

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

October 11, 2012

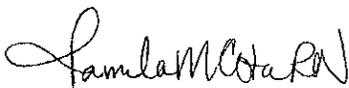
Ms. Jessica Jennings, Administrator
Saint Albans Healthcare And Rehabilitation Center
596 Sheldon Road
Saint Albans, VT 05478-8011

Dear Ms. Jennings:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **September 12, 2012**. 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

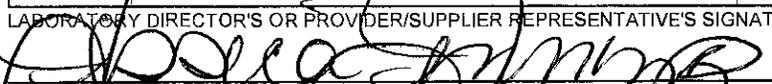
PRINTED: 09/27/2012
FORM APPROVED
OMB NO. 0938-0391

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 09/12/2012
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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
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F 000	INITIAL COMMENTS	F 000	<p>St. Albans Health and Rehabilitation Center provides this plan of correction without admitting or denying the validity or existence of the alleged deficiencies. This plan of correction is prepared and executed solely because it is required by federal and state law.</p>	
F 281 SS=D	<p>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 on observation, record review and interview, the facility failed to provide services that meet professional standards for one applicable resident regarding reporting, monitoring and management of diabetes for 1 applicable resident. (Resident #2) Findings include:</p> <p>1. Per record review on 09/12/12 of Resident #2's Medication Administration record (MAR), there was a failure to monitor blood sugars, a failure to administer medications according to physician's orders, a failure to clarify physician orders that do not have clear and accurate parameters for blood sugar (BS) readings, as well as reporting to the physician status changes. Per the MAR, Lantus insulin (a medication to manage diabetes) 25 units was not administered in the evening of 01/23/12 or 01/24/12. There is no documentation in the nursing notes or the MAR as to why this was not given or notes that it was given. Similarly, the morning BS on 01/21/12 & 01/22/12 were not documented as being</p>	F 281	<p>F281 483.20(k) (3) (i) Services Provided Meet Professional Standards</p> <p>Resident #2 diabetes management occurs per MD orders.</p> <p>Residents have diabetes have the potential to be affected by this alleged deficient practice.</p> <p>Education to licensed staff will be provided on following MD orders for insulin administration, following MD orders on monitoring of blood sugars and notification of MD when a resident refuses insulin.</p> <p>Random audits of the Medication Administration Records (MAR) to ensure that residents who require blood sugar checks and/or insulin are provided these services as ordered by the MD and if a refusal of insulin occurs the MD is notified. These audits will be done weekly x4 then monthly x3 with remedial measures initiated as needed.</p> <p>Findings and trends will be reviewed at the Quality Assurance meeting for a minimum of 3 months.</p> <p><u>The Director of Nursing is responsible</u></p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE Administrator	(X6) DATE 10/05/12
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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 281	<p>Continued From page 1</p> <p>monitored or assessed, nor were there notes in the chart of the residents status or if the physician was made aware of the above developments.</p> <p>The twice daily BS is listed on the January MAR as "FS - b.i.d" (finger stick [to obtain blood sugar reading] twice per day), with reading of anywhere from 76 to 360. Per interview, the Unit Manager stated that s/he was sure the physician or nurse practitioner knows of the results/readings because they come in just about every week, but also stated that s/he was not aware when to notify the physician regarding this individual resident's blood sugars.</p> <p>Resident #2's Medication Administration Record (MAR) showed that the resident had refused the morning doses of Novolog Insulin (a medication to manage diabetes) 70/30 on 01/09/12 - 01/13/12 resulting in blood sugar readings of 315, 286, 320, 349, 347 respectively. Per a note in the resident's chart dated 01/13/12 at 12:46 PM, the Physician Non-visit Progress Note states "Notified by nursing that [resident's] AM [morning] Novolog 70/30 has not been administered for the past 5 mornings resulting in significant hyperglycemia in the afternoon - 300 - 310. Nursing unable to find vial of Novolog 70/30 to administer today's dose. [Physician] had increased dose from 8 units to 12 units q am [every morning] on 1/13/12. Unknown if [physician] was aware that [resident] has not gotten the morning 70/30 Novolog". Per interview on 09/12/12 at 1:27 PM, the Unit manager stated that when a physician is notified, there would be a note in the chart to the date and time of notification and confirmed that there is no evidence that the physician was notified of the</p>	F 281	<p>for the overall management of this individual plan of correction.</p> <p>Corrective actions will be completed October 12, 2012.</p> <p><i>F281 POC accepted 10/10/12 Stammus RN / Pmc</i></p>		

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F 281	Continued From page 2 residents' refusal of medications and subsequent high blood sugar readings. Per interview on 09/12/12 at 3:45 P.M. the DNS (Director of Nursing Services) confirmed that medications were not given as ordered, the BS readings were not documented as being monitored, that the orders for the BS were not individualized nor had parameters and the physician was not made aware changes in treatments according to professional standards. Reference: Lippincott Nursing Manual, Williams & Wilkins, 8th edition	F 281	F353 483.30 (e) Comprehensive Care Plans Resident #4 is now dressed in time for the noon meal. Resident # is now offered to go outside for a walk after lunch, several times a week.		
F 353 SS=E	483.30(a) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care. The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: Except when waived under paragraph (c) of this section, licensed nurses and other nursing personnel. Except when waived under paragraph (c) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty.	F 353	Residents throughout the facility have the potential to be affected by this alleged deficient practice. The facility will pursue an additional 21 hours of staffing/week on the dementia unit to assist in meeting resident needs identified in their care plan. In addition, staff shall be provided with education on developing an effective routine to ensure that there is time to meet the needs of the residents based on their plan of care. Random observations of the noon meal will occur to ensure that residents who are care planned to be dressed by the noon meal are dressed. Additional random observations will occur to ensure that residents who are care planned to be offered walks outdoors occur per the resident's care plan. This will be done weekly x4, then monthly x3 with		

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F 353	Continued From page 3 This REQUIREMENT is not met as evidenced by: Based on observation and staff interviews, the facility failed to assure sufficient staff to provide nursing and related services to maintain the highest practicable well-being of each resident according to residents' assessments and individual plans of care. (Resident #2, #3 & #4) Findings include: 1. Per observation on the Special Care Unit on 09/11/12 at the noon hour meal, Resident #4 was not dressed or showered, and was still in sleep wear. Staff stated that the resident needs a shower and is washed in the morning, but the staff member was unable to 'get to the resident yet'. Per review of the care plan, this resident needs assistance in all areas of care. In addition, during the evening meal at 5:46 P.M., Resident #3 was observed in a small dining area, attempting to pull the bulletin board off the wall, with 2 other residents present. Residents in this small area had no direct supervision. The Unit Manager at that time came to the assistance of the resident. Staff expressed that "especially during meals it gets hectic and we try to meet that residents' needs". 2. Per review of the care plan and assessments for Resident #2, they stated "it is very important to go outside". There are nursing and social service notes since the beginning of the year 2012 that the resident attempted to go out the front door and notes of staff returning the resident to the unit. Per interview on 09/12/12 at 3:15 PM	F 353	remedial measures initiated as needed. Findings and trends will be reviewed at the Quality Assurance meeting for a minimum of 3 months. The Administrator is responsible for the overall management of this individual plan of correction. Corrective actions will be completed October 12, 2012. <i>F353 POC accepted 10/10/12 Seminow RN/PMC</i>		

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F 353	Continued From page 4 the Activity Director (A.D.) stated, "we don't have staff to take [the resident] outside after lunch" and acknowledged that the attempts to leave the building were noted especially after the lunch hour, the resident's preference to go outside. The A.D. confirmed that by the time there is staff available the resident is already napping.	F 353			
F 356 SS=C	483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis: o Facility name, o The current date, o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses, - Licensed practical nurses or licensed vocational nurses (as defined under State law), - Certified nurse aides, o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors. The facility must, upon oral or written request, make nurse staffing data available to the public	F 356	F356 483.30 (a) Sufficient 24-hr Nursing Staff per Care Plan The nurse staffing data is now posted in a prominent area daily. Residents throughout the facility have the potential to be affected by this alleged deficient practice. The staffing coordinator will be provided education on the daily posting of nurse staffing data in a prominent location. Random observations will be conducted to ensure that the nurse staffing data is posted in a prominent area. This will be done weekly x4, then monthly x3 with remedial measures initiated as needed. Findings and trends will be reviewed at the Quality Assurance meeting for a minimum of 3 months.		

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F 356	Continued From page 5 for review at a cost not to exceed the community standard. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure that daily census and staffing information was posted as required. This potentially affects all Residents in the facility. Findings Include: During observation of the facility on Monday 09/11/12 at 1:33 P.M., the facility's census and daily staffing information was inaccurate. The posting was dated Friday 09/07/12 and did not list that a Registered Nurse (RN) was working on any unit. Per interview at that time, the personnel staff who is in charge of staffing (PSS) stated that a RN was working "but this was not captured by the system". In addition, the PSS stated that usually the posting is done first thing in the morning for all three shifts and if there are changes to the staffing or resident census that it is not changed on the posting but rather through their system. The posting for both days of the week-end are prepared in advance (on Friday) which are stacked one upon the other. The PSS confirmed the information was inaccurate for RN coverage, the wrong day was posted and that the data is not posted on a daily basis at the beginning of each shift.	F 356	The Administrator is responsible for the overall management of this individual plan of correction. Corrective actions will be completed October 12, 2012. <i>F356 POC accepted 10/10/12 Summons RN/PMC</i>	
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS	F 441		

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F 441	Continued From page 6 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. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.	F 441	F441 483.65 Infection Control, Prevent Spread, Linens Resident #1 indwelling catheter bag is now covered and placed in a manner to prevent it from touching the floor. Residents with indwelling catheters have the potential to be affected by this alleged deficient practice. Staff will be provided education on keeping the indwelling catheter bags off of the floor. Random observations of residents will indwelling catheters will be conducted to ensure that the catheter bag is not touching the floor. This will be done weekly x4, then monthly x3 with remedial measures initiated as needed. Findings and trends will be reviewed at the Quality Assurance meeting for a minimum of 3 months. The Director of Nursing is responsible for the overall management of this individual plan of correction. Corrective actions will be completed October 12, 2012. <i>F441 PDC accepted 10/10/12 Summers Ruj Pmc</i>	

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F 441	Continued From page 7 This REQUIREMENT is not met as evidenced by: Based on observation and interview the facility failed to implement proper infection control measures for one applicable resident . (Resident #1) Finding include: 1. Per observation on 09/11/12 between 11:15 AM and 2:15 PM, Resident #1, who has a history of urinary tract infections, was noted to have his/her Foley catheter drainage bag uncovered and it was observed to be dragging on the floor. When asked by the nurse surveyor at 2:00 PM, about the drainage bag touching the floor, the LPN (Licensed practical nurse) stated "it wasn't dragging this morning" and was not aware if the drainage bag should be or should not be on the floor . Per interview on 09/12/12 at 12:25 PM the Clinical Staff Educator confirmed the Foley drainage bag should be covered and that there was a breach of infection control practice.	F 441			