

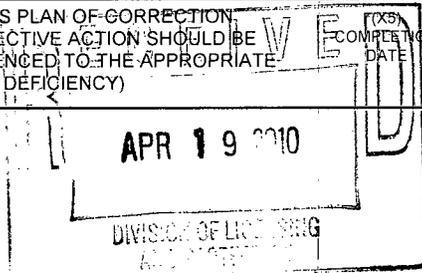
DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/07/2010
FORM APPROVED
OMB NO. 0938-0391

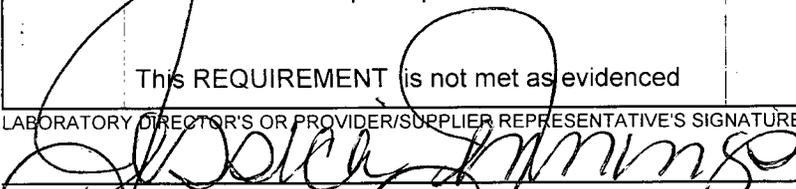
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 475021	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/24/2010
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NAME OF PROVIDER OR SUPPLIER SAINT ALBANS HEALTHCARE AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 596 SHELDON ROAD SAINT ALBANS, VT 05478
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F 000	INITIAL COMMENTS The Division of Licensing and Protection conducted an onsite, unannounced annual recertification survey 3/22/10 - 3/24/10.	F 000	
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F 272 SS=D	<p>483.20, 483.20(b) COMPREHENSIVE ASSESSMENTS</p> <p>The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity.</p> <p>A facility must make a comprehensive assessment of a resident's needs, using the RAI specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed through the resident assessment protocols; and Documentation of participation in assessment.</p> <p>This REQUIREMENT is not met as evidenced</p>	F 272	<p>St. Albans Health & Rehabilitation Center provides this plan of care without admitting or denying the validity or existence of the allege deficiencies. The plan of correction is prepared and executed solely because it is required by federal and state law.</p> <p>Resident #85's care plan was updated on 3/22/10 to reflect his individual plan of care regarding nutritional status, edema, and interventions that had been in progress.</p> <p>In order to identify other residents having the potential of being affected by the same alleged deficient practice any resident with a weight loss of 5% or greater in a month has been identified to ensure that a comprehensive assessment has been completed.</p> <p>Licensed staff will be in-serviced on Nursing Policy 3.0 Assessment and Management of Patients Weights. A Weekly audit will be conducted for the next 4 weeks to Ensure that any weight loss of 5% or greater has been Reported t the Dietician and physician and that a comprehensive Nutritional Assessment has been completed.</p> <p>Results of these audits will be reported to the CQI Committee by the DNS. The CQI committee will Evaluate the data and act on the information as indicated.</p> <p>Corrective action will be completed by April 22, 2010</p>
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE NHA	(X6) DATE 4-15-10
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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 272	Continued From page 1 by: Based upon interview and record review, the facility failed to conduct a comprehensive assessment for one resident (Resident #85) following a significant weight loss. Findings include: Per record review conducted on 3/24/10, Resident #85's weight was documented on the Weight and Vitals Summary as being 212.1 pounds on 10/12/09. On 11/18/09, the weight was documented as being 190.2 which indicated a 21.9 weight loss since admission on 10/9/09. Staff interviews with the Dietician on 3/24/10 at 8:18 AM and the DNS on 3/24/10 at 11:47 AM confirmed that Resident #85 lost 21.9 pounds from 10/12/09 to 11/18/09 and that a comprehensive assessment was not conducted.	F 272	<i>4/12/10 pic A accepted F272</i> 		
F 279 SS=G	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under	F 279			

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F 279	Continued From page 2 §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on observation, interviews and record review, the facility failed to develop a comprehensive care plan for 3 residents (#s 78, 164, 166) in the applicable sample. Findings include: 1. Per record review for Resident #78 on 3/24/10, staff failed to develop a comprehensive care plan for potential for skin breakdown. Resident #78 did not have a pressure ulcer upon admission to the facility and subsequently developed an unstageable pressure ulcer on the left heel. Resident #78 has a diagnosis of diabetes and scored less than 10 on the Norton Pressure Ulcer scale. Scores less than 10 indicate high risk for pressure ulcers. The Unit Manager confirmed during a 2:47 PM interview on 3/24/10 that there was no care plan for potential for skin breakdown and stated that it is "absolutely" normal procedure to develop this type of care plan for a resident with the above conditions. 2. Per record review on 3/24/10, staff failed to develop a comprehensive care plan for Resident #166 to address the Stage I pressure ulcer present since admission on 3/4/10. Per interview on 3/24/10 at 9:00 AM, the charge nurse confirmed that staff had not developed a comprehensive assessment for the left heel Stage I pressure ulcer for Resident #166.	F 279	St. Albans Health & Rehabilitation Center provides this plan of care without admitting or denying the 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. Care plans were updated for residents #78, #166, and #164 to reflect the individuals care plan in regards to potential for alteration in skin integrity. In order to identify other residents having the potential of being affected by the same alleged deficient practice any resident at high risk for skin breakdown has been identified to ensure that care plans for "Potential for Skin Breakdown" are in place. Any resident admitted to the center with a pressure ulcer and/or foley catheter has been identified to confirm that care plans have been initiated. In-servicing is being conducted with all licensed staff on care plan development. Audits will be conducted on all new admissions for the next 4 weeks to ensure that care plans are developed to reflect the care that will be provided. Results of these audits will be reported to the CQI committee by the DNS. The CQI committee will evaluate the data and act on the information as indicated. Corrective action will be completed by April 22, 2010		

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page for R-279
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F 279	Continued From page 3	F 279			
F 281 SS=D	<p style="text-align: center;">F281</p> <p>3. Per observation and record review, Resident #164 was admitted from the hospital on 3/11/10 with an indwelling Foley catheter in place, which was still in use during the first two days of survey. Per review of the resident's record, the MDS Assessment stated there was an indwelling Foley catheter, the RAP was triggered, and the box checked to proceed to care planning, however there was no care plan developed for the use of the indwelling catheter. Per interview on 3/24/10 at 2:40 PM, the charge nurse confirmed that due to an oversight, the care plan was never developed to reflect the goals and interventions related to the use of an indwelling catheter.</p> <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 record review and staff interview, the facility failed to transcribe a physician telephone order to the resident's record for one resident in the sample (Resident # 164). Findings include:</p> <p>1. Per observation and staff interview, Resident #164 was admitted from the hospital on 3/11/10 with an indwelling Foley catheter in place, which was still in use during the first two days of survey. Per review of the resident's record, there was no physician order recorded for the use of the catheter. Per interview on 3/24/10 at 2:40 PM, the</p>	F 281	<p>St. Albans Health & Rehabilitation Center provides this plan of care without admitting or denying the validity or existence of the allege deficiencies. The plan of correction is prepared and executed solely because it is required by federal and state law.</p> <p>Resident #164's charge nurse was re-educated on admission transcription orders.</p> <p>In order to identify other residents having the potential of being affected by the same alleged deficient practice any resident with a foley catheter has been identified to ensure that a physicians order is written in the medical record.</p> <p>F 28: All licensed staff will be in-serviced on Nursing Policy 4.2, Transcription of orders and Administrative Policy 2.16 taking Medication and Treatment orders. For the next 4 weeks audits will be conducted on all residents admitted with a foley catheter to ensure that an MD order is in place in the medical record.</p> <p>Results of these audits will be reported to the CQI committee by the DNS. The CQI committee will evaluate the data and act on the information as indicated.</p> <p>Corrective action will be completed by April 22, 2010</p>		

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F 281	Continued From page 4 charge nurse confirmed that s/he discussed the catheter with the physician, who said to leave it in temporarily for medical reasons. The nurse confirmed that the admission orders, including the catheter use, were taken over the telephone, however the order for the catheter was never written on the sheet for this resident, and there was no record of the conversation in the resident's record. A telephone order from the physician was received on 3/23/10 to remove the Foley catheter, which was done on that date.	F 281	<p><i>4/22/10 pac for F 281 accepted</i></p> <p>St. Albans Health & Rehabilitation Center provides this plan of care without admitting or denying the 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>Resident #78's treatment sheets were reviewed to assure that diabetic foot checks were in place. Unit managers were educated on transfers from one unit to assure care plans were being followed.</p> <p>In order to identify other residents having the potential of being affected by the same alleged deficient practice any resident with a diagnosis of Diabetes has been identified to ensure that Diabetic foot checks are being completed per plan of care.</p> <p>Licensed staff will be in-serviced on Nursing Policy 9.28 Treatments. Treatment Administration Sheets of Diabetic residents will be audited weekly for 4 weeks to ensure compliance.</p> <p>Results of these audits will be reported to the CQI Committee by the DNS. The CQI committee will evaluate the data and act on the information as indicated.</p> <p>Corrective action will be completed by April 22, 2010</p>	
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to implement the care plan for one resident in the applicable sample (Resident #78). Findings include: Per record review on 3/24/10, staff failed to perform diabetic foot checks for Resident #78 as indicated by the care plan. Resident #78 has a diagnosis of diabetes and developed a pressure ulcer on the left heel. A diabetic care plan dated 12/8/09 called for daily diabetic foot checks. Review of the Treatment Record showed that no foot checks were done in December 2009 and were not initiated until 1/3/10. This was confirmed by the Unit Manager on 3/24/10 at 2:47 PM	F 282		
F 314	483.25(c) TREATMENT/SVCS TO	F 314		

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F 314 SS=G	Continued From page 5 PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure that one resident (#78) did not develop an avoidable pressure ulcer. Findings include: Per record review on 3/24/10, Resident #78 who has a diagnosis of diabetes, developed a pressure ulcer on the left heel. Per the initial nursing assessment on 11/25/09, the resident did not have a pressure ulcer. Per a 2/11/10 note from a vascular physician, Resident #78 has "dry, gangrenous eschar left heel secondary to pressure". The facility did not develop a care plan upon admission despite a Norton Pressure Ulcer Scale that indicated high risk and a diagnosis of diabetes. The facility also failed to perform daily diabetic foot checks for the month of December 2009 as indicated on the diabetic care plan. The above failures were confirmed by the Unit Manager on 3/24/10.	F 314	St. Albans Health & Rehabilitation Center provides this plan of care without admitting or denying the validity or existence of the allege deficiencies. The plan of correction is prepared and executed solely because it is required by federal and state law. Resident #78 care plan was updated on 03/24 /10 to include a care plan on alteration in skin integrity with interventions being performed. In order to identify other residents having the potential of being affected by the same alleged deficient practice any resident at high risk for alteration in skin integrity has been identified t ensure a care plan for Potential for Skin Breakdown is in place. Diabetic residents have also been identified to ensure that diabetic foot care is being conducted per the resident's care plan. Licensed nurses will be in-serviced on pressure ulcer prevention, care plan initiation and diabetic foot care and ensuring completion of necessary treatments. Audits will be conducted weekly for 4 weeks confirming that care plans are in place for residents at high risk for skin breakdown. Treatment sheets will also be audited for compliance. Results of these audits will be reported to the CQI committee by the DNS. The CQI team will evaluate the data and act on the information as indicated. Corrective action will be completed by April 22, 2010	

F314
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F314 accepted
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