
DEPARTMENT OF DISABILITIES, AGING AND INDEPENDENT LIVING

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

January 30, 2014

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 **January 14, 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

PRINTED: 01/22/2014
FORM APPROVED
OMB NO. 0938-0391

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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 C 01/14/2014 |
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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

An unannounced onsite complaint investigation of multiple self reports was conducted by the Division of Licensing and Protection on 1/13/14 and 1/14/14. Regulatory citations were found. The findings are as follows:

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.

This REQUIREMENT is not met as evidenced by:
Based on record review, staff interview and observation, the facility failed to follow the written plan of care for 1 of 5 sampled residents (Resident #3). The findings include:

Per self report to the Division and Licensing and Protection (L&P), medical record review and staff interview, on two (2) separate occasions, Resident #3 wandered into Resident #4's bedroom, attempted to lie down in the bed and occupy Resident #4's private space.

Resident #3 was admitted on 05/12/12 with diagnoses to include Alzheimer's Disease, Dementia with Behavioral Disturbances, Coronary Artherosclerosis, Diabetes, Bipolar Disorder, Depressive Disorder, Biliary Cirrhosis, Incontinence of Urine and Feces, Difficulty Walking and Cerebral Ataxia.

Resident #4 was admitted on 07/29/13 with

F 000 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 282 F282 Resident #3 care plan will be updated and reviewed with staff. Team meeting with resident's guardian on 1/27/14 related to plan of care for resident and resident's behavior of sitting on the floor.

Residents who wander on the dementia Unit have the potential to be affected By this alleged deficient practice.

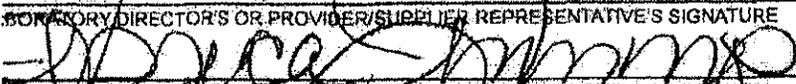
Staff on the dementia unit will be educated Regarding this resident's plan of care by 1/30/14.

Audits will be performed weekly x 4 and Monthly x 3 to assure that resident's with behavior care plans are being followed.

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

Corrective action will be completed by January 30, 2014.

F282 ROC accepted 1/29/14 mbehrnd RN/pmc

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| SUPERVISOR/DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  | TITLE NHA | (X5) DATE 1/28/14 |
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A deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting provided it is determined that her 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 282 | <p>Continued From page 1</p> <p>diagnoses to include Dementia, without behavior disturbances, Diabetes with Neurological Manifestations and Urinary Tract Infections, Cerebral Vascular Accident, Renal insufficiencies, Depression and Right Bundle Branch Block.</p> <p>Per medical record review and staff interview, on 10/23/13 Resident #3, who is a known wanderer, is intrusive to others, drops her/him self to the floor, is unable to communicate her/his needs and has no safety awareness, was witnessed in Resident #4's room.</p> <p>Resident #4 was holding Resident #3 by the back of the neck pushing her/him out of the bedroom.</p> <p>Per medical record review and staff interview, on 10/25/13 Resident #3 was witnessed in Resident #4's room sitting on the floor next to Resident #4's bed. Staff approached the room and Resident #4 requested that Resident #3 be removed. Resident #3 was wearing a V-Neck shirt when staff noted red marks on Resident #3's torso. After examination, the Licensed Practical Nurse (LPN) approached Resident #4 who admitted pushing Resident #3 out of his/her room using a cane.</p> <p>Per interview on 1/13/14 at 10:50 AM with nursing home psychologist, h/she confirms that Resident #3, is intrusive to others, drop his/herself on the floor, is unable to verbally communicate his/her needs, has no safety awareness, wanders about aimlessly, has no boundaries, is easily agitated and has an ataxic gait that affect his/her ability to ambulate safely. All of which is attributed to his/her psychiatric illness.</p> <p>Per interview with UM on 1/13/14 @ 12 noon, confirmation is made that both incidents occurred</p> | F 282 | | | |

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| F 282 | Continued From page 2 as documented in medical record, incident report and L&P intake form. Per Interdisciplinary Care Plan for Resident #3 the following initiatives to be utilized when resident exhibits specific behaviors: staff to provide 1:1 interactions and support as needed, redirect resident away from other's personal area, redirect resident to chair or bed when sitting/sleeping on the floor, redirect resident when wandering into other resident's rooms. There is no evidence in the medical record that demonstrates the above approaches were initiated during the incidents of 10/23/13 and 10/25/13, as Resident #3 was not redirected away from other's personal area nor redirected prior to entering Resident #4's room. | F 282 | | |
| F 323 SS=D | 483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on record review, staff interview and observation the facility failed to supervise 2 of 5 sampled residents (Resident #3 and Resident #4) to prevent accidents. The findings include: 1. Per record review, Resident #3 was admitted on 05/12/12 with diagnoses to include Alzheimer's | F 323 | | |

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| F 323 | <p>Continued From page 3</p> <p>Disease, Dementia with Behavioral Disturbances, Coronary Arthorosclosis, Diabetes, Bipolar Disorder, Depressive Disorder, Billiary Cirrhosis, Incontinence of Urine and Feces, Difficulty Walking and Cerebral Ataxia.</p> <p>Resident #4 was admitted on 07/29/13 with diagnoses to include Dementia, without behavior disturbances, Diabetes with Neurological Manifestations and Urinary Tract Infections, Cerebral Vascular Accident Renal Insufficiencies, Depression and Right Bundle Branch Block.</p> <p>Per medical record review and staff interview on 10/23/13 resident #3, who is a known wanderer, is intrusive to others, drops her/him self onto the floor, is unable to communicate her/his needs and has no safety awareness, was witnessed in Resident #4's room. Resident #4 was holding resident #3 by the back of the neck pushing her/him out of the bedroom.</p> <p>Per medical record review and staff interview on 10/25/13 Resident #3 was witnessed in Resident #4's room sitting on the floor next to Resident #4's bed. Licensed Nurse Aides (LNA) approached the room and Resident #4 requested that Resident #3 be removed. Resident #3 was wearing a V-Neck shirt when staff noted red marks on Resident #3's torso. After examination, the Licensed Practical Nurse (LPN) approached Resident #4 who admitted pushing resident #3 out of his/her room using his/her cane.</p> <p>Per interview on 1/13/14 at 10:50 AM with nursing home psychologist, h/she confirms that Resident #3, is intrusive to others, drop his/herself on the floor, is unable to verbally communicate his/her needs, has no safety awareness, wanders about</p> | F 323 | <p>F323</p> <p>Nursing staff on the Dementia unit will Be educated regarding care plan interventions Related to the supervision required by Resident #3 and #4 by January 30, 2014.</p> <p>Other residents from the dementia unit Have the potential to be affected by this alleged deficient practice.</p> <p>Care plan intervention audits will be performed Weekly X 4 weeks and then monthly x 4 to assure that the center is compliant with providing our residents on the dementia unit with the supervision per individual plan of care</p> <p>Results of the audits will be discussed at CQI for further evaluation and recommendations.</p> <p>Corrective action will be completed by January 30, 2014</p> <p>F323 POC accepted 1/29/14 mBertrand RN/ame</p> | |

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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 323 | <p>Continued From page 4</p> <p>aimlessly, has no boundaries, is easily agitated and has an ataxic gait that affect his/her ability to ambulate safely. All of which is attributed to his/her psychiatric illness.</p> <p>Per interview with UM on 1/13/14 @ 12 noon confirmation is made that both incidents occurred as documented in medical record, incident report and L&P intake form.</p> <p>Per Interdisciplinary Care Plan for Resident #3 the following initiatives are to be utilized when resident exhibits specific behaviors: staff to provide 1:1 interactions and support as needed, redirect resident away from other's personal area, redirect resident to chair or bed when sitting/sleeping on the floor, redirect resident when wandering into other resident's rooms. There is no evidence in the medical record that demonstrates the above approaches of 1:1 or redirection when wandering into other resident's rooms was initiated during the incidents of 10/23/13 and 10/25/13.</p> <p>The facility failed to implement the care plan interventions for Resident #3 and adequately supervise the resident to prevent him/her from wandering into another resident's room on 10/23/13. After the incident on 10/23/13, the facility failed to adequately supervise Resident #3 and Resident #4 to prevent the incident that occurred on 10/25/13.</p> <p>2. Per observation on 1/13/14 @ 4 PM Resident #3 was observed with her feet/legs on the dining room table while other residents were present. At 4:30 PM Resident #3 was observed sitting on the floor under a large round dining room table pushing the table with her head (hard helmet in</p> | F 323 | | |

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| F 323 | <p>Continued From page 5</p> <p>place) off the floor while Resident #5 was sitting at the table.</p> <p>At 4:45 PM Resident#3 had scooted herself from sitting under the table, to the front then to the back of Resident #5's wheelchair. During a 15 minute time period, Resident #3 was observed pushing Resident #5's chair, making grunting noises and changing positions from sitting to lying. Both professional and nonprofessional staff were observed to walk around and over Resident #3 while distributing the evening meal. At no time did any staff ask Resident #3 if s/he needed assistance, wanted help to get off the floor or questioned if s/he was in distress. Other wandering residents were noted to walk around Resident #3, putting themselves and Resident #3 at risk for injury.</p> <p>Per interview with evening nurse on 1/13/14 @ 4:35 PM confirmation was made that Resident #3 had been on the floor for a period of 15 minutes, pushing at the table, pushing at other resident's chairs, left unattended with no staff intervention. LPN voiced concern that Resident #3 should not be allowed to lie on the floor, that instructions have been directed that floor lying has been care planned and Resident #3 has the right to lie on the floor.</p> <p>Nursing Home Administrator (NHA) confirms on 1/13/14 @ 5:05 PM that Resident#3 has a care plan to lie on the floor. However, NHA requests assistance from an LNA to help her up and remove her from the dining room at this time.</p> <p>1/13/14 @ 5:15 PM Resident #3 is observed by Unit Manager and Surveyor to be wandering in the hallway unattended with an unsteady gait</p> | F 323 | | |

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| F 323 | Continued From page 6 walking into the wall. Per Interdisciplinary Care Plan for Resident #3 the following initiatives are to be utilized when resident exhibits specific behaviors: staff to provide 1:1 interactions and support as needed, redirect resident away from other's personal area, redirect resident to chair or bed when sitting/sleeping on the floor, redirect resident when wandering into other resident's rooms. Staff failed to provide 1:1 interactions and failed to redirect the resident to a chair or bed, thus failing to implement the care plan. | F 323 | | |
| F 387 SS=B | 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 the facility failed to ensure that physician visits occur every 30 days for the first 90 days after admission, and at least once every 60 days thereafter for 4 of 5 sampled residents during a complaint investigation (Residents #1, #3, #4, #5). The findings include: 1. Resident #1 admitted on 10/03/11 with | F 387 | F387 Residents #1, #3, #4, #5 have received their physician visits by Dr. Marco. All residents have the potential to be affected by this alleged deficient practice. A physician visit schedule has been completed and education provided to the medical records assistant and Physician on 1/15/14. Physician visit audits will randomly Be performed weekly x 4 and then Montly x 3. Results of the audits will be discussed at CQI for further evaluation and recommendations. | |

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| F 387 | <p>Continued From page 7</p> <p>diagnoses to include Hypertension, Alzheimer's Disease, Anxiety, Hyperlipidemia and Dementia with Psychotic Features. Per medical record review on 1/13/14, Physician progress notes verify visits on 02/22/13, 05/08/13, 08/08/13 and 10/23/13. Interview with Unit Manager on 1/13/14 at 10:15 AM confirms that the physician is out of compliance with visits.</p> <p>2. Resident #3 admitted on 05/09/12 with diagnoses to include Alzheimer's Disease, Dementia with Behavioral Disturbances, Coronary Arteriosclerosis, Diabetes, Bipolar Disorder, Depressive Disorder, Biliary Cirrhosis, Urinary Incontinence and Cerebral Ataxia. Per medical record review on 1/13/14, Physician progress notes verify visits on 01/23/13, 04/03/13, 06/05/13, 09/05/13, 12/1/13 and 01/08/14. Interview with Unit Manager on 1/13/14 at 10:15 AM confirms that the physician is out of compliance with visits.</p> <p>3. Resident #4 admitted on 07/29/13 with diagnoses to include Dementia with Behavioral Disturbances, Diabetes with Neurological Manifestations, Urinary Tract Infections, Cerebral Vascular Accident, Renal Insufficiencies, Depression and Right Bundle Branch Block. Per medical record review on 1/13/14, Physician progress notes verify visits on 08/01/13, 09/13/13 and 01/18/14. Interview with Unit Manager on 1/13/14 at 10:15 AM confirms that the physician is out of compliance with visits.</p> <p>4. Resident #5 admitted on 09/27/12 with diagnosis to include Alzheimer's Disease, Spondylosis, Hypertension, Depression, Osteoarthritis and Dysphagia. Physician progress notes verify visits on 04/03/13, 06/07/13,</p> | F 387 | <p>Corrective action will be completed by January 30, 2014.</p> <p>F387 POC accepted 1/29/14 mbechandra RN/AME</p> | |

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| F 387 | Continued From page 8 09/05/13 and 12/11/13. Interview with Unit Manager on 1/13/14 at 10:15 AM confirms that the physician is out of compliance with visits. Per telephone interview with physician for all of the above residents on 01/13/14 @10:40 AM confirmation was made that the physician was away on vacation from 12/20/13 through 01/02/14. Physician voices that he has had office and staffing problems and increase work loads all of which could contribute to the misplacement of documentation or the possibility of a missed visit. | F 387 | | | |
| F9999 | FINAL OBSERVATIONS Vermont State Licensing and Operating Rules for Nursing Homes 7.13 Nursing Services: The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care or as specified by the licensing agency. (d) Staffing Levels. The facility shall maintain staffing levels adequate to meet resident needs. (1) At a minimum, nursing facilities must provide: (i) no fewer than 3 hours of direct care per resident per day, on a weekly average, including nursing care, personal care and restorative nursing care, but not including administration or supervision of staff, and of the three hours of direct care, no fewer than 2 hours per resident per day must be assigned to provide standard | F9999 | F9999 Direct nursing care hours were not correctly allocated in the computer to reflect the care given between LNA's & RN/LPN's. The center has a new nursing scheduler who is receiving on the job training. She has been educated on the state staffing requirements. The Daily HPPD will be maintained in the Center. All the residents have the potential to be affected by this alleged deficient practice. Staffing audits will randomly Be performed weekly x 4 and then Montly x 3. Audits will be discussed at CQI for further evaluation and recommendations. Corrective action will be completed by January 30, 2014. | | |

F9999 POC accepted 1/29/14 mBertrand RN/PMC

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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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| F9999 | <p>Continued From page 9</p> <p>LNA care (such as personal care, assistance with ambulation, feeding, etc.) performed by LNAs or equivalent staff and not including meal preparation, physical therapy or the activities program.</p> <p>This REQUIREMENT is NOT MET as evidenced by:</p> <p>Based on review of the facility staffing patterns and staff interviews, the facility failed to meet the 2 hours per resident per day to provide standard Licensed Nurse Aide (LNA) care for the months of September, October, November, December 2013 and January 2014 to date. The findings include:</p> <p>Per review of the daily staffing pattern sheets, documentation identifies that 24 days in the past four and one half months were below the requirement of 2.0 for Licensed Nurse Assistants (LNA'S). Per interview with the Nursing Home Administrator on 1/14/13 at 9 AM, confirmation was made that according to the staffing pattern documented the requirement was not met.</p> | F9999 | | |