Refer also to F279. 483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.	F 441		

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F 441	<p>Continued From page 5</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it -</p> <ol style="list-style-type: none"> (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. <p>(b) Preventing Spread of Infection</p> <ol style="list-style-type: none"> (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and staff interview for 1 of 11 sampled residents (Resident #40), the facility failed to maintain an infection control program designated to provide a safe and sanitary environment and to help prevent the development and transmission of disease and</p>	F 441	<p>F-441 No residents were negatively affected by the alleged deficient practice. All residents have the potential to be affected by the alleged deficient practice. The nurse involved was immediately educated in maintaining a sanitary environment related to passing medications. Center licensed staff will be re-educated on policies and procedures for maintaining sanitary conditions related to passing medications. Administrator or designee will conduct random weekly audits x 3 months with results to be reviewed at QA meeting for further review and recommendations.</p> <p>Date of compliance: 4/10/2014</p> <p>F441 POC accepted 4/10/14 SDennis APRN/pmc</p>	

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F 441	<p>Continued From page 6 infection. The findings include the following:</p> <p>Per medical record review on 3/11/14 at 10 AM, Resident #40 admitted on 8/10/10 with diagnoses including Dementia, Chronic Airway Obstruction, Asthma, Osteoarthritis, Abnormal Involuntary Movements, Depression and Hypertension.</p> <p>Per Medication Administration Observation on 3/11/14 at 9:30 AM, a Licensed Practical Nurse (LPN) was preparing medications for Resident #40. In her/his attempt to push the capsule/tablet of Cymbalta 60 milligrams (mg) and Atenolol 25 mg out of the bubble pack, s/he missed the medication cup and dropped the capsule and tablet onto the surface of the medication cart. The LPN acknowledged that she dropped the medications, gloved her right hand and picked up the medications, placed them into the medication cup that contained other non-contaminated medications. S/he then proceeded to administer all medications to Resident #40.</p> <p>On 3/11/14 at 9:40 AM, the LPN confirmed, after the administration, that the medications were contaminated and should have been discarded.</p>	F 441		
F9999	<p>FINAL OBSERVATIONS</p> <p>Vermont Licensing Rules for Nursing Homes: 7.15 Physician Services</p> <p>A physician must personally approve in writing a recommendation that an individual be admitted to a facility. Each resident must remain under the care of a physician.</p> <p>(c) Frequency of physician visits. The resident</p>	F9999		

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F9999	<p>Continued From page 7</p> <p>must be seen by a physician:</p> <p>(1) within 48 hours prior to admission or within 48 hours following admission; and</p> <p>(2) at least every 6 months thereafter and as the resident's condition warrants. The facility must assure that physician visits occur as clinically indicated for the resident.</p> <p>Based on record review and staff interviews for 1 of 25 sampled residents (Resident #134), the facility failed to ensure that s/he was seen by the physician within 48 hours prior to admission or within 48 hours following admission. The findings include the following:</p> <p>Per medical record review on 3/11/14, Resident #134 was admitted on 2/17/13 with diagnoses that include Alzheimer's Disease, Atrial Fibrillation, Osteoporosis, Osteoarthritis, Hypertension, Scoliosis, Depressive Disorder, Cardiac Pacemaker, Pulmonary Embolism and Infarction with Deep Vein Thrombosis.</p> <p>Per interview with the Staff Development Nurse on 3/12/14 at 10:25 AM confirmation was made that Resident #134 was last seen by a medical provider at the Community Health Clinic on July 10, 2013.</p> <p>Per medical record review Resident #134 was admitted to the facility from a Community Care Home on 2/17/14.</p> <p>Per medical record review on 3/11/14, Resident #134 was seen by the Nurse Practitioner (NP) on 2/24/14.</p> <p>Per medical record review on 3/11/14, Resident #134 was seen by the attending physician on</p>	F9999	<p>F9999</p> <p>Resident #134 was seen by the Physician on 3/5/2014 and the Physician was made aware the of the visit schedule and required visits on 3/11/2014 No residents were negatively impacted by the alleged deficient practice.</p> <p>All new residents have the potential to be affected by the alleged deficient practice.</p> <p>An audit was conducted to ensure new admissions had a physician visits per required schedule.</p> <p><u>Administrative nursing staff,</u></p> <p><u>Admissions staff, Medical Director and Medical Records staff will be re-educated on the Vermont licensing rules for Physician services related to frequency of physician visits.</u></p> <p><u>Administrator or designee will conduct weekly audits x3 then monthly x3 with results to be reviewed at QA meeting for further discussion and recommendations</u></p> <p><u>Date of compliance: 4/10/2014</u></p> <p><i>F9999 POC accepted 4/10/14</i> <i>S Dennis APRN/PMC</i></p>	

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F9999	<p>Continued From page 8 3/5/14, sixteen days after admission to the facility.</p> <p>Per interview on 3/11/14 at 11 AM, the attending physician confirmed that the date of the his/her first visit with the resident was on 3/5/14.</p> <p>Per interview with the Unit Manager on 3/12/14 at 10:15 AM the physician was notified on 2/17/14 of the resident's admission and orders were verified. Confirmation was also made that the initial visit was by the NP and the physician's first visit was untimely.</p>	F9999		