



VERMONT

AGENCY OF HUMAN SERVICES
DEPARTMENT OF DISABILITIES, AGING AND INDEPENDENT LIVING

Division of Licensing and Protection
103 South Main Street, Ladd Hall
Waterbury VT 05671-2306
<http://www.dail.vermont.gov>
Voice/TTY (802) 241-2345
To Report Adult Abuse: (800) 564-1612
Fax (802) 241-2358

September 21, 2011

Jessica Jennings, Administrator
St. Albans Healthcare and Rehab Ctr
596 Sheldon Road
St. Albans VT 05478

Dear Ms. Jennings:

Enclosed is a copy of your acceptable plans of correction for the on-site complaint investigation on **August 24, 2011**. 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,

A handwritten signature in black ink that reads "Pamela M. Cota".

Pamela M. Cota, RN, BS
Licensing Chief

Enclosure: As noted above.



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

n 9/07/11

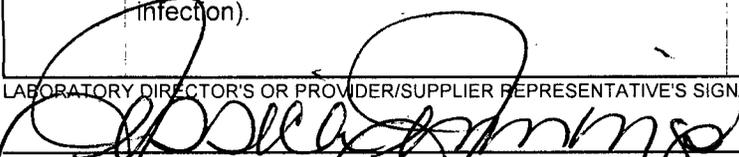
PRINTED: 08/25/2011
FORM APPROVED
OMB NO. 0938-0391

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 08/24/2011
--	---	--	--

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	<p>INITIAL COMMENTS</p> <p>The Division of Licensing and Protection conducted an on-site complaint investigation on 8/24/11. The following regulatory deficiency was identified during the survey:</p> <p>F 281 SS=D 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 upon interview and record review, the facility failed to provide services that meet professional standards of quality for one resident by not following physician orders concerning obtaining a lab specimen, not notifying the physician and family when the lab specimen was unable to be obtained, and not monitoring vital signs per facility policy and procedure. (Resident #1). Finding includes:</p> <p>1. Per record review and confirmed with the Director of Nursing (DNS) at 11:17 AM on 8/24/11, the 7/9/11 Physician's Order for Resident #1 states obtain a Urinalysis and Culture & Sensitivity (UA and C&S) and the 7/9/11 nursing note states "Unable to obtain specimen. Will re-attempt". There is no documentation or laboratory report to confirm that the re-attempt to obtain the specimen was done. The DNS stated the UA and C&S were not done. (A UA and C&S specimen is obtained to determine if a resident has a urinary tract infection).</p>	F 000	<p>F281 St. Albans Health & 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.</p> <p>All residents have the potential to be affected by this deficient practice.</p> <p>The nurse caring for resident #1 who obtained the physician's order for a UA and C&S has been counseled and educated regarding the proper procedure for following a physician's order, notification of the MD and family that the order was not followed, and the center's policy on obtaining vital signs.</p> <p>RN's and LPN's will be educated on tag #281 and the center's policy regarding following physician orders, family and MD notification, and monitoring of vital signs by September 23, 2011.</p>	
-------	--	-------	--	--

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE Administrator	(X6) DATE 9/2/11
---	-------------------------------	----------------------------

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

PRINTED: 08/25/2011
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 08/24/2011
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 281	Continued From page 1 2. Per record nursing note review and confirmed with DNS on 8/24/11 at 2:40 PM there is no documentation that Resident #1's family was notified that the UA and C&S was not done. 3. Per interview and confirmed with the DNS on 8/24/11 at 1:45 PM there is no documentation that Resident #1's physician was notified that the UA and C&S was not done. 4. Per review of the Weights and Vitals Summary and confirmed with the DNS on 8/24/11 at 10:58 AM, Resident #1's Blood Pressure (BP) was not taken from 4/5/11 to 7/29/11. (Resident #1's BP was taken on 4/4/11 and on 7/30/11 prior to admission to the hospital). 5. Per review of the Weights and Vitals summary and confirmed with the DNS on 8/24/11 at 10:50 AM that no temperatures were obtained for Resident # 1 from 4/17/11 to 7/29/11. (Resident #1's temperature was taken on 4/16/11 and on 7/30/11 prior to admission to the hospital). 6. Per record review of the Center's Nursing Policies and procedures 3.5 Vital Signs and confirmed with the DNS on 8/24/11 at 11:54 AM the policy and procedure states "Vital signs (blood pressure, pulse, respiration, and temperature) are monitored monthly for long term admissions or more frequently based upon resident condition. Additional monitoring may be done based upon nursing judgment, physician order or pharmacy recommendation". The DNS stated Resident #1's temperature was not monitored after the physician ordered a UA and C&S for a potential urinary tract infection, Vital Signs were not monitored per facility policy and	F 281	1. The unit managers are to bring all new physician's orders to clinical rounds each morning to ensure that all orders are followed through. Lab audits will be conducted weekly by the DON and/ r her designee to ensure all labs results are placed in the resident's chart in a timely manner. 2. Unit managers will review all physician orders to ensure that family and MD have been updated per center policy. 3. Vital Signs have been added to the resident's treatment sheets. The unit managers will review the TAR's weekly to assure that vitals are obtained per center policy. Audits will be presented during the quarterly meetings x 2 to ensure compliance is met. Corrective action will be completed by September 23, 2011. F281 P.O.C. Accepted 9/17/11 T. Cummings RN, RN, RN		

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

PRINTED: 08/25/2011
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 08/24/2011
--	---	--	---

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 281	Continued From page 2 procedure, and it is the DNS ' s expectation that Vital Signs should be monitored per facility policy and procedure.	F 281		
-------	--	-------	--	--