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

December 30, 2021

Ms. Coleen Kohaut, Administrator
Franklin County Rehab Center Llc
110 Fairfax Road
St Albans, VT 05478-6299

Dear Ms. Kohaut:

Enclosed is a copy of your acceptable plans of correction for the recertification survey and complaint investigation completed on **December 1, 2021.** 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

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

PRINTED: 12/15/2021
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 ______	(X3) DATE SURVEY COMPLETED C 12/01/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRANKLIN COUNTY REHAB CENTER LLC	110 FAIRFAX ROAD ST 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
E 000	Initial Comments An unannounced onsite emergency preparedness survey was completed by the Division of Licensing and Protection from 11/29/-12/1/21. The facility was found in substantial compliance with emergency preparedness regulations.	E 000		
F 000	INITIAL COMMENTS An unannounced onsite recertification survey was completed by the Division of Licensing and Protection from 11/29 - 12/1/21. The following regulatory violations were cited as a result of the recertification survey:	F 000		
F 641 SS=B	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Per staff interview and record review, the facility failed to ensure that the resident assessment accurately reflects the resident's status for two of 21 residents (Resident #7 and Resident #12). 1. Per review of the MDS (minimum data set) assessment from 6/9/21, Resident #7 was marked as having had a UTI (urinary tract infection) in the last 3 months. Per review of the resident record, Resident #7 had a laboratory confirmed UTI in April of 2021 and was prescribed antibiotics for treatment. Per review of the MDS assessment from 9/8/21, Resident #7 was again marked as having had a UTI in the last 3 months. Review of the resident record did not show any indication of Resident #7 having had a	F 641	F 641 – Accuracy of Assessments 1. Previous corrective action had previously taken place for the residents affected: Resident #7 MDS for 6/2021 stated correctly that the resident had tested positive for a UTI. MDS for 9/2021 should have removed this finding and did not. This was corrected for the MDS completed on 12/1/2021. Resident # 12 developed a stage 2 in 2/2021. This was coded correctly on the MDS in 3/2021. It was inadvertently left of the 6/2021 MDS although the stage 2 was not healed. On the 9/8/2021 MDS the continued stage 2 was coded correctly and therefore the MDS was correct as of 9/8/2021. Continued	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Colleen Kohaut
TITLE: Administrator/owner
(X6) DATE: 12/20/21

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 641	Continued From page 1 UTI during that time period. Per interview on 11/29/21 at approximately 3:00 PM, the MDS Coordinator confirmed that the documentation of a UTI in the 9/8/21 MDS assessment for Resident #7 was done so in error. 2. Per review of Resident #12's record, Resident #12 has had a small stage 2 pressure ulcer on their right second toe since March of 2021. Weekly skin assessments in the record show that the pressure ulcer has been present since its discovery in March 2021. Per review of the MDS assessment from 6/9/21, Resident #12 was marked as not having any pressure ulcers in the last 3 months. Per interview on 12/1/21 at approximately 11:00 AM, the MDS Coordinator confirmed that the documentation of no pressure ulcers in the 6/9/21 MDS assessment for Resident #12 was done so in error.	F 641	2. Identification of other residents having the potential to be affected by the MDS coordinator and was determined that all residents have the potential to be affected. 3. Education was provided to the MDS staff addressing the importance of the accuracy of the MDS. 4. The MDS staff will conduct a random audit of 2 residents per week for a review of the accuracy of the MDS. Findings of the audits will be discussed at QAPI. This will continue for a period of 4 weeks. If substantial compliance has been met the random audit of 2 residents will then be performed monthly for a period of 5 months. Audits will end if substantial compliance continues to be met.	
F 657 SS=E	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff.	F 657	Date of Completion: 12/20/2021 F657 see next pg. Tag F641 POC accepted on 12/29/21 by L.Lovell / [illegible]	

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F 657	Continued From page 2 (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based upon interview and record review, the facility failed to review and revise Care Plans related to fall prevention for 3 residents [Res. #42, #22, and #40] of 21 sampled residents. Findings include: 1). Per record review, Res. #42 was admitted to the facility on 10/27/21 with diagnoses that include dementia and a history of falls and weakness. Progress notes record the resident requires 'a maximum assist of two to three persons for turning, repositioning in bed and transfers with mechanical lift and three persons. Admitted for worsening dementia with possible Long Term Care placement due to increased need for 24 hour a day care.' Progress notes also record 'Alert and oriented to self only ...Lives in her own world. Fall risk'. On the day of h/her admission, Res. #42's Care Plan was initiated and identified the resident as 'at risk for falls related to a history of several recent falls at home, confusion and impulsivity. H/her fall risk score upon admission = 17,	F 657	F 657 – Care Plan Timing and Revision 1. Corrective action taken for the residents found to have been affected include: The MDS coordinator updating the care plan for Residents #42, #22, #40. 2. Identification of other residents having the potential to be affected by the MDS coordinator / Charge Nurse and was determined that all residents have the potential to be affected. 3. The Staff Development Nurse provided the LTC & Rehab Charge Nurse as well as the MDS department education regarding the importance of fall prevention and intervention as well as how to properly update the care plan following a fall. Continued	

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F 657	Continued From page 3 indicating a high risk for falls.' An interview was conducted with the Director of Nursing [DON] and the Long Term Care Unit Manager [LTC UM] on 12/01/21 at 1:00 PM. The DON and LTC UM stated that a fall risk assessment should be completed as soon as possible after each fall by a resident, and that a resident's Care Plan should be updated/revised with new interventions after each fall. Per review of Res. #42's medical record, on 11/4/21 at 4:30 PM Res. #42 'yelled for help from [h/her] room, upon entering room the resident was observed lying in prone position on floor at the foot of [h/her] bed. Resident was noted to have [h/her] head near the bed and feet towards the wall ...Resident with prior history of falls, has poor safety awareness.' Per record review and confirmed during the interview with the Director of Nursing [DON] and the Long Term Care Unit Manager [LTC UM] on 12/01/21 at 1:00 PM, the DON and LTC UM stated that a fall risk assessment should have been completed after Res. #42 fell on 11/4/21 but was not. The DON and LTC UM further stated that Res. #42's Care Plan should have been reviewed and revised to include additional interventions after the fall on 11/4/21 in order to prevent future falls but was not. 2.) Res. #22 was admitted to the facility with diagnoses that include neoplasm of the brain and seizures. Res. #22's Care Plan, dated 9/11/2020 identified the resident 'at risk for falls related to a history of recent falls, impaired cognition, incontinence, and seizures. [H/she] is a high fall risk.' An interview was conducted with the Director of Nursing [DON] and the Long Term Care Unit Manager [LTC UM] on 12/01/21 at 1:00 PM. The	F 657	4. The MDS staff will conduct a weekly audit of at least one resident care plan who has had a fall that week to ensure that it has been updated to include new interventions per facility policy. This will continue for a period of 4 weeks. If substantial compliance has been met the audit will then be performed monthly for a period of 5 months. Audits will end if substantial compliance continues to be met. Audits will be shared with the QAPI team. Date of Completion: 12/23/2021 Tag F657 POC accepted on 12/29/21 by L. Lovell / D. [illegible]	

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F 657	Continued From page 4 DON and LTC UM stated that a fall risk assessment should be completed as soon as possible after each fall by a resident, and that a resident's Care Plan should be updated/revised with new interventions after each fall. Per review of Res.#22's medical record, on 7/19/21, 'This RN was called down to [Res. #22's] room at 9:45 AM related to [Res. #22] falling in the bathroom. When this writer entered the bathroom [Res. #22] was sitting on the floor with h/her back against the wall. An LNA found [Res. #22] in h/her bathroom after h/her fall.' A Care Plan note, dated 10/12/21, approximately 3 months after the fall on 7/19/21, records Res. #22 'had a fall on 7/19/21 with no injuries noted. Fall assessments completed per protocol.' Per record review, there was no fall risk assessment completed after Res. #22's fall on 7/19/21. A fall risk assessment dated almost 2 months later, on 9/2/21, records 'History of falls: No falls=0'. Per record review and confirmed during the interview with the Director of Nursing [DON] and the Long Term Care Unit Manager [LTC UM] on 12/01/21 at 1:00 PM, the DON and LTC UM stated that a fall risk assessment should have been completed after Res. #22 fell on 7/19/21 but was not. The DON and LTC UM further stated that Res. #22's Care Plan should have been reviewed and revised to include additional interventions after the fall on 7/19/21 in order to prevent future falls but was not. 3.) Per review of Resident #40's record, Resident #40 sustained falls at the facility on 1/30/21, 4/13/21, 5/28/21, 6/8/21, 8/22/21, 10/12/21, 10/25/21, and 11/3/21. Per review of Resident #40's care plan, there is a care plan focus of "[Resident #40] is at risk for falls related to history of falls, poor safety awareness, and rolling walker recommended for ambulation which [they] often	F 657		

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F 657	Continued From page 5 do not use" initiated on 5/27/19. All interventions under this care plan focus were added to the care plan on 5/27/19. There have been no updates to the care plan interventions since 5/27/19. Per review of the facility's policy Fall Prevention and Post-Fall Protocol, bullet #9 under the section Post fall assessment/instructions states, "Interdisciplinary team will review and revise care plans as necessary after each fall. The team will determine if additional interventions/strategies can minimize or prevent additional [falls]." Per interview on 12/1/21 at approximately 12:00 PM, the Charge Nurse discussed many interventions that have been implemented following Resident #40's repeated falls to try and prevent further falls. These include removing tray tables from the room, 1:1 observation, keeping their bed in the lowest position, and others. The Charge Nurse confirmed that these interventions were not documented in Resident #40's care plan.	F 657		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a	F 758	F758 – Free From Unnecessary Psychotropic Meds/PRN Use 1. Immediate action taken for the resident found to have been affected include: The medication regimen for Resident #40 was reviewed, the medication prescribed for prn anxiety was re-ordered to include a stop date and the medication for major depressive disorder was amended to include a corresponding diagnosis. Continued	

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F 758	Continued From page 6 resident, the facility must ensure that-- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility failed to ensure a resident's drug regimen is free from unnecessary psychotropic drugs as	F 758	2. Identification of other residents having the potential to be affected was accomplished by: The facility has determined that all residents have the potential to be affected. A review of all PRN medication orders and indications for use was completed on 12/6/2021. 3. Actions taken/systems put into place to reduce the risk of future occurrence include: In servicing all licensed nursing staff on the facility policy for Use of Psychotropic Medication along with education regarding medication admin. Physicians were provided a copy of the facility policy. 4. The corrective action will be monitored to ensure the error will not recur: The DNS or designee will complete random weekly audits for four weeks of new prn medication orders to ensure that appropriate indications and stop dates for use of any prn psychotropic medications are clearly documented in the medical record. Audits will end if substantial compliance continues to be met. Audits will be shared with the QAPI team. Date of Completion: 12/23/2021	

Tag F758
POC accepted
on 12/29/21
by L.Lovell / D.Widawski RN

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F 758	Continued From page 7 evidenced by drugs used without adequate indications for use and PRN (as needed) drugs used without a defined duration for one of 5 sampled residents (Resident #40). Findings include: 1. Per review of Resident #40's MAR (medication administration record), Resident #40 was ordered PRN Ativan (a medication for anxiety) and scheduled Olanzapine (an antipsychotic). The Ativan order placed on 11/15/21 reads, "Ativan 0.5 mg tablet - give one tablet by mouth every 6 hours as needed for anxiety/agitation." There is no designated end date or duration ordered for this medication. The Olanzapine order placed on 6/10/21 reads, "Olanzapine 10mg tablet - give one tablet by mouth every morning." There is no indication in the order of what specific condition or diagnosis the Olanzapine is ordered to treat. Per interview on 12/1/21 at approximately 2:00 PM, the Director of Nursing confirmed that the Olanzapine and PRN Ativan orders do not meet the regulatory requirements for psychotropic medications.	F 758		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State	F 812	see next pg.	

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F 812

Continued From page 8

and local laws or regulations.
(ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices.
(iii) This provision does not preclude residents from consuming foods not procured by the facility.

§483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety.
This REQUIREMENT is not met as evidenced by:
Based on observation, staff interview, and record review, the facility failed to store food and drink in accordance with professional standards for food service safety as evidenced by the presence of expired food items and opened perishable food items without proper storage. Findings include:

1. Per observation on 11/29/21 at approximately 10:00 AM, the front kitchen fridge contained an opened bottle of thickened orange juice. There was no open date written on the bottle. The manufacturer's instructions on the bottle instructs the user to discard the contents within 10 days of opening.

Per interview with the Dietary Manager at the time of observation, the Dietary Manager confirmed that this bottle was not labeled with an open date.

Per observation on 11/30/21 at approximately 12:30 PM, the long-term care unit nourishment kitchen fridge contained the following items:
- An unopened single-serve container of yogurt with an expiration date of 11/22/21.
- An opened bottle of thickened orange juice without an open date written on the bottle and

F 812

F812 – Food Procurement Store/Prepare/Serve-Sanitary

1. Immediate action taken included discarding any expired or not dated items.
2. The facility has determined that all residents have the potential to be affected.
3. Actions taken/systems put into place to reduce the risk of future occurrence include: In servicing all kitchen staff on the importance of checking all refrigerators daily for expired / non dated items and discarding such items. Signage has also been placed on refrigerators reminding all staff to date any opened items.
4. The corrective action will be audited weekly by the dietary manager for a period of four weeks. Audits will end if substantial compliance continues to be met.

Date of Completion: 12/21/2021

Tag F812
POC accepted
on 12/29/21
by L. Lovell/P. Lindemann

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F 812	Continued From page 9 manufacturer's instructions on the bottle to discard the contents within 10 days of opening. - An opened bottle of thickened water without an open date written on the bottle and manufacturer's instructions on the bottle to discard the contents within 10 days of opening. - An opened bottle of a resident's personal vegetable juice without an open date written on the bottle and manufacturer's instructions on the bottle to discard the contents within 14 days of opening. Per observation on 11/30/21 at approximately 12:40 PM, the rehab unit nutrition fridge contained an opened bottle of apple juice without an open date on the bottle and manufacturer's instructions on the bottle to discard the contents within 14 days of opening. Per interview on 11/30/21 at approximately 12:45 PM, the Dietary Manager confirmed the presence and condition of these food items. Per review of the facility's policy Date Marking for Food Safety, the policy states, "2. The food shall be clearly marked to indicate the date or day by which the food shall be consumed or discarded. 3. The individual opening or preparing a food shall be responsible for date marking the food at the time the food is opened or prepared." Per interview on 11/30/21 at approximately 3:30 PM, the Dietary Manager confirmed that the observed expired/unlabeled food and drink items were not stored appropriately.	F 812		