

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 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 **February 6, 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

PC:jl



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

RECEIVED
Division of

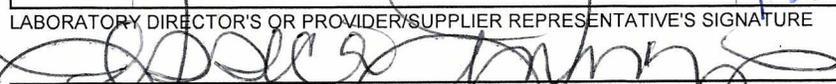
PRINTED: 03/01/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 475021	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ Licensing and Protection	(X3) DATE SURVEY COMPLETED C 02/06/2013
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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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F 000	INITIAL COMMENTS	F 000		
F 225 SS=D	<p>An unannounced on-site complaint investigation was conducted from 02/05/13 to 02/06/13 by the Division of Licensing and Protection. The following are regulatory findings.</p> <p>483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS</p> <p>The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.</p> <p>The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.</p> <p>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance</p>	F 225	<p>F225 St. Albans Health and Rehabilitation Center Provides this plan of correction without admitting or denying the validity or existence of the alleged deficiencies. This plan of correction is prepared and executed solely because it is required by federal and state law.</p> <p>The employee in question has since had her Employment terminated. All employees have Signed the center's policy regarding cell phone Use and it has been implemented in the new Staff orientation program.</p> <p>All residents have the potential to be affected by This deficient practice.</p> <p>All staff will be in serviced on the center's Abuse Prohibition policy and the Personal Cell Phone Policy by March 22, 2013.</p> <p>Random audits will be conducted to ensure that the nursing staff are education on the proper procedure for reporting incidents of alleged abuse. This will be completed weekly x 4 and then monthly x 3.</p> <p>Findings and trends will be reviewed at the Quality Assurance Meeting for a minimum of three months.</p> <p>The Administrator is responsible for the overall Management of this individual plan of Correction.</p> <p>Corrective Action will be completed by March 22, 2013.</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE Administrator	(X6) DATE 3/10/13
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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 225	<p>Continued From page 1 with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility failed to provide evidence that all alleged violations of mistreatment are thoroughly investigated and reported to other officials in accordance with State law through established procedures for 1 applicable resident (Resident #3). The findings include:</p> <p>1. A video of Resident #3 who is identified as having dementia, was posted on a social media web-site without family or the resident's permission. Per interview on 02/05/13 at 8:15 A.M. the DNS said "it was brought to my attention by [staff] that on [another staff's social media web-site] posted something that said 'this is why I love my job' and then there were people's feet but no faces and [Resident #3] was singing. I didn't do an investigation because there was no identifiable people and not sure if [Administrator] might have spoke to [her/him]". The DNS was unable to state the date of the incident, but believes it was before December 2012.</p> <p>Per review of the of the facility policy for 1.102 -Personal cell phones and hand held devices Policy: "staff may not use cell phones....when in patient care area including patient rooms, dining areas, community room, and adjacent hallways or while attending patients in any location on the</p>	F 225			

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F 225	Continued From page 2 grounds or in the Center." Purpose [second bullet] "to protect patient privacy" Process: 4. "prohibit taking patient photographs for any reason without both Administrator and patient authorization in writing " 4.1 "prohibit 'sending' or 'posting' patient photographs" Per interview with nursing staff on 02/05/13 at 11:27 stated "I think anytime you post something even if the resident is not seen that would still be a violation because of our policy on cell phones. And this could be a dignity thing if the family could recognize the voice or the area where it was taken. It is not very professional to be carrying a phone and doing that whether or not the face is seen". Per interview on 02/05/13 at 12:04 P.M. the Administrator stated that all employees are given the handbook that states the policy of cell phone use and "I don't think there is a record of the incident." S/he confirmed that the resident and/or family were not asked permission prior to the social media web-site posting of Resident #3's singing. Although s/he spoke to the staff person to remove the posting, there was no documented thorough investigation nor was this reported to the State Agency.	F 225			
F 241 SS=D	Also see F241. 483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in	F 241			

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F 241	Continued From page 3 full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on record review and interviews the facility failed to promote care for 1 applicable resident in a manner and that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. (Resident #3) The findings include: 1. An anonymous complaint received on 12/18/12 to the Division of Licensing and Protection (State Agency) stated that a resident of the facility was posted on a staff person's social media web-site. This resident was identified as living on the dementia unit at that time. The complainant also stated that you could hear [Resident #3] singing 'You are my sunshine', and although [the resident's] face wasn't visible, the reporter said s/he could identify who the resident was. Per the follow up interview with the Nurse surveyor, the witness stated "it was on the web-site for a few days. The resident was asked several times to sing and [the staff] was heard giggling". Per interview on 02/05/13 at 8:15 AM the DNS said "it was brought to my attention by [staff] that on [another staff's social media web-site] posted something that said 'this is why I love my job' and then there were people's feet but no faces and [Resident#3] was singing. I didn't do an investigation because there was no identifiable people and not sure if [Administrator] might have spoke to [her/him]". The DNS was unable to state the date of the incident, but believes it was	F 241	F241 All employees have Signed the center's policy regarding cell phone use and it has been implemented in the new staff orientation program. The Genesis Authorization to Use, and Disclose Medical Information for Marketing/Publicity form has been included in the admission paperwork, and a system has been implemented by Social Service to obtain Signatures of residents already in house. All residents have the potential to be affected By this deficient practice. All nursing staff will be educated on the center's policy regarding Personal Cell Phone use in relation to residents dignity and respect by March 22, 2013. Random audits will be conducted to ensure that the staff are educated on the proper procedure for maintaining resident's dignity in relation to cell phone usage. This will be completed weekly x 4 and then monthly x 3. Findings and trends will be reviewed at the Quality Assurance Meeting for a minimum of three months. The Administrator is responsible for the overall Management of this individual plan of Correction. Corrective Action will be completed by March 22, 2013.		
			F-241 Poc Accepted 3/20/13 Joan J. Emmons RN		

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F 241	Continued From page 4 before December 2012. Per interview with nursing staff on 02/05/13 at 11:27 AM stated "I think anytime you post something even if the resident is not seen that would still be a violation because of our policy on cell phones. It is not very professional to be carrying a phone and doing that whether or not the face is seen. And this could be a dignity thing if the family could recognize the voice or the area where it was taken". Per interview on 02/06/13 at 12:04 P.M. the Administrator confirmed the posting of the resident heard singing and that the incident did not enhance the resident's dignity and respect in full recognition of his or her individuality.	F 241			
F 280 SS=D	Also see F225 483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed	F 280	F280 Resident #2 care plan has been revised to Reflect this resident's current status. All residents with the potential for falling Are at risk for this deficient practice. The nurses will receive education related To the center's policy and procedure for Care plan revisions by March 22, 2013. Random audits will be completed to Ensure that residents with falls have had A care plan revision weekly x 4 and then Monthly x 3.		

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F 280	Continued From page 5 and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interviews the facility failed to revise the care plan for 1 of 6 residents in the sample. (Resident #2) Findings include: 1. Per observation on 02/05/13 at 9:09 A.M. Resident #2 had numerous bruises on the top/left forehead and butterfly strips on the right side temple area of the head. Per review of the medical record and care plan the resident was noted to have had 6 falls in 3 days. The care plan was dated 02/02/13. Per interview at 3:30 P.M. the staff nurse stated that over the weekend (02/02/13-02/03/13) the resident had multiple falls. S/he also stated that the physician was notified and made changes to the pain medication. There were no revisions to the care plan for any of the additional falls noted. Per interview at 5:04 P.M. the Unit Manager confirmed "the care plan should've been revised with each fall and new interventions should've been noted, which did not happen in this case".	F 280	Findings and trends will be reviewed at the Quality Assurance Meeting for a minimum of three months. The Director of Nursing and or her designee is responsible for the overall Management of this individual plan of Correction. Corrective Action will be completed by March 22, 2013.		
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.	F 282	F282 After speaking with this resident's husband the care plan has been updated to reflect that the resident's current status related to her eye glasses. All residents wearing glasses have the potential to be affected by this deficient practice.		

*F-280 POC Accepted
3/22/13 Susan J. Emmerson RN*

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F 282	Continued From page 6 This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to assure services were provided in accordance to the care plan for 1 of 6 residents in the applicable sample. (Resident #1) Findings include: 1. Per observation on 02/05/13 at 9:07 A.M. Resident #1 was ambulating unsteadily and staff assisted the resident back to the bed. The resident did not have glasses on at this time. Per interview at 10:07 A.M. a family member was visiting and stated to the nurse surveyor that "an \$800 pair of glasses went missing in October 2012, the facility is aware [and looked for them], they were bifocals...but we brought in another pair of glasses". Per review of the care plan, it states "at risk for falls, cognitive loss, episodes of syncope, poor safety awareness, refusal with assist with ambulation and will self transfer", interventions include to help "sit up and regain equilibrium; assist out of bed; 1 assist w/ gb [with gait belt] and rw [rolling walker] if res refuses, monitor safety and re-approach; provide glasses when ambulating; verbal cues for safety; clutter free environment". Per interview at 3:15 P.M. the staff nurse stated, "the glasses are in the med room, I don't think [s/he] used them since we got them [in Oct 2012]. [S/he] seemed to not adjust to them so we didn't use them". The nurse confirmed that there was	F 282	The nursing staff will receive education related to the center's policy regarding implementation of individual resident's care plan. Random audits will be performed to assure that residents with glasses have their services provided in accordance to their plan of care. Findings and trends will be reviewed at the Quality Assurance Meeting for a minimum of three months. The Director of Nursing and or her designee is responsible for the overall management of this individual plan of Correction. Corrective Action will be completed by March 22, 2013.		

*F282 POC Accepted
3/20/13 Susan J. Emmons RN*

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F 282	Continued From page 7 no nursing note to that effect and was not sure if the family was aware as there was a care plan meeting in December 2012 with no revisions regarding glasses. S/he confirmed that the care plan was not followed as written.	F 282			
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.	F 441	F441 The product "Dispatch" was purchased for rooms designated as isolation rooms. Housekeeping staff will use premixed solutions and will no longer mix their own bleach products. All residents have the potential to be affected by This deficient practice. The housekeeping staff will be educated on the proper procedure for cleaning and disinfecting per the center's policy by March 22, 2013. Random audits will be performed by the Director of Housekeeping weekly x 4 and Then monthly x 3 to assure that proper Cleaning materials are utilized to prevent Spread of infection. Findings and trends will be reviewed at the Quality Assurance Meeting for a minimum of three months. Corrective Action will be completed by March 22, 2013.		
			F441 POC Accepted 3/20/13 Susan J. Commons RN		

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F 441	<p>Continued From page 8</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and observation, the facility failed to assure that staff follow cleaning procedures to prevent possible spread of infection. The practice can affect residents dependent on staff on the special care unit. (Up to 30 residents per the Resident Roster) Findings include:</p> <p>1. Per interview, a housekeeping staff member stated on 02/05/12 at 2:10 P.M. that for cleaning beds and general surface areas, that either Virexx or a combination of bleach and water is used. The housekeeper further explained that Virexx is pre-mixed, however the bleach/water combination needs to be prepared. S/he further explained and showed that s/he puts "a capful of bleach in the bottle". It is noted that the bottle was a quart size with a spray top.</p> <p>LNA and nursing staff stated at 2:25 P.M. that when housekeeping is not available that they use the pre-mixed Lysol wipes [which contain bleach]. They do not use the bleach/water combination.</p> <p>Per interview on 02/05/13 at 2:47 P.M. the Housekeeping Director (HKD) confirmed that staff at times will use the bleach/water combination and also stated "a capful [of bleach] into the quart bottle [with water]". A review of the</p>	F 441		

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F 441	Continued From page 9 the MSDS [material safety data sheet] and Manufacturer's bleach label states that for proper disinfection a 1/4 cup {2 oz/4 Tbsp} per quart. Per observation at that time the HKD measured 1 capful which was less than 1 ounce. The HKD confirmed at that time "1 capful would not be enough in 1 quart of water to disinfect". The HDK stated staff will be directed to use only the pre-mix Virexx from now on.	F 441		
F 465 SS=E	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to provide a safe environment for residents on the special care unit. Findings include: Per observation, on 02/05/13 at 9:09 A.M., the metal base board heating covers in the dining/common area and in the small dining area under the window had sharp protruding bent metal edges. Room 21 had no end cover on the heater plus the vents were dusty and dirty. Room 26 window bed had the base cove coming off the wall and exposure to the sheet rock/wallboard. During interview and joint observation later that day, the Maintenance Director confirmed the above findings and immediately fixed the metal heaters, stated that the heater's vents will be scheduled and cleaned and that the base cove	F 465	F465 The environmental areas of mention were repaired immediately by the maintenance assistant. The heaters have been cleaned Throughout. All residents on the dementia unit have the Potential to be affected by this deficient Practice. Education was provided to the maintenance staff regarding physical plant inspection and routine maintenance. The nursing staff was educated on the use of using the maintenance log on each unit to maintain a safe and comfortable environment. Random audits will be performed by the Maintenance Director and or his designee Weekly x 4 and then monthly x 3 to assure that the center maintains a safe and comfortable living environment. Findings and trends will be reviewed at the Quality Assurance Meeting for a minimum of three months. Corrective Action will be completed by March 22, 2013.	

F465
Doc accepted 3/20/13
Susan J. Emmons RN

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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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F 465	Continued From page 10 needed to be re-glued.	F 465		
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