



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 15, 2010

Ms. Jessica Jennings, Administrator
Saint Albans Healthcare And Rehabilitation Center
596 Sheldon Road
Saint Albans, VT 05478

Dear Ms. Jennings:

Enclosed is a copy of your acceptable plans of correction for the complaint investigation conducted on August 25, 2010. 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 cursive script that reads "Pamela M. Cota".

Pamela M. Cota, RN
Licensing Chief



STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER # 475021	MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	DATE SURVEY COMPLETE: 8/25/2010
NAME OF PROVIDER OR SUPPLIER SAINT ALBANS HEALTHCARE AND REHABILITATION	STREET ADDRESS, CITY, STATE, ZIP CODE 596 SHELDON ROAD SAINT ALBANS, VT		RECEIVED Division of SEP 14 10 RECEIVED Division of SEP 14 10
ID PREFIX TAG F 514	SUMMARY STATEMENT OF DEFICIENCIES		Licensing and Protection Licensing and Protection
	<p>483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE</p> <p>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.</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to maintain a complete, accurately documented clinical record for 1 of 6 residents in the sample (Resident #1). Findings include:</p> <p>In an interview on 8/25/10 at 9:09 AM, the West Wing unit manager confirmed being called to the room of Resident #1 when a Licensed Nurse Assistant (LNA) discovered maggots in the padded footrest of Resident #1's wheelchair. The unit manager confirmed having visualized maggots and that s/he summoned maintenance to take the wheelchair away, then reported to the DNS. In a telephone interview on 8/25/10 at 9:30 AM, an LNA confirmed that on an afternoon in late June, 2010, after putting Resident #1 into bed, s/he was wiping spilled liquid from the wheelchair when maggots began to ooze out of the creases of the cushioned footrest. The LNA estimated seeing 50-60 maggots in the footrest. On 8/24/10 at 2:12 PM, the facility Administrator and Director of Nursing Services (DNS) confirmed that they were immediately advised by West Wing staff of the maggot infestation on an unknown date in late June, 2010. Per review of Resident #1's medical record, there was no documentation pertaining to this incident. When asked, the facility Administrator and/or the DNS were unable to produce any documentation related to the incident or identify a specific date that this occurred.</p>		

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

The above isolated deficiencies pose no actual harm to the residents

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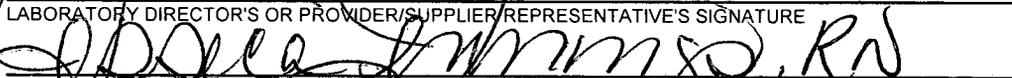
PRINTED: 09/03/2010
FORM APPROVED
OMB NO. 0938-0391

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 08/25/2010
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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	INITIAL COMMENTS	F 000		
F 253 SS=D	<p>483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES</p> <p>The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to provide housekeeping and maintenance services necessary to maintain sanitary resident care equipment for 1 of 6 residents in the sample (Resident #1). Findings include:</p> <p>1. In an interview on 8/24/10 at 1:30 PM, the Director of Maintenance and Housekeeping confirmed that on an unknown date in late June, 2010, the maintenance assistant was called to West Wing to remove the wheelchair of Resident #1 because it was found to have maggots in the creases of the cushioning on the footrest. S/he confirmed having visualized maggots while working with the maintenance assistant to thoroughly wash and disinfect the wheelchair. S/he confirmed that maintenance and/or housekeeping does not have a routine wheelchair washing schedule. In an interview on 8/24/10 at 1:45 PM, the assistant maintenance employee confirmed having been called to West Wing on an afternoon in late June, 2010 in order to remove a wheelchair which had a maggot infestation. S/he described "lots of" maggots coming out of the</p>	F 253	<p>St. Albans Healthcare and Rehabilitation Center provides this plan of correction without admitting or denying any 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>F253</p> <p>Resident #1's wheelchair and foot rest cushion are clean.</p> <p>Residents that utilize wheelchairs have been identified to ensure wheelchairs are clean. A wheelchair cleaning schedule has been developed to ensure each wheelchair is cleaned on a monthly basis.</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER/REPRESENTATIVE'S SIGNATURE 	TITLE NHA	(X6) DATE 9/13/10
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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.

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F 253	Continued From page 1 creases in the cushioned footrest, and that s/he pulled the wheelchair outside to hose it down. On 8/24/10 at 2:12 PM, the facility Administrator and Director of Nursing Services (DNS) confirmed that they were immediately advised by West Wing staff of the maggot infestation on an unknown date in late June, 2010. In an interview on 8/25/10 at 9:09 AM, the West Wing unit manager confirmed being called to the room of Resident #1 when the Licensed Nurse Assistant (LNA) discovered maggots in the padded footrest. The unit manager confirmed having visualized maggots and that s/he summoned maintenance to take the wheelchair away, then reported to the DNS. In a telephone interview on 8/25/10 at 9:30 AM, an LNA confirmed that on an afternoon in late June, 2010, after putting Resident #1 into bed, s/he noticed spilled liquid on the wheelchair seat and down into the footrest, as well as an odor. While s/he was wiping the footrest, maggots began to ooze out of the creases, and s/he ran to get the unit manager. The LNA estimated seeing 50-60 maggots in the footrest. The facility was unable to identify a specific date of this incident or produce any documentation of measures taken to address the maggot infestation. In an interview on 8/24/10 at 2:22 PM, the DNS described the facility wheelchair cleaning policy as at least weekly washing by the night shift nursing staff. The facility was unable to provide a written wheelchair cleaning policy or written evidence that staff had been adhering to the facility's expectation of weekly cleaning.	F 253	Staff has been educated on the new wheelchair cleaning schedule. Audits will be conducted to ensure compliance of cleaning schedule. Administrator and DNS will randomly spot check wheelchairs for cleanliness. Audits will be completed weekly for 4 weeks, monthly for 3 months and quarterly X 3. results of these audits will be reported at CQI, CQI committee will evaluate data and act on the information as indicated. Oversight will be provided by the Administrator and DNS. Corrective Action will be completed by 9/25/10. <i>F253 POC Accepted 9/14/10 AmataRN</i>	
F 371 SS=D	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY	F 371		

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F 371	<p>Continued From page 2</p> <p>The facility must -</p> <p>(1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and</p> <p>(2) Store, prepare, distribute and serve food under sanitary conditions</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to assure that food was stored under appropriate temperatures and sanitary conditions, according to facility policy. Findings include:</p> <p>1. On 8/24/10 at 9:00 AM, the refrigerator in the Center unit nourishment kitchen contained one undated and unlabeled container of a food substance, identified by staff as chocolate mousse, and one undated individual meal. At 9:30 AM, the refrigerator in the West unit nourishment kitchen contained one undated and unlabeled container of a food substance, identified by staff as chocolate mousse. On 8/24/10 at 9:30 AM, the Food Services Director confirmed that the food was undated and unlabeled, and that facility policy is to date and label all food items stored for reuse.</p> <p>2. On 8/24/10 from 9-9:30 AM during the initial facility tour, the posted August temperature logs for the West and Center unit nourishment kitchen refrigerators contained a total of 15 recorded temperatures which were above 41 degrees Fahrenheit. On 8/25/10 at 12:00 PM, the Food</p>	F 371	<p>F371</p> <p>Any food product stored in nourishment kitchen refrigerator is properly stored and labeled.</p> <p>Refrigerators in the nourishment kitchens have been reviewed to ensure that temperature logs are being completed and that all food being stored is labeled and stored appropriately.</p> <p>Staff has been educated on temperature log documentation and proper labeling and storing of food products.</p> <p>Food Service Director will audit temperature logs and food storage and labeling weekly for 4 weeks, monthly for 3 months and quarterly X 3. results of these audits will be reported at CQI, the CQI committee will evaluate the data and act on the information as indicated. Oversight will be provided by the Administrator.</p> <p>Corrective action will be completed by 9/25/10.</p> <p><i>F371 POC Accepted 9/14/10 [Signature]</i></p>	

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F 371	Continued From page 3 Services Director confirmed that there were documented temperatures greater than 41 degrees Fahrenheit, and that no written evidence was available to demonstrate that refrigerator storage temperatures which were above 41 degrees Fahrenheit had been addressed according to facility policy.	F 371			
F 441 SS=D	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. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (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. (b) Preventing Spread of Infection (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.	F 441	F 441 The traveling nurse involved was re-educated on infection control practices and has since been relocated to another center. Residents that require dressing changes have been identified. Licensed staff has been educated on Nursing Policy and Procedure 14.1 Dressing: Aseptic. All licensed staff will have annual competency on aseptic dressing change techniques which will include proper infection control practices in regards to dressing changes.		

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F 441	Continued From page 4 (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to assure that infection control precautions were observed for the cleaning of contaminated, reusable equipment, according to facility policy for 1 applicable resident (Resident #2). Findings include: On 8/24/10 at 11:11 AM, during observation of a dressing change for a wound on the abdomen of Resident #2, the Licensed Practical Nurse (LPN) placed soiled dressing items and gloves directly onto the resident's overbed table. After completing the dressing procedure, disposal, and handwashing, the LPN proceeded out of the room without disinfecting the table. The surveyor voiced a concern that the contaminated table had not been disinfected, and at 11:20 AM, after the observation, the LPN stated, "You were right. I was not going to clean the table top before you asked". Per record review, the wound on Resident #2's abdomen is colonized with Methicillin resistant staphylococcus aureus (MRSA) and "contact precautions" had been ordered. MRSA refers to bacteria that can cause infection which is resistant to treatment with certain antibiotics. Contact precautions are measures that are intended to prevent spread of infectious microorganisms through direct or indirect contact with the resident or the resident's	F 441	Random observations will be completed weekly for 4 weeks, monthly for 3 months and quarterly X 3. results of these audits will be reported at CQI, the CQI committee will evaluate the data and act on the information as indicated. Oversight will be provided by the Administrator and DNS. Corrective action will be completed by 9/25/10. <i>F441 POC Accepted 9/14/10 Administrator</i>	

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F 441	Continued From page 5 environment.	F 441			
F 520 SS=D	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on interview, the facility failed to identify issues with respect to which quality assessment and assurance activities are necessary, and develop and implement appropriate plans of action to correct identified quality deficiencies. Findings include:	F 520	F520 The building has an established a CQI committee that meets quarterly. Concerns will be documented immediately when reported to facility staff. Concerns will be reviewed by the ADM and DNS to determine the appropriate action that needs to be taken. These concerns will be brought forward to the CQI committee. Staff will be inserviced on Administrative policy and procedure 1.15 Center Quarterly Improvement Process. Concerns log will be reviewed by the ADM to determine compliance. Audits will be completed weekly for 4 weeks, monthly for 3 months and quarterly X 3. results of these audits will be reported at CQI, the		

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F 520	Continued From page 6 In late June, 2010, a resident's wheelchair footrest was found to be infested with maggots. On 8/24/10 at 2:12 PM, the Director of Nursing Services (DNS) confirmed that the West Wing unit manager reported to him/her immediately after witnessing the maggots. During this same interview, the facility Administrator confirmed that the DNS had immediately advised him/her of the maggot infestation. The facility Administrator and/or DNS were unable to identify a specific date that this occurred or produce any documentation pertaining to the incident. The facility was unable to provide a written wheelchair cleaning policy or written evidence that staff had been adhering to the facility's expectation of weekly cleaning. The facility was unable to provide documented evidence that follow up was done to assess the extent of the situation in regards to other residents. Furthermore, the facility was unable to produce evidence that they developed or implemented any action plans to address the issue.	F 520	CQI committee will evaluate the data and act on the information as indicated. Oversight will be provided by the Administrator. Corrective Action will be completed by 9/25/10. <i>F520 POC Accepted 9/14/10 AmetARN</i>	