

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

January 18, 2013

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 **December 28, 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:ne

Enclosure



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

RECEIVED
Division of LICENSING and PROTECTION
PRINTED: 01/11/2013
FORM APPROVED
JAN 17 11
OMB NO. 0938-0391

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 475021 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | Licensing and Protection | (X3) DATE SURVEY COMPLETED C 12/28/2012 |
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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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INITIAL COMMENTS

F 225
SS=D

An unannounced, on-site complaint investigation was conducted by the Division of Licensing and Protection on 12/28/2012. The following regulatory deficiencies were identified:

483.13(c)(1)(ii)-(iii), (c)(2) - (4)
INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS

The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law, or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.

The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).

The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.

The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance

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F 225

F225 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.

The employee referenced was suspended upon notification and terminated after the investigation was completed.

All residents have the potential to be affected by this deficient practice.

Education regarding the Vermont Abuse Prohibition Regulation and Genesis Policy will be completed by January 28, 2013 to all nursing staff.

Random audits will be conducted to ensure that the nursing staff are education on the proper procedure for reporting incidents of alleged abuse. This will be completed weekly x 4 and then monthly x 3.

Findings and trends will be reviewed at the Quality Assurance Meeting for a minimum of three months.

The Administrator is responsible for the overall Management of this individual plan of Correction.

Corrective Action will be completed by January 28, 2013.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X8) DATE

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 225

Continued From page 1
with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.

This REQUIREMENT is not met as evidenced by:
Based on review of personnel records, resident medical records, facility investigations and staff interviews, the facility staff failed to promptly notify the administration of an alleged incident involving one resident (Resident #1) of 5 residents reviewed. The specifics are as follows:

Per review of medical record review on 12/28/2012 at 3:42 PM, the nurses notes indicate that Resident #1 raised his/her fist to an employee on 08/27/2012. The facility had reported to the Licensing Agency on 08/29/2012 that a staff member yelled at and grabbed Resident #1's arm on 08/27/2012. Pending the outcome of the facility internal investigation, the employee involved in the episode was suspended when the administration became aware of the situation on 08/29/2012.

Per review of the facility investigation and written witness statements, the LNAs (Licensed Nursing Assistants) who witnessed this incident did not report it to the administration when it first happened, assuming that the nurse in charge was aware and would make the proper notification. The employee was subsequently terminated on 08/31/2012.

During interview with the Director of Nursing

F 225

F225 POC accepted 1/18/13
G Coleman RN / PMC

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| F 225 | Continued From page 2 (DON) on 12/28/2012 at 4:45 PM, s/he confirms that direct care staff did not report this incident as directed in the facility abuse prohibition policy but that the facility did notify the State Licensing Office when they became aware of it, 2 days later. | F 225 | | |
| 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 medical record review and staff interviews, the facility failed to implement the written care plan for 1 of 5 residents in the sample (Resident #1). The specifics are as follows:</p> <p>Per medical record review on 12/28/2012 at 3:42 PM, Resident #1 is hearing impaired and has bilateral hearing aids. The care plan, revised on 08/14/2012, directs the staff to "speak directly to the resident, do not yell or shout." Per nurses notes dated 08/27/2012, an LNA was heard to be yelling at Resident #1 indicating that s/he needs to wait to use the bathroom.</p> <p>The DNS confirms during interview on 12/28/2012 at 4:43 PM that the care plan was not followed by the staff, resulting in an escalation of both resident and staff behaviors.</p> | F 282 | <p>F282 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> <p>The employee referenced was suspended upon notification and terminated after the investigation was completed.</p> <p>All residents have the potential to be affected by this deficient practice who have impaired hearing loss.</p> <p>The nursing staff will be educated by January 28, 2013 regarding the center's policy for implementing interventions per the written plan of care.</p> <p>Care plan intervention audits for residents who have been identified as having impaired hearing will be conducted three times per week x 4 and then monthly x 3 by the Director of Nursing and/or her designee.</p> <p>Results of the audits will be reviewed at the Quality Assurance Meeting for a minimum of three months.</p> <p>The Director of Nursing is responsible for the Overall management of this individual Plan of correction.</p> | |

Corrective Action will be completed by January 28, 2013.

FABA POC accepted 1/18/13
G Coleman RN/PMC