

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

May 14, 2012

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

Provider #: 475021

Dear Ms. Jennings:

Enclosed is a copy of your acceptable plans of correction for the survey and complaint investigation conducted on **April 13, 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, MS  
Licensing Chief

PC:ne

Enclosure



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

MAY 08 2012

PRINTED: 04/27/2012  
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 04/13/2012
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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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F 000	INITIAL COMMENTS	F 000		
F 223 SS=G	<p>483.13(b), 483.13(b)(1)(i) FREE FROM ABUSE/INVOLUNTARY SECLUSION</p> <p>The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion.</p> <p>The facility must not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion.</p> <p>This REQUIREMENT is not met as evidenced by: Based on staff interviews and record review, the facility failed to protect 2 residents from the known abusive and assaultive behavior of another resident. (Residents #1, #2 and #4) Findings include: Per record review, Resident #1, who was admitted to the Special Care Unit on 1/2/12 with cognitive impairment, assaulted 2 other residents on the unit, on 3 separate occasions, between 3/27/12 and 3/29/12. On two of the occasions, residents had entered Resident #1's room, unsupervised, and subsequently were assaulted, resulting in injury to one resident which required transfer to the ED (Emergency Department) for evaluation and treatment. Per review a nursing progress note, dated 1/24/12, revealed that the spouse of Resident #1 stated s/he was afraid to</p>	F 223	<p>St. Albans Health and Rehab Center provides this plan of correction without admitting or denying the validity or existence of the allege deficiency. The plan of correction is prepared and executed solely because it is required by federal and state law.</p> <p>Resident #1 has been reviewed by the IDT members. The pharmacist reviewed his medications and made recommendations. The physician made the adjustments and resident has had no further verbal or physical behaviors. A beam alarm is at the bedroom door to alert staff if any resident attempts to enter this resident's room. His care plan has been updated to include 1:1 supervision prn.</p> <p>Resident #2's fracture is healing without Complications.</p> <p>Resident #4 without physical or psychological effects from mentioned incident.</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *[Signature]* TITLE: Administrator DATE: 5.7.2012

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.

*PMK*

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F 223	<p>Continued From page 1</p> <p>bring the resident home due to past violence towards the [spouse]. Subsequent progress notes throughout January and February indicated that Resident #1 had exhibited, on numerous occasions, behaviors targeted at other residents, which included; following, touching and kissing them. Despite this ongoing behavior, there was no evidence that Resident #1 was monitored in a consistent, ongoing manner, during the month of February.</p> <p>A Behavior flow sheet, utilized as a way of monitoring resident behaviors, identified one targeted behavior as; 'sexually inappropriate -kissing other residents', and did not contain documentation indicating the number of episodes of that behavior on 19 of 72 opportunities, for the month of February, 2012. A Psychological consult was conducted on 3/12/12 which included; "inappropriate sexual behaviors" as one of the reasons for referral and identified behavior/conduct problem as one targeted goal for treatment. Subsequent nursing progress notes throughout the month of March revealed ongoing behavioral issues with Resident #1 including notes on 3/25/12 that stated the resident was overheard telling another resident that it was ok to "hit other residents if they are bothering them", and a note on 3/26/12 that indicated Resident #1 was encouraging others to exhibit inappropriate behaviors and "agitating others".</p> <p>A Progress Note, dated 3/27/12, revealed that Resident #1 struck Resident #4 "in the chest making [resident #4] fall to the floor." The following evening, on 3/28/12, another note stated that Resident #1 again struck Resident #4 "in the chest making [resident #4] fall to the floor, back</p>	F 223	<p>All residents on the dementia unit have the potential to be affected by this deficient practice.</p> <p>Medication in-service related to behaviors provided to nurses by Omnicare nurse on 4/24/12 and 4/26/12.</p> <p>Behavior in-service related to dementia scheduled for 5/10/12 and 5/11/12 for all nursing staff.</p> <p>Behavior intervention monitoring audits will be conducted weekly x 4 then monthly x 3. Behavior flow sheets will be audited weekly x 4 and then monthly x 3. This will be monitored by the DON and/or her designee.</p> <p>Results of the audits will be discussed in morning meeting and presented during CQI for further evaluation and recommendations.</p> <p>Corrective action will be completed by <del>May 31, 2012</del>. <i>May 13, 2012</i></p> <p><i>Change in date requested by Administrator for all completion dates on 5/11/12 via electronic mail.</i></p> <p><i>F223 POC accepted 5/11/12</i> <i>BHOWERN/DMCOTARN</i></p>	

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F 223	<p>Continued From page 2</p> <p>and head up against a wheelchair, Witnessed, No injuries." The note further stated that a new order had been obtained that evening to give Seroquel (antipsychotic) 25 milligrams for escalation of behaviors. Despite the two assaults on Resident #4, there was no evidence that Resident #1 was supervised more closely to prevent further incidents.</p> <p>Progress notes revealed that the following evening, on 3/29/12, Resident #2 was assaulted by Resident #1, upon entering that resident's room. Per review, a nursing progress note for Resident #2, dated 3/29/12, indicated that Resident #2 entered Resident #1's room and was "seen flying through the air like a ragdoll and hit [his/her] head and spine on the carpeted floor and hollered out "Oh My Head"...at the time [Resident #2] c/o pain severe in head, spine..." Resident #2 was transferred to the ED (Emergency Department) for evaluation and treatment where a "large tender hematoma" (blood filled tissue) was noted on the back of his/her head. The resident returned to the facility later that evening and a subsequent note, on 3/30/12, revealed s/he had "c/o pain all over", primarily in lower back and had requested assistance with standing and sitting due to pain. The facility was notified, on 3/30/12, by the ED, of a potential discrepancy in the results of the X-ray completed on 3/29/12 and, as a result, Resident #2 was transferred back to the ED on 3/30/12, where follow up diagnostic imaging revealed a fracture of the resident's tailbone. Following the incident on 3/29/12, Resident #1 was monitored continuously throughout the night to assure resident safety and a doorbell alarm was placed on the door of Resident #1's room to alert staff to anyone</p>	F 223			

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F 223	Continued From page 3 entering/exiting the room. Resident #2 had a physician order, dated 3/30/12 at 1:45 PM that stated to increase Tramadol (pain medication) to 50 mg PO (by mouth) every 4 hours for 7 days then re-evaluate. There was a subsequent order, 6 days later, dated 4/5/12, to obtain a head CT scan due to increased confusion and recent trauma, and an order to decrease the Tramadol to 50 mg 3 times a day.  During interview, at 8:57 AM on 4/11/12, the Nurse Unit Manager confirmed that Resident #2 had sustained a fractured tailbone and hematoma on the back of the head as a result of the assault by Resident #1, which resulted in increased pain and required administration of more pain medication. The Unit Manager further stated that Resident #2 subsequently underwent a CT scan of the head related to increasing confusion ultimately thought to have been induced by the increased amounts of pain medication. Per interview, at 4:01 PM on 4/11/12, Nurse #1, who had been responsible for oversight of the care provided to the residents on 3/29/12, confirmed that Resident #2 had entered the room of Resident #1 on the evening of 3/29/12, had been assaulted by Resident #1 and had sustained injury requiring evaluation and treatment at the ED. Nurse #1 further confirmed that Resident #1 had assaulted Resident #4 on 2 separate occasions on the 2 consecutive nights prior to 3/29/12.	F 223			
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP  The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to	F 280			

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F 280	<p>Continued From page 4 participate in planning care and treatment or changes in care and treatment.</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Based on staff interview and record review the facility failed to revise the plan of care to reflect the current status of 2 of 3 residents reviewed. (Residents #1 and #3) Findings include:</p> <p>1. Per record review, the care plan for Resident #1, who was admitted to the facility on 1/2/12 with cognitive impairment, had not been revised to reflect ongoing behavior issues involving aggressive and assaultive behavior towards other residents. The comprehensive care plan, initiated on 1/4/12, identified behaviors exhibited by the resident which included wandering, hugging and kissing other residents. Interventions to address the behaviors included; approach resident in a calm friendly manner, assess and manage unmet needs such as: pain, toileting, fatigue and hunger;</p>	F 280	<p>St. Albans Health and Rehab Center provides this plan of correction without admitting or denying the validity or existence of the allege deficiency. The plan of correction is prepared and executed solely because it is required by federal and state law.</p> <p>Resident #1's care plan has been revised to reflect his behavior issues involving assaultive &amp; aggressive behaviors and interventions.</p> <p>Resident #3 care plan/interventions have been revised to reflect his behavior issues involving aggressive and assaultive behaviors.</p> <p>All residents with behavior care plans have the potential to be affected by this deficient practice.</p> <p>Licensed staff will be educated on center policy and procedure regarding revision of plan of care to reflect resident's current status.</p> <p>Behavior care plan audits will be Conducted weekly x 4 and then Monthly x 3 by DON and/or her Designee. Results of the audits Will be discussed at CQI for Further evaluation and Recommendations.</p>		

Corrective action will be completed by  
~~May 31, 2012~~ May 13, 2012

F280 POC accepted 5/11/12  
BHowe RN / PMcotarn

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F 280	<p>Continued From page 5</p> <p>redirect resident when wandering into other resident's rooms; remind resident of personal space and redirect resident to provide space between self and others, and remind resident to alert staff when residents wander into his/her space.</p> <p>A progress note, dated 3/27/12, revealed that Resident #1 struck Resident #4 "in the chest making [resident #4] fall to the floor." The following evening, on 3/28/12, another note stated that Resident #1 again struck Resident #4 "in the chest making [resident #4] fall to the floor..." The note further stated that a new order had been obtained that evening to give Seroquel (antipsychotic) 25 milligrams for escalation of behaviors. Despite the two assaults on Resident #4, Resident #1's care plan was not revised to reflect the assaultive behavior, the use of medication to address behaviors, nor were any other new interventions, such as heightened supervision of the resident, identified and implemented to prevent further assaultive behavior.</p> <p>Per review, a nursing progress note for Resident #2, dated 3/29/12, indicated that Resident #2 entered Resident #1's room and Resident #2 was "seen flying through the air like a ragdoll and hit [his/her] head and spine on the carpeted floor and hollered out 'Oh My Head'...at the time [Resident #2] c/o pain severe in head, spine..." Resident #2 sustained a hematoma on the back of the head and a fractured tailbone as the result of the assault. It wasn't until after the third assault that Resident #1's care plan was revised to reflect the assaultive behavior and new interventions implemented to prevent further incidents.</p>	F 280		

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F 280	Continued From page 6  2. Per record review, staff failed to revise the care plan for Resident #3 to reflect episodes of increasing aggressive and assaultive behaviors towards other residents and failed to identify and implement new interventions to address the behavior. The resident, who was admitted on 3/7/12 and whose medical conditions included dementia, had a care plan, last revised on 3/9/12, that identified specific behaviors as; "resistive to care, physical and verbal aggression towards others with redirection, combative with staff, wandering, socially inappropriate, yelling, and inappropriate urinating patterns." Interventions to prevent/reduce episodes of behavior included: allow resident time to vent feelings/needs; approach resident in a calm friendly manor; assess and manage unmet needs such as pain, toileting, fatigue and hunger; encourage resident to attend activities of choice and adjust time; if first refused care re-approach resident at a later time; and document interventions and resident's response.  Review of progress notes from 3/9/12 through 4/11/12 revealed multiple incidents of verbal and physical abusive and aggressive behavior towards staff and other residents. A nursing progress note, dated 3/9/12 indicated Resident #3 had been in an altercation with his/her room mate and redirection and "1:1" provided. Subsequent progress notes, dated 3/10/12 and 3/11/12 indicated that 1:1 or "closer observation" at the nurses station were interventions utilized by staff to assure safety. Despite the ongoing behaviors, and the recognized need for closer supervision at times, the care plan had not been updated to include this intervention or any new	F 280			

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F 280

Continued From page 7 intervention since 3/9/12.

During interview, at 4:01 PM on 4/11/12 , the Nurse Unit Manager confirmed the care plan for Resident #1 had not been revised until after the 3rd incident of assault. S/he also confirmed that, despite the ongoing behavioral issues, Resident #3's care plan had not been updated to reflect any new interventions identified since 3/9/12.

F 280