

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

June 21, 2013

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 **May 1, 2013**. 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



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

RECEIVED
Division of
PRINTED: 06/10/2013
JUN 10 11 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 01 - 01 BUILDING B. WING _____	Licensing and Protection (X3) DATE SURVEY COMPLETED 05/01/2013
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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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K 000	INITIAL COMMENTS	K 000		
K 017 SS=D	<p>An unannounced onsite Life Safety Code inspection was completed by the Division of Fire Safety on 5/1/13. The following are violations of applicable Life Safety Code requirements.</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Corridors are separated from use areas by walls constructed with at least ½ hour fire resistance rating. In sprinklered buildings, partitions are only required to resist the passage of smoke. In non-sprinklered buildings, walls properly extend above the ceiling. (Corridor walls may terminate at the underside of ceilings where specifically permitted by Code. Charting and clerical stations, waiting areas, dining rooms, and activity spaces may be open to the corridor under certain conditions specified in the Code. Gift shops may be separated from corridors by non-fire rated walls if the gift shop is fully sprinklered.) 19.3.6.1, 19.3.6.2.1, 19.3.6.5</p> <p>This STANDARD is not met as evidenced by: Based on observation, the facility failed to ensure partitions resist the passage of smoke in 1 area of the building.</p> <p>Per observation on 5/1/13, accompanied by facility staff, the corridor doors located at W19 and the Scheduling office have door coordinators that do not allow the doors to close as designed.</p>	K 017 K 017	<p>St. Albans Health and Rehab Center provides this plan of correction without admitting or denying the validity or existence of the alleged deficiency. The plan of correction is prepared and executed solely because it is required by federal and state law.</p> <p>All residents have the potential to be affected by this deficient practice.</p> <p>The two doors that were cited were adjusted on May 1st to properly close per Life Safety Regulations.</p> <p>The maintenance department will be inspecting all corridor doors to assure that they close properly each month during the generator testing and with the monthly fire alarm drill.</p> <p>The Maintenance Director will present The results of these audits at the CQI For further evaluation and recommendations.</p> <p>Corrective action will be completed by June 30, 2013.</p>	
K 038	NFPA 101 LIFE SAFETY CODE STANDARD	K 038	<i>K017 not accepted 6/20/13 JBenard /PMC</i>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>[Signature]</i>	TITLE <i>Administrator L.M.</i>	(X6) DATE
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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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K 038 SS=D	Continued From page 1 Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 This STANDARD is not met as evidenced by: Based on observation, the facility failed to assure that exits are readily accessible at all times for 1 exit in the facility. Per observation on 5/1/13, accompanied by facility staff, the egress door located at the north end of the East Wing would not open within the 15 second time limit when tested.	K 038	F 038 The magnet on the East Wing door was adjusted to assure that the door opened within 15 seconds per Life Safety regulations. Residents residing on the east wing have the potential to be affected by this deficient practice. The maintenance director and/or his designee will perform monthly audits to ensure that all exit doors are in proper operation. Results of these audits will be presented at CQI for further evaluation and recommendations.		
K 046 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Emergency lighting of at least 1½ hour duration is provided in accordance with 7.9. 19.2.9.1. This STANDARD is not met as evidenced by: Based on observation, the facility failed to ensure emergency lighting is provided in 1 area of the facility. Per observation on 5/1/13, accompanied by facility staff, the emergency light located at the west wing nurses' station failed to function when tested.	K 046	K 046 Corrective action will be completed by June 30, 2013. K 046 The emergency light at the west wing nursing station has been replaced with a new emergency light. Residents on the west wing have the potential to be affected by this deficient practice. The maintenance director and/or his designee will perform monthly audits to ensure that all emergency lighting is working properly.		
K 052 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety is installed, tested, and maintained in accordance	K 052	K 052 Results of these audits will be presented at CQI for further evaluation and recommendations. Corrective action will be completed by June 30, 2013.		

*K038 + K046 POCS accepted 5/20/13
J. Benard / MLC*

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K 052	Continued From page 2 with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4 This STANDARD is not met as evidenced by: Based on observation, the facility failed to ensure the fire alarm system is maintained in accordance with NFPA requirements. Per observation on 5/1/13, accompanied by facility staff, there are violations noted for the fire alarm system.	K 052	K 052 Life Safety has been in once and are Scheduled to return on 6/17/13 to correct the mentioned violations noted for the fire alarm system. All residents have the potential to be affected by this deficient practice. Audits will be completed with fire Panel inspections and results of these audits will be presented at CQI for further evaluation and recommendations. Corrective action will be completed by June 30, 2013.	
K 062 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA-13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: Based on observation, the facility failed to ensure that sprinkler systems are continuously maintained in reliable operating condition. Per observation on 5/1/13, accompanied by facility staff, the protective caps for the exterior	K 062	K 062 The protective caps for the exterior Fire department connection located At the rear of the center have been Replaced by R&R company. All residents have the potential to be affected by this deficient practice. Maintenance and R&R will check these caps twice a year with each testing of the sprinkler system to assure they are not broken. The maintenance director and/or his designee will present these audits at CQI for further evaluation and recommendations.	

Corrective action will be completed by June 30, 2013.

*Rosa - K062 CQI accepted 5/10/13
J. Bernard / RMC*

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K 062 K 130 SS=D	<p>Continued From page 3 fire department connection located at the rear of the building near the portable generator are broken.</p> <p>NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786</p> <p>This STANDARD is not met as evidenced by: Based on observation, the facility failed to ensure compliance with all other applicable Life Safety Codes.</p> <p>Per observation on 5/1/13, accompanied by facility staff, the following was observed:</p> <ol style="list-style-type: none"> 1. Inspection revealed that there appears to be a lack of adequate combustion air for the Laundry Room. The screens were removed and the openings blocked with plastic, thereby restricting the flow of combustion air for the dryers. 2. Inspection revealed a smell of natural gas in the kitchen. It was discovered that two gas valves were in the on position for a griddle they no longer use. The pilots for the burners also did not function. 3. Inspection revealed that the records for the building systems were not up to date. 	K 062 K 130	<p>The plastic on the windows in the Laundry room was removed on 5/1/13 To assure proper ventilation of air flow.</p> <p>The mentioned griddle in the kitchen has been eliminated and capped so it no longer can be used.</p> <p>The Maintenance Director is on a FMLA and will receive a Performance Improvement Plan regarding record keeping when and if he returns. A Maintenance Consultant from another Genesis Center has been brought in to work with our maintenance assistance. A system has been put into place to assure that records are maintained per regulation.</p> <p>The maintenance director and/or his designee will perform monthly audits x 4 months and results of these audits will be presented at CQI for further evaluation and recommendations.</p> <p>Corrective action will be completed by June 30, 2013.</p>	

*K130 rec accepted 6/20/13
JBenard/arc*