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

February 25, 2019

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 30, 2019.** 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	475021	A. BUILDING _____ B. WING _____	01/30/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAINT ALBANS HEALTHCARE AND REHABILITATION CENTER	596 SHELDON ROAD SAINT 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 a review of the facility emergency preparedness requirements on 1/30/19. The facility was found to be in substantial compliance with these requirements.	E 000	St. Albans Health and Rehab Center provides this plan of correction without admitting or denying the validity or existence of the allege deficiency. The plan of correction is prepared and executed solely because it is required by federal and state law.	
F 000	INITIAL COMMENTS The Division of Licensing and Protection conducted an unannounced, onsite annual recertification survey on January 28 - 30, 2019. The following regulatory violations were cited as a result.	F 000	F756 *Corrective Action* Resident #43's medical record was updated to reflect that the resident did not have an allergy to prednisone.	
F 756 SS=D	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a	F 756	*Identification of Other Residents* All residents that have an allergy have the potential to be affected By this deficient practice. *Systematic Changes* The administrator and pharmacist reviewed The center's policy Medication Regimen Review On January 31, 2019. POC accepted 2.25.19 RT/RN	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	475021	A. BUILDING _____ B. WING _____	01/30/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAINT ALBANS HEALTHCARE AND REHABILITATION CENTER	596 SHELDON ROAD SAINT 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
F 756	Continued From page 1 minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the consultant Pharmacist failed to identify and follow up on an irregularity in the medication regimen for 1 of 6 residents reviewed (Resident # 43). Findings include: Per record review of Resident #43, the resident is prescribed Prednisone 3 mg. daily as part of arthritis treatment. On the Physician's orders, Medical Doctor and Nurse Practitioner progress notes, it lists Prednisone as an allergy for this resident. Per review of the monthly consult by the Pharmacist, they acknowledge that the resident is on Prednisone, but do not have it listed on the consult notes with the resident's other allergies, and there was no evidence that the Pharmacist had questioned the physician regarding the prescribed medication that is listed as an allergy. The Unit Manager was not aware	F 756	*Monitoring* The Center Executive Director and or designee Will perform pharmacy review audits weekly x 4 and then monthly x 3. Results of the audits will be reviewed at CQI for further evaluation and recommendations. Corrective action will be completed by March 1, 2019. POC amt 2.25.19 RT/SL	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	475021	A. BUILDING _____ B. WING _____	01/30/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAINT ALBANS HEALTHCARE AND REHABILITATION CENTER	596 SHELDON ROAD SAINT 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
F 756	Continued From page 2 of the discrepancy, and not able to find any explanation for this discrepancy in the medical record that was on the unit, however did produce a progress note filed in medical records written by the Nurse Practitioner on 7/25/18 that explained a discussion with the family who said they were not aware of any adverse reactions to this medication, and that the resident had been taking it for some time before admittance to the facility. Per interview on 1/30/19 at 9:05 AM, the Unit Manager confirmed that the documentation in the record still listed Prednisone as an allergy in multiple areas of the resident record, including on the Medication Administration Record, and that there was no explanation for the discrepancy in the Pharmacist consultant's notes or the more recent MD notes that also still listed this as an allergy.	F 756		
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 observation and staff interviews the facility failed to assure that food and drink served is palatable, and at a safe and appetizing temperature. 1. Per observation on the morning of 1/29/2019	F 804	F804 *Corrective Action* The drinks were taken off the food trays and served chilled in individual bins of ice. Aladdin warming plates have been purchased to assist in keeping food at regulation temperatures. *Identification of Other Residents* All residents have the potential to be affected By this deficient practice. BC agrd 2.25.19 RT/SL	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	475021	A. BUILDING _____ B. WING _____	01/30/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAINT ALBANS HEALTHCARE AND REHABILITATION CENTER	596 SHELDON ROAD SAINT 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
F 804	Continued From page 3 at 8:05 am, a test tray served on the East wing was obtained. Using a thermometer, which had been calibrated, the foods on a regular breakfast tray were checked for serving temperatures. The desired serving temperature for hot food is 135 degrees Fahrenheit (F) and for cold foods 40 degrees F. The danger zone for holding and serving foods is between 41 and 140 degrees F. The foods served were as follows: Eggs 94 degrees F Sausage 104 degrees F Hot cereal 102 degrees F Coffee 140 degrees F Orange Juice 60 degrees F There was also toast and bacon on the plate, which are difficult to check via thermometer, but felt lukewarm to the touch. The Unit Manager observed and confirmed the above findings. The thermometer was recalibrated to recheck the orange juice and the result was unchanged. 2. A pattern of not completing temperature logs for hot and cold food holding temperatures was evident in the review of the kitchen practices at the facility. The temperature logs for breakfast and lunch holding temperatures for serving, steam table and trayline were completely blank starting 12/13/18 and throughout January to 1/27, 2019. For dinner, the logs were incomplete for 12/9, 10, 12, 13, 15, 17, 19, 21, 24, 27, 28, 29, 30/18. Dinner logs are also blank on 1/1, 1/3, 1/7, 1/9, 1/10, 1/12, 1/14, 1/16, 1/17, 1/19, 1/20, 1/23, 1/24, and 1/25/19. This was confirmed with the Food Services Director on 1/30/19 at approximately 10:30 AM.	F 804	*Systematic Changes* The dietary staff have been educated on food And drink that is palatable, attractive and at a Safe and appetizing temperature. The dietary Staff has been educated on the requirement for completing temperature logs for hot and cold foods, dish machine temperatures, and water temperatures. The dietary staff will document temps on the service line and a dietary designee will temp a test tray once a day. *Monitoring* The Center Executive Director and or designee Will perform audits 3 times per week x 4 and then monthly x 3 to assure that food is served at a safe and appetizing temperature, and temperature logs are complete for dish machines and water temperatures. Results of the audits will be reviewed at CQI for further evaluation and recommendations. Corrective action will be completed by March 1, 2019. Roc amnt 2.25.19 RT 181	
F 806	Resident Allergies, Preferences, Substitutes	F 806		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	475021	A. BUILDING _____ B. WING _____	01/30/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAINT ALBANS HEALTHCARE AND REHABILITATION CENTER	596 SHELDON ROAD SAINT 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
F 806 SS=D	Continued From page 4 CFR(s): 483.60(d)(4)(5) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(4) Food that accommodates resident allergies, intolerances, and preferences; §483.60(d)(5) Appealing options of similar nutritive value to residents who choose not to eat food that is initially served or who request a different meal choice; This REQUIREMENT is not met as evidenced by: Based on staff and resident interviews and record review, the facility failed to provide to 1 of 22 residents in the sample (Resident #14) an appealing option of similar nutritive value when the menu options did not meet his/her expressed preferences. Findings include: During interview after lunch on 1/28/19, Resident #14 expressed that for the past two months, meals served have often not been consistent with his/her known preferences. Resident #14 stated that, for example, the meal served for lunch this day had not been consistent with his/her preferences. Per Week 3, Week-at-a Glance menu, the menu choices for 1/28/19 were sausage, pepper, onion or Sloppy Joe on roll. Resident #14 stated that h/she does not eat pork or red meat, and needs a bland diet due to a history of pancreatic problems. The sausage is a pork product, and the Sloppy Joe is hamburger/red meat; both are not bland, but spicy. Per the "Meal Tracker meal ticket" for Resident #14, as confirmed by the Food Services Director on 1/30/19 at 10:30 AM,	F 806	F806 *Corrective Action* The Dietary Director has consulted with resident #14. He will provide her with a personal Choice menu at the beginning of the week And will collect at the end of the week To assure personal choices for the following Week. *Identification of Other Residents* All residents have the potential to be affected By this deficient practice. *Systematic Changes* The dietary staff have been educated On personal food choices to accommodate Resident allergies, intolerances, and preferences. *Monitoring* The Center Executive Director and or her Designee will perform weekly audits x 4 and Monthly x 3 to assure that residents are Receiving food per personal preference to Meet their dietary needs. RC ans 2.25.19 RT/8	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	475021	A. BUILDING _____ B. WING _____	01/30/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAINT ALBANS HEALTHCARE AND REHABILITATION CENTER	596 SHELDON ROAD SAINT 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
F 806	Continued From page 5 Resident #14 is to receive bland, white meat only, no pork. Resident #14 was served Sloppy Joe on a roll for lunch on 1/28/19, despite the clear documentation on the meal ticket, as confirmed by both Resident #14 and the Food Services Director. During the Resident Council meeting for the survey on 1/28/19 at 2 PM Resident #14 stated that she has to be extremely careful about his/her food. She stated that she has had pancreatitis and it's very painful: She as to eat bland foods including white meat and nothing spicy. She states that there are often no menu choices that fit into her medical and religious restrictions.	F 806	Results of the audits will be reviewed at CQI for further evaluation and recommendations. Corrective action will be completed by March 1, 2019.	
F 812 SS=F	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 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	F 812	F812 *Corrective Action* The Director of Dining and or the scheduled Cook will conduct accuracy audits to assure Completion of identified temperature logs Upon arrival in the morning and before Leaving for the day. Pc ant 2.25.19 RT

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	475021	A. BUILDING _____ B. WING _____	01/30/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAINT ALBANS HEALTHCARE AND REHABILITATION CENTER	596 SHELDON ROAD SAINT 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
F 812	Continued From page 6 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 monitor equipment in accordance with professional standards for food service safety and per the written policies of Healthcare Services Group in the main kitchen. Findings include: During the initial tour of the facility's main kitchen where food for residents is stored and prepared, on 1/28/19 at approximately 9:45 AM, the surveyor observed that temperature logs for the walk-in freezer, walk-in refrigerator and the milk cooler were incomplete. The Dish Machine Log was also incomplete regarding wash and rinse temperatures. The Three-Compartment Sink Log where pots and pans are washed and sanitized was for December and was incomplete. Refrigerator Temperature Logs for 3 of 3 unit kitchenette refrigerators were incomplete. Logs for holding temperatures of hot and cold foods held for service, steam tables, holding boxes and trayline were incomplete in both December 2018 and January 2019. Upon further examination, with confirmation by the Food Services Director, the following was evident: 1. For December, 2018, the freezer log lacked entries for evenings from 12/16 through 12/31/18; morning entries were missing for 12/28 through 12/31/18. In January 2019, no freezer log entries were made at all from 1/11 through 1/27/19. 2. Refrigerator temperature logs lacked entries for 12/28 through 12/31/18. In January 2019, no	F 812	*Identification of Other Residents* All residents have the potential to be affected By this deficient practice. *Systematic Changes* The dietary staff will be educated on F tag 812 for daily completion of the temperature logs. *Monitoring* The Center Executive Director and or her Designee will perform weekly audits x 4 and Monthly x 3 to assure that residents are Receiving food per personal preference to Meet their dietary needs. Results of the audits will be reviewed at CQI for further evaluation and recommendations. Corrective action will be completed by March 1, 2019. Doc cmt 2.25.19 RT 18	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	475021	A. BUILDING _____ B. WING _____	01/30/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAINT ALBANS HEALTHCARE AND REHABILITATION CENTER	596 SHELDON ROAD SAINT 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
F 812	Continued From page 7 temperature log entries were made from 1/11 through 1/27/19. 3. Milk cooler temperature logs lacked entries for 12/28 through 12/31/18. In January 2019, no entries were made in the milk cooler log from l/11 through 1/27/19. 4. The Dish Machine Log labeled January 2019, which is to be filled in during dishwashing after each of three meals per day, had missing entries all or in part on 1/3 through 1/27/19. 5. The Three-Compartment Sink Log was dated December 2018. This is to be logged for sanitization, part per million (PPM) readings after each meal. There were no lunch entries at all; breakfast logs were blank from 12/13 forward; dinner logs were blank on 12/12/18, 12/21-24/18, and 12/27-31/18. There was no Three-Compartment Sink Log for January 2019. 6. Refrigerator Temperature Logs for 3 of 3 refrigerators on 3 of 3 units in the facility, labeled January 2019, lacked entries for temperature monitoring as follows: #1, on 1/1, 1/23/1/27/19; #2, on 1/1, 1/20, 1/21, 1/23, 1/27/19; #3, on 1/1, 1/6, 1/21, 1/23, 1/27/19. These unit refrigerators are used to store snacks and supplements for residents, and food brought in by visitors. 7. Holding temperature logs for breakfast and lunch were completely blank starting 12/13/18. For dinner, the logs were incomplete for 12/9, 10, 12, 13, 15, 17, 19, 21, 24, 27, 28, 29, 30/18. Dinner logs are also blank on 1/1, 1/3, 1/7, 1/9, 1/10, 1/12, 1/14, 1/16, 1/17, 1/19, 1/20, 1/23, 1/24, and 1/25/19. The Food Services Director further confirmed the above on 1/30/19 at approximately 10:30 AM. Policies and procedures, as well as instructions	F 812	BC amt 2.25.A RT 181	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	475021	A. BUILDING _____ B. WING _____	01/30/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAINT ALBANS HEALTHCARE AND REHABILITATION CENTER	596 SHELDON ROAD SAINT 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
F 812	Continued From page 8 and log sheets, are contained in the written policies of Healthcare Services Group, as follows: HCSG Policy 019, Food Storage: Cold, 1, 2, 3, accurate daily temperatures kept in each refrigerator and freezer 41 degrees Fahrenheit (F) and 0 degrees F or below; HCSG Policy 3-401.11 Cooking raw animal foods, internal temperature charts and meal logs; HCSG Policy 022 Warewashing, high and low temperatures maintained, Dish Machine Log; HCSG Policy 023 Manual Warewashing, Wash temperature and chemical sanitizer testing and concentrations, Three-Compartment Sink Log; HCSG Policy 031 Food: Safe Handling for Foods from Visitors, daily temperature monitored.	F 812		
F 814 SS=D	Dispose Garbage and Refuse Properly CFR(s): 483.60(i)(4) §483.60(i)(4)- Dispose of garbage and refuse properly. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and record review, the facility failed to ensure that one trash container in the main kitchen was covered. Findings include: During the initial kitchen tour on 1/28/19 at approximately 9:45 AM, the surveyor observed that the large trash collection bin did not have a cover. At the time of the tour and observation, the Food Service Director confirmed that a cover was not used routinely. Per Healthcare Services Group written policy titled HCSG Policy 028, Environment, procedure #6, "All trash will be contained in covered, leak-proof containers that	F 814	F814 *Corrective Action* *The cover to the trash can was Securely fastened to the can itself.* *Identification of Other Residents* All residents have the potential to be affected By this deficient practice. *Systematic Changes* BC ant 2.25.19 RT/RT	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	475021	A. BUILDING _____ B. WING _____	01/30/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAINT ALBANS HEALTHCARE AND REHABILITATION CENTER	596 SHELDON ROAD SAINT 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
F 814	Continued From page 9 prevent cross contamination".	F 814	*The director of dining in serviced the dietary Staff on the trash can policy and policy and Procedure.* *Monitoring* The Center Executive Director and or her Designee will perform weekly audits x 4 and Monthly x 3 to assure that residents are Receiving food per personal preference to Meet their dietary needs. Results of the audits will be reviewed at CQI for further evaluation and recommendations. Corrective action will be completed by March 1, 2019. Rec and 2.25.19 RT/R	

Genesis

Date: February 21, 2019

To: Ms. Pamela Cota, RN

Re: St. Albans Health & Rehab Center
Plan of Correction,
Credible Allegation of Compliance, and
Request for Re-survey

Dear Ms. Cota:

On January 30, 2019 surveyors from Division of Licensing and Protection completed an inspection at St. Albans Health Care & Rehab Center. As a result of the inspection, the surveyors alleged that the Facility was not in substantial compliance with certain Medicare and Medicaid certification requirements. Enclosed you will find the Statement of Deficiencies (HCFA-2567) with the Facility's Plan of Correction for the alleged deficiencies. Preparation of the Plan of Correction does not constitute an admission by the Facility of the validity of the cited deficiencies or of the facts alleged to support the citation of the deficiencies.

Please also consider this letter and the Plan of Correction to be the Facility's credible allegation of compliance. The facility will achieve [or has achieved] substantial compliance with the applicable certification requirements on or before March 1, 2019. Please notify me immediately if you do not find the Plan of Correction acceptable.

This letter is also our request for a re-survey, if one is necessary, to verify that the Facility achieved substantial compliance with the applicable requirements as of the dates set forth in the Plan of Correction and credible allegation of compliance.

Thank you for your assistance with this matter. Please call me if you have any questions.

Yours truly,

Jessica Jennings, RN

Administrator