

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

March 20, 2014

Mr. Phillip Condon, Administrator
Franklin County Rehab Center Llc
110 Fairfax Road
St Albans, VT 05478-6299

Dear Mr. Condon:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **February 5, 2014**. 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:jl

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

RECEIVED
Division of
PRINTED: 03/06/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 475047	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	MAR 10 14 Licensing and Protection	(X3) DATE SURVEY COMPLETED 02/05/2014
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NAME OF PROVIDER OR SUPPLIER FRANKLIN COUNTY REHAB CENTER LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 110 FAIRFAX ROAD ST 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
F 000	INITIAL COMMENTS	F 000		
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 comprehensive plan of care.</p> <p>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.</p> <p>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).</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility failed to assure the development of a care plan for one resident receiving anticoagulant therapy for 1 of 19 in the stage 2 sample (Resident #17). Findings include:</p>	F 279	<p>F-279. FCRC has reviewed and revised its care plan procedures. The revision is: a 2nd nurse will review the care plan for accuracy. This will be monitored by the QAPI nurse to ensure compliance. Completion date March 4, 2014.</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *Phillip A. Gordon* TITLE: *administrator* (X6) DATE: *03/14/2014*

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.

F279, F319, F367 POC's accepted 3/19/14 PML

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F 279	Continued From page 1 Per record review, Resident #17 is receiving Coumadin (a blood thinning medication) 5 mg (milligrams) by mouth every Monday through Friday and Coumadin 7.5 mg by mouth every Saturday and Sunday. During Stage 1 observations on 2/3/2014, bruises were noted on the back of the resident's left hand. Per resident interview on 2/3/14 at 3:43 PM the resident stated, "I get bruises really easy and I just bump my hands and there they are. Sometimes I bump into doors." The resident was observed self-propelling his/her wheelchair around the facility independently during the survey. Per interview on 2/5/2014 at 9:36 AM, the LTC Unit Manager stated that s/he does the LTC care plans and there is input from the Interdisciplinary Team (ID). Other departments also develop and revise care plans related to their departments. S/he acknowledged that a resident on anticoagulant therapy would usually have a Bleeding Risk care plan and that there was no anticoagulant care plan in the record, active or discontinued, for this resident.	F 279			
F 319 SS=D	483.25(f)(1) TX/SVC FOR MENTAL/PSYCHOSOCIAL DIFFICULTIES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who displays mental or psychosocial adjustment difficulty receives appropriate treatment and services to correct the assessed problem. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility	F 319	F-319 FCRC has implemented an interdisciplinary team who reviews all residents with uncontrolled behaviors to establish an appropriate plan of care. This is monitored by the DON. Date of Completion 3/17/2014		

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F 319	<p>Continued From page 2</p> <p>failed to ensure that residents who display mental or psychosocial adjustment difficulty receive appropriate treatment and services to correct the assessed problem for 1 of 19 residents in the stage 2 sample (Resident # 48). Findings include:</p> <p>Per 2/4/14 medical record review, Resident #48 was admitted to the facility on 8/14/13 with a diagnosis of anxiety and was identified as having behavioral symptoms. His/her nursing progress notes from 8/25/13 to January 2014 document agitation and striking out at staff providing AM care; 8/27/13 "combative with staff;" 9/1/13 Ativan (an anti-anxiety medication) given for anxiety; 9/5/13 combative, "hit LNA in face with hand," "unable to provide care at this time;" 10/2/13 increased agitation overnight, "yelling, swinging fists;" 10/4/13 was "shaking fist" at RN; 10/13/13 hitting the aide, "became aggressive" "struck RN with [his/her] hand on left cheek" and "balled up [his/her] fist;" 11/1/13 threatened to harm staff, "shaking [his/her] fist and started yelling;" 11/6/13 kicked aide during care; 12/6/13 kicking staff; 1/30/14 monthly summary, combative at times, refuses to come out of room. Per review of the physician progress notes, on 11/11/13 Resident #48 was started on Remeron (an antidepressant).</p> <p>Per 2/5/14 interview at 9:33 AM, the social service staff confirmed that Resident #48 was identified as having an adjustment disorder and combative behaviors. There is no evidence that the facility systematically assessed the behavioral symptoms and arranged for appropriate treatment and services to correct the assessed problem.</p> <p>(See also F387)</p>	F 319			

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F 387 F 387 SS=E	Continued From page 3 483.40(c)(1)-(2) FREQUENCY & TIMELINESS OF PHYSICIAN VISIT The resident must be seen by a physician at least once every 30 days for the first 90 days after admission, and at least once every 60 days thereafter. A physician visit is considered timely if it occurs not later than 10 days after the date the visit was required. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff and administrative interview, the facility failed to ensure that residents were seen by a physician at least once every 30 days for the first 90 days after admission and at least every 60 days thereafter for 5 of 19 residents in the stage 2 sample (Residents # 12, # 48, # 101, # 65, and # 50). Findings include: 1. Per 2/4/14 medical record review, Resident #12, a resident for 2 years in the facility, was seen by his/her physician on 7/25/13. The next documented physician visit occurred on 11/4/13, an interval of more than 3 months later. Per regulation, Resident #12 was to have physician visits at least every 60 days. Per 2/4/14 interview at 2:00 PM, the Director of Nursing (DNS) reported that the resident's doctor transferred his/her care to another provider on 9/9/13. Per 2/4/14 interview at 4:24 PM, the facility administrator reported there was a difficult transition when the former medical director and primary physician for many of the facility's residents stopped seeing patients in the facility in	F 387 F 387	F- 387. FCRC has developed a system to track physician visits and notify providers when their required 30 or 60 day visits are due. This will be monitored by the charge nurses and the DON. Completion date March 4, 2014.		

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F 387	<p>Continued From page 4 early September (2013) and the new medical director assumed care.</p> <p>2. Per 2/4/14 medical record review, Resident # 48 was admitted to the facility on 8/4/13 and was seen by his/her physician on 8/5/13; the requirement was for the resident to have physician visits at a 30 day interval for 90 days, then every 60 days thereafter. The next documented physician visit occurred on 11/11/13, more than 3 months after the initial visit. Per 2/5/13 interview at 11:38 AM, the DNS confirmed s/he was not able to provide evidence of any other physician visits occurring during the interval between 8/4/13 and 11/11/13.</p> <p>3. Per 2/5/14 medical record review, Resident # 101 was admitted to the facility on 7/2/13 and was seen by his/her physician on 7/5/13; the requirement was for the resident to have physician visits at a 30 day interval for 90 days, then every 60 days thereafter. The next documented physician visit occurred on 11/11/13, more than 4 months later. Per 2/5/13 interview at 11:38 AM, the DNS confirmed s/he was not able to provide evidence of any other physician visits occurring during the interval between 7/2/13 and 11/11/13.</p> <p>4. Per record review on 2/4/14, Resident #65 was seen by the physician on 7/25/13. The next physician visit was due by the end of September 2013, however the resident was not seen by the physician until 11/4/13 due to the transition of doctors as stated above. This was confirmed by the Director of Nursing on 2/5/14 at 9:30 AM.</p> <p>5. Per record review on 2/4/14, Resident #50 was admitted to the facility on 7/12/13. Due to this</p>	F 387			

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F 387	Continued From page 5 being a new admission to the facility, the requirement was for the resident to have 30 day physician visits for 90 days, then every 60 days after that. Per review, the physician saw the resident on 7/19/13, and then again on 11/18/13. This did not meet the requirement for 30 day visits, and was almost 4 months between physician visits to the resident. This was also confirmed by the DNS on 2/5/14 at 9:30 AM.	F 387			

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER # 475047	MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	DATE SURVEY COMPLETE: 2/5/2014
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ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES		
F 514	<p>483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE</p> <p>The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.</p> <p>The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.</p> <p>This REQUIREMENT is not met as evidenced by: Based on medical record review and administrative and staff interview, the facility failed to maintain clinical records on each resident that are complete, accurate and readily accessible and in accordance with accepted professional standards and practices for 1 of 19 residents in the stage 2 sample (Resident #12). Findings include:</p> <p>Per 2/4/14 medical record review, the physician orders for the period covering 10/1/13-10/31/13 and 11/1/13-11/30/13 were missing from Resident #12's clinical record. Per 2/4/14 interview at 2:55 PM, the Director of Nursing (DNS) reported the facility had had a recent change in the staff that does medical record filing and would look for the missing documents. On 2/5/14 at 11:38 PM, the DNS confirmed that the orders had not been found.</p>		

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The above isolated deficiencies pose no actual harm to the residents