VERMONT

AGENCY OF HUMAN SERVICES

DEPARTMENT OF DISABILITIES, AGING AND INDEPENDENT LIVING

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

September 25, 2018

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 survey conducted on **July 25, 2018**. 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	475047	A. BUILDING _____ B. WING _____	07/25/2018

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 The Division of Licensing and Protection conducted an unannounced onsite emergency preparedness survey 7/25/18. There were no regulatory violations identified related to emergency planning.	E 000		
F 000	INITIAL COMMENTS The Division of Licensing and Protection conducted an unannounced onsite recertification survey July 23 - 25. The following regulatory findings were identified:	F 000		
F 656 SS=E	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) 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 §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR	F 656	F656 All residents on a psychoactive medication will have their Care Plan updated to include monitoring of possible side effects, appropriate Gradual Dosage Reductions and any non-pharmacological interventions that may be used. All resident's medication orders will be reviewed for psychoactive medications during Care Plan review. All Care Plans will be updated with any new psychoactive medications and reviewed quarterly. Date of Completion 8/17/2018 F656 POC accepted 9/19/18 PMcotaRN	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Coleen Kohaut
TITLE: Administrator/owner
(X6) DATE: 08/20/2018

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 656	Continued From page 1	F 656		

recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record.
(iv)In consultation with the resident and the resident's representative(s)-
(A) The resident's goals for admission and desired outcomes.
(B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.
(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.
This REQUIREMENT is not met as evidenced by:
Based on staff interview and record review, the facility failed to ensure that a comprehensive person-centered care plan for each resident was developed for psychoactive medication use for 2 of 20 applicable residents (Residents #39 & # 22). Findings include:

1. Per record review, Resident #39 has a diagnosis of Dementia with Behavior Disturbance. Per review of history & physical notes in the EMR (Electronic Medical Record), the resident was transferred to the facility with a history of aggressive behaviors. The most recent care plans for each resident are found in a binder on unit according to the Unit Charge Nurse and the DNS (Director of Nursing Services). The care plan for this resident contains a section with the problem Dementia with behaviors. That section of the care plan contains interventions present in the program but no resident specific information

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F 656	Continued From page 2 regarding behaviors or effective interventions specific to this resident. Additionally the resident is receiving an Anti-psychotic medication (Risperidone 0.5mg) for these behaviors. There is no care plan for the psychotropic medication in the record containing the required information regarding monitoring side effects, GDR (Gradual Dose Reduction), use of nonpharmacologic interventions, pharmacy review, and the specific class of medication in use. The DNS confirmed in an interview on 7/25/18 that the plan of care provided was the most up to date. 2. Per record review, Resident #22 has diagnoses that include Dementia with Behavioral Disturbance and is sometimes aggressive toward other residents and staff. The resident has scheduled doses of Seroquel (anti-psychotic) prescribed daily. Per review of the plan of care, there is no plan in place that mentions the use of antipsychotic medications and the interventions associated with this such as monitoring for side effects. Per interview on 7/24/18 at 3:30 PM, the Unit Manager confirmed that the plan of care did not include the specific category of psychoactive medication use.	F 656		
F 657 SS=D	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	F 657	F657 On next page.	

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F 657	Continued From page 3	F 657	F657	

resident.
(C) A nurse aide with responsibility for the resident.
(D) A member of food and nutrition services staff.
(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 on staff interviews and record review, the facility failed to assure that the comprehensive care plan was revised for 1 of 20 applicable residents (Resident #43). Findings include:

Per record review and confirmed by staff interview, the care plan for Resident #43 was not revised despite multiple falls. Resident #43 was readmitted to the facility on 5/21/2018. Per record review, the resident was found on the floor on 6/13/2018, 6/30/2018, 7/3/2018 (hitting her head, requiring medical evaluation at the hospital), and 7/11/2018 (when h/she reported pain in his/her right hip and leg, requiring medical evaluation at the hospital). There is no evidence in the medical record that the resident's at risk for falls care plan, initiated on 6/4/2018, had been reviewed and revised. During interview on 7/25/2018 at 10:30 AM, the Director of Nursing (DON) and the

Care Plans will be updated to include resident's risk of falls and interventions.

The Fall Committee will review the incident log and will review and update the Care Plans prior to QAPI meeting. They will present any findings at QAPI.

Staff will be trained regarding resident falls.

Date of Completion 8/24/2018

F657 POC accepted 9/19/18 PMcotaRN

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F 657	Continued From page 4 Minimum Data Set (MDS) coordinator confirmed that the care plan had not been revised.	F 657		
F 658 SS=E	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility failed to assure that services provided meet professional standards for 15 of 20 residents in the applicable sample, (Residents # 8, 40, 43, 50, 11, 62, 39, 10, 25, 28, 18, 37, 41, 26, & 1) regarding pain assessments. Findings include: Per observation and record review there is no evidence of regular pain assessments present in the records of 15 residents residing on two long term care units. There is a pain scale 0-10 flow sheet in the Electronic Medical Record (EMR) which is found, in all cases, to be blank. In an interview, on 7/24/18, the Director of Nursing Services (DNS) confirmed that the facility does not use a pain scale assessment and does not do pain assessments on every resident on every shift. S/he stated that pain assessments can be found in resident records in the notes section of the record. In review of the notes sections in resident records there are notes stating no complaints of pain or simply no complaints voiced, found at random. These notes are not found on any regular basis-every shift, daily, or weekly. The DNS also stated in interview, on	F 658	F658 All residents will be assessed on admission and placed on an appropriate pain scale. Pain scales will be assigned as they relate to patient cognition. Pain assessment order will be put in the eMAR for completion every shift. If resident reports pain the nurse will document the pain scale rating and provide interventions as appropriate. If pain is not relieved with interventions a pain assessment will be completed for further intervention. Nursing staff will be trained on new Pain Management Policy, procedure and documentation. The eMAR will be reviewed for completion by oncoming and off going staff every shift. Pain audits will be completed by nurse management to ensure compliance. Date of Completion 8/24/2018 F658 POC accepted 9/19/18 pmcotaRN	

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F 658	Continued From page 5	F 658		

7/25/18, that the facility does not have a pain management policy.

During observations Resident #26, who has a BIMS (Brief Interview for Mental Status) score of 9, was observed to be crying frequently throughout the survey. In interview, the resident stated that she had pain constantly. The resident triggered for pain almost constantly in the MDS (Minimum Data Set) dated 5/31/2018. In interview on 7/23/18 the MDS coordinator stated that s/he had gathered the information regarding pain in interview with the resident. In record review there was no evidence that staff systematically asked about pain or monitored non-verbal signs and/or symptoms of pain.

*Reference: Pain Management Nursing Scope and Standards of Practice 2nd Edition ANA (American Nurses Association) and ASPMN (American Society for Pain Management Nursing) 2016.
Standard 1. Assessment: The registered nurse collects pertinent data and information relative to the patient's health, pain, or situation...The registered nurse:
-Employs the biopsychosocial-spiritual model to collect comprehensive assessment in a systematic and ongoing process to identify the impact of pain with compassion and respect for the inherent dignity, worth, and unique attributes of every person.
-Uses appropriate valid and reliable evidence-based pain assessment tools and techniques that are developmentally, cognitively, and culturally sensitive; appropriate age, level of communication, language, and understanding; and sensitive to patient's preference and values to identify patterns and variations.

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F 658	Continued From page 6 -Uses analytical models, problem-solving tools and terminology appropriate for describing pain and its sequelae. -Documents accurately and in a manner accessible to the interprofessional team that facilitates patient privacy, data retrieval, reassessment, and follow-up. (pgs 39-40)	F 658	F804 All residents shall be served food at a safe and appetizing temperature that conserves nutritional value and flavor. All hot beverages will be checked for appropriate temperatures three times per day. Temperatures will be recorded on a temperature log in the kitchen. Any temperatures found to be outside of the appropriate range will result in hot beverages not being used until temperatures are back in range and the dietary manager has been notified. All food will be temped before leaving the kitchen. Food temperatures will be recorded on a temperature log in the kitchen. If food is found outside of the appropriate range corrective action will be taken to ensure proper temperature is met. Kitchen staff will be trained on policies. Dietary Manager will review logs for completion. Date of Completion 8/17/2018	
F 804 SS=F	Nutritive Value/Appear, Palatable/Prefer Temp CFR(s): 483.60(d)(1)(2) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility failed to ensure that food and drink were served at a safe and appetizing temperature. Findings include: Per review of facility food temperature logs from 4/6/18 - 7/25/18, there were no recorded temperatures for beverages served at any meal during this timeframe. There were also no recorded temperatures for any of the food served for the breakfast meal during this same timeframe. This was confirmed by the Dietary Manager on 7/25/18 at 8:42 A.M.	F 804		

F804 POC accepted 9/19/18 MMcfaRN