

Division of Licensing and Protection
103 South Main Street
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

March 2, 2015

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 **February 4, 2015**. 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

PRINTED: 02/12/2015
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 02/04/2015
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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	F252 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.	
F 252 SS=D	<p>483.15(h)(1) SAFE/CLEAN/COMFORTABLE/HOMELIKE ENVIRONMENT</p> <p>The facility must provide a safe, clean, comfortable and homelike environment, allowing the resident to use his or her personal belongings to the extent possible.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to provide a safe and homelike environment in one resident bathroom shared by 4 residents (Residents #16, #22, #107, and #114). Findings include:</p> <p>Per observation on 2/2/15 at 9:50 AM, during the initial tour of the facility, the bathroom shared by the four residents in rooms 16 and 18 on the west wing unit was noted to have bare purple sheetrock behind the toilet that had not been primed or painted. On the wall above and to the right of the toilet there were three plumbing fixtures that were no longer in use that protruded from the wall a couple of inches. Near the floor also on the right of the toilet, there were two metal plumbing fixtures no longer in use that protruded out a couple of inches. On 2/4/15 at 9:45 AM, during the environment tour, the Head of Maintenance stated that the contractors who</p>	F 252	<p>The wall in the mentioned bathroom between West 16 and 18 will be repaired, the plumbing fixtures will be closed in, and the wall will be painted.</p> <p>The residents in West 16 & 18 have the potential to be affected by this deficient practice.</p> <p>Maintenance will assess bathrooms as part of their preventative maintenance rounds monthly and make appropriate repairs.</p> <p>Audits will be performed weekly x 4 and Monthly x 3 to assure that residents have a safe and homelike environment.</p> <p>Results of the audits will be discussed at CQI for further evaluation and recommendations.</p> <p>Corrective action will be completed by March 4, 2015</p> <p>F252 POC accepted 2/24/15 sDennis APW/PWL</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
	NHA	2.18.2015

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 252	Continued From page 1 installed the new bathroom fixtures a few months ago and put up the mold resistant sheetrock, should have removed the old plumbing fixtures that are protruding out of the wall as they are no longer in use, and that the wall had not been primed or painted yet to improve the homelike quality of the bathroom.	F 252		
F 257 SS=E	483.15(h)(6) COMFORTABLE & SAFE TEMPERATURE LEVELS The facility must provide comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 - 81° F This REQUIREMENT is not met as evidenced by: Based on observation and interviews, the facility failed to provide comfortable and safe temperatures in the building. Findings include: Per observation during the initial tour on 2/2/15 at 10:20 AM, the hallway between one of the doors to the Special Care Unit and heading toward the west wing felt very cold. Per observation at that time, there was a sliding glass door that led from the hallway out to the courtyard that was allowing a very cold draft to blow in. Per further inspection, there was two areas at the bottom of the door that were not sealed, and the light was visible through those spaces. At the edge of the glass door, the draft was easily felt coming into the hallway. A tour was conducted between 11:05 and 11:25 AM with a laser surface thermometer, starting with the hallway where the broken glass door is located. The hallway near the door registered an average of 54 Degrees Fahrenheit. This hallway	F 257	F257 Estimates have been obtained from Gene's Electric to add additional heat to Center's utility hallway~attached. All residents have the potential to be affected by this deficient practice. Maintenance is monitoring the temperatures on the units to assure that the center re- mains in compliance with the temps between 71-81 degrees. This is being performed twice a day for at least 5 times per week and will continue until the heat is installed. Audits after the heat is installed will continue Weekly x 4 and then monthly x 3. Results of the audits will be discussed at CQI for further evaluation and recommendations. Corrective action will be completed by March 10, 2015	

F257 POC accepted 2/24/15 SDennis APPA/PML

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F 257	<p>Continued From page 2</p> <p>also contained the beauty parlor, a staff break room, a loading dock door to the outside, and just outside the fire doors, a resident activity room. Around the corner from the hallway going toward the Center wing, the Rehab gym was tested for temperatures. The highest reading for the surface temperatures in that room were 62 Degrees F. The Physical Therapist present in the room at the time confirmed these readings at 11:15 AM.</p> <p>On C-wing the room temperatures were all under 71 Degrees F, with room 26 reading only 66 degrees F on 2/3/15 at 11:30 AM. The room temperatures were reading higher as I progressed around to Center West wing, but did not read over 71 Degrees F. until the middle of the Center West hallway. Per interviews with residents and family members during the three days of survey, there were multiple complaints of cold temperatures and drafty windows. On 2/4/15 at 9:50 AM, during a tour of the environment with the Head of Maintenance, the broken glass door was observed to be covered with sheetrock, which had been recommended as a temporary solution by the fire safety inspectors during the time of the survey. The hallway was warmer, reading 63 Degrees F., and the fire doors leading to the hallway remained closed to contain the colder air. Per interview at the time of this observation, the Head of Maintenance confirmed that the door had been broken since before the winter, and that the plan was to fix the door in the spring.</p>	F 257		
F 279 SS=D	<p>483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS</p> <p>A facility must use the results of the assessment to develop, review and revise the resident's</p>	F 279		

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F 279

Continued From page 3 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 §483.10, including the right to refuse treatment under §483.10(b)(4).

This REQUIREMENT is not met as evidenced by:
Based upon record review and staff interview, the facility failed to develop a comprehensive care plan that addressed the care needs and parameters around changes for an indwelling catheter for 1 of 3 residents in the stage 2 sample with a urinary catheter (Resident #131). Findings include:
Per 2/3/15 record review, Resident #131 was admitted to the facility on 1/20/15 with an indwelling Foley catheter for urinary retention. On 2/3/15 at approximately 2:50 PM, a facility nurse Unit Manager (UM) confirmed that although there was a care plan for the indwelling catheter, the plan and the Treatment record (TAR) did not specify the catheter type or size or parameters around changing the catheter or the date of the last catheter change. The above information was

F 279

F279 Resident #131 care plan was updated to include the catheter type/size and the parameters on changing the catheter.

All residents having a catheter have The potential to be affected by this deficient Practice.

All nurses have been educated on the center Policy for writing care plans.

Care Plan audits will be completed weekly X 4 and then monthly x 3 to assure that Comprehensive care plans developed.

Results of the audits will be discussed at CQI for further evaluation and recommendations.

Corrective action will be completed by March 4, 2015.

F279 POC accepted 2/24/15 SDavis/APR/PMU

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F 279	Continued From page 4 confirmed by the UM at the time of the interview.	F 279		
F 281 SS=D	<p>(Refer 281) 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 medical record review and staff interview, the facility failed to meet professional standards of practice by failing to obtain physician orders for an indwelling Foley catheter for 1 of 24 residents in the stage 2 sample (Resident #131). Findings include:</p> <p>Per 2/3/15 record review, Resident #131 was admitted to the facility on 1/20/15 with an indwelling Foley catheter for urinary retention. Per review of the physician orders, there were no orders to indicate the urinary catheter size or type or parameters around the frequency of change. The Unit Manager (UM) stated that the facility protocol for catheter changes typically includes that the urinary catheter be changed at the frequency indicated by the physician and if it became obstructed (plugged), the resident was experiencing pain related to the catheter, there was heavy sediment or as needed for problems.</p> <p>On 2/3/15 at approximately 2:50 PM, a facility nurse Unit Manager (UM) confirmed that physician orders had not been obtained for the urinary catheter and were missed when the resident was admitted to the facility.</p>	F 281	<p>F281 A physician order was obtained on Resident #131 for the urinary catheter.</p> <p>All residents having a catheter have The potential to be affected by this deficient Practice.</p> <p>All nurses have been educated on the center's Policy regarding physician orders.</p> <p>Physician order audits will be completed Weekly x 4 and then monthly x 3 to assure Services provided meet professional Standards.</p> <p>Results of the audits will be discussed at CQI for further evaluation and recommendations.</p> <p>Corrective action will be completed by March 4, 2015.</p> <p><i>F281 POC accepted 2/24/15 SDevin/APRW/PMU</i></p>	

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F 281	Continued From page 5 (Refer F279)	F 281		
F 309 SS=D	<p>Reference: Lippincott Manual of Nursing Practice (9th ed.). Wolters Kluwer Health/Lippincott Williams & Wilkins.</p> <p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING</p> <p>Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to accurately communicate to caregivers the correct amount of daily fluid restriction as per the written physician's order for 1 of 24 residents in the applicable sample (Resident #53). Findings include:</p> <p>During an interview with a Licensed Nurse Assistant (LNA) on 2/4/15 at 9:00 AM, s/he described the process for tracking resident consumption of fluids and reviewed with this surveyor the LNA fluid intake documentation for Resident #53 (admitted on 1/12/15). The Intake and Output ("I & O") sheets for Resident #53 indicated that s/he should receive no more than 1800 cc (1 cc=1 mL) per day of fluid intake. Per record review, the physician's written medical order indicated that Resident #53 should be limited to a daily total fluid intake of 1500 cc</p>	F 309	<p>F309 The I/O sheet for resident #53 was corrected to reflect the physician order.</p> <p>All nurses have been educated on accurate Communication of physician orders regarding Fluid restrictions to care Givers.</p> <p>All residents on a fluid restriction have The potential to be affected by this Deficient practice.</p> <p>Audits of daily fluid restrictions will be Performed weekly x 4 and then monthly X 3. Results of the audits will be discussed at CQI for further evaluation and recommendations.</p> <p>Corrective action will be completed by March 4, 2015.</p> <p><i>F309 POC accepted 2/24/15 SDennis APRN/pmc</i></p>	

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F 309	Continued From page 6 (related to End Stage Renal Disease and dialysis). On 2/4/15 at 9:10 AM, the nurse unit manager confirmed that the I & O sheets for Resident #53 were set up with a fluid restriction of 1800 cc per day rather than 1500 cc per day as ordered by the physician. Per interview with the Dietary Services Manager later on 2/4/15, s/he confirmed that for residents with a fluid restriction order, no fluids are served or placed on the dining trays by dining staff; the fluids are provided by LNA staff so that they can track the liquids consumed. Review of the documentation did not indicate that Resident #53 had actually been given fluids to exceed 1500 cc per day; however, the process of fluid administration and tracking by LNA staff had no other safeguards in place to prevent potential excessive fluid intake.	F 309		