

Division of Licensing and Protection

HC 2 South, 280 State Drive

Waterbury, VT 05671-2060

<http://www.dail.vermont.gov>

Survey and Certification Voice/TTY (802) 241-0480

Survey and Certification Fax (802) 241-0343

Survey and Certification Reporting Line: (888) 700-5330

To Report Adult Abuse: (800) 564-1612

April 6, 2016

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 March 16, 2016. 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: 03/30/2016
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 03/16/2016
NAME OF PROVIDER OR SUPPLIER SAINT ALBANS HEALTHCARE AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 596 SHELDON ROAD SAINT ALBANS, VT 05478		
(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	
F 000	INITIAL COMMENTS An unannounced onsite recertification survey was conducted by the Division of Licensing & Protection on 3/14/16-3/16/16 . The following regulatory deficiencies were identified as a result of the survey:	F 000	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.		
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to Store, prepare, distribute and serve food under sanitary conditions. Findings include: Per observation on 3/14/16 at 9:20 AM, the following unsanitary conditions were observed in the kitchen during the initial tour accompanied by the Dining Services Director (DSD): In the walk-in refrigerator: 1. An open box of Frozen Nutritional Treats approximately 1/3 full of individual containers was observed. The box label states "keep frozen at 0 Degrees F or below". The DSD identified the	F 371	F371 All food items mentioned in F371 were Disposed of immediately, the walk-in freezer Floor was cleaned on 3/14/16, and the fan was Removed from the kitchen immediately to be Cleaned. All residents have the potential to be affected By this deficient practice. Dietary staff will be educated on proper Procedure for food storage, preparation/serve And sanitation by 4/4/2016. Audits will be performed 5 times a week x 4 weeks, And then 3 times per week. Results of the audits will be discussed at CQI for further evaluation and recommendations. Corrective action will be completed by April 16, 2016.		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *[Signature]* TITLE *Executive Director* (X8) DATE *4.1.16*

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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CENTERS FOR MEDICARE & MEDICAID SERVICES

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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 _____	(X3) DATE SURVEY COMPLETED 03/16/2016
NAME OF PROVIDER OR SUPPLIER SAINT ALBANS HEALTHCARE AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 596 SHELDON ROAD SAINT ALBANS, VT 05478	
(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			

F 371 | Continued From page 1

F 371 | F371 POC accepted 4/15/16 SDennis/PW/pme

items as Magic Cups and stated that they should be frozen and were probably stored in the refrigerator by mistake

2. A plastic container labeled tomato puree dated good through 3/5/16.

3. Plastic container of what the DSD identified as vanilla pudding that is unlabeled as to date and content.

In the walk-in freezer:

1. On the left side of the walk-in freezer floor there is an approximately 12" x 36" ice buildup. The ice appears to range from 1/2" - 3" thick. There was additional loose ice buildup at the rear of the freezer on the floor. The floor of the freezer had dirt and debris in several locations.

A fan on the floor in operation was heavily soiled with dust. The fan was directed across the kitchen area.

The DSD confirmed the above observations on 3/14/16 at 9:30 AM.

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

AH
"A" FORM

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER # 475021	MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	DATE SURVEY COMPLETE: 3/16/2016
NAME OF PROVIDER OR SUPPLIER SAINT ALBANS HEALTHCARE AND REHABILITAT	STREET ADDRESS, CITY, STATE, ZIP CODE 596 SHELDON ROAD SAINT ALBANS, VT		
ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES		
F 278	<p>483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED</p> <p>The assessment must accurately reflect the resident's status.</p> <p>A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.</p> <p>A registered nurse must sign and certify that the assessment is completed.</p> <p>Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.</p> <p>Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$5,000 for each assessment.</p> <p>Clinical disagreement does not constitute a material and false statement.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility failed to assure that the MDS comprehensive assessment accurately reflected the resident status for 2 residents in a sample of 19, Residents #15 and #129 (R#15 & R#129). Findings include:</p> <p>1). Per record review, R#129 was admitted to the facility on 12/11/15 on Hospice. In review of the admission MDS dated 12/18/15, the resident is coded not to have a terminal illness that may result in a life expectancy of less than 6 months. In a physician's note completed by the facility Nurse Practitioner on 12/14/15 s/he states that the resident was "Admitted to SAHR [St Albans Health and Rehab] on 12/11/15 from NMC on HOSPICE with newly dx'd [diagnosed] bronchogenic lung cancer." In order for a resident to receive Hospice services s/he must be certified to have a terminal diagnosis that will result in a life expectancy of less than 6 months. The facility MDS coordinator is currently on medical leave. On 3/16/16 the Director of Nurses confirmed that the MDS stated that the resident was not coded as having a terminal illness. Per record review, the resident died 33 days after admission to the facility.</p> <p>2). Per review of the nursing progress notes dated 1/19/16, Resident #15 was admitted to the facility on 1/19/16 for "recent acute illness" and "rehabilitation." Per review of the resident's 2/20/16 thirty day MDS (minimum data set), Resident #15 was coded "yes" as having a "condition or chronic disease that may result in a life expectancy of less than 6 months." On 03/14/2016 at 3:33:48 PM, the center west unit manager confirmed that the resident does not have a terminal illness or life expectancy of less than 6 months and that there was an error in the MDS coding.</p>		

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The above isolated deficiencies pose no actual harm to the residents