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

June 15, 2021

Ms. Amanda Moxley, Administrator
Saint Albans Healthcare And Rehabilitation Center
596 Sheldon Road
Saint Albans, VT 05478-8011

Dear Ms. Moxley:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **May 12, 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

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 _____	C 05/12/2021

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 000	INITIAL COMMENTS An unannounced onsite complaint investigation was conducted by the Division of Licensing and Protection on 4/20/2021, and completed on 5/12/2021. The following regulatory deficiency was identified.	F 000		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to ensure that a resident with a pressure ulcer received necessary treatment and services, consistent with professional standards of practice, to promote healing, by failing to ensure thorough monitoring of the size and status of pressure ulcers, failing to ensure that a dressing was changed when due, and not being able to ensure that a repositioning schedule was followed for 1 of 4 residents sampled (Resident #1). Findings include: Per record review, Resident #1 was admitted to	F 686	Please see attached Word [F686 POC accepted as attached 6/11/21 KCampos RN/PMC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Amanda Mallett | TITLE: Administrator | (X6) DATE: 6/10/2021

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 686	Continued From page 1 the facility on 3/17/2021 for a respite stay due to the resident's caregiver being ill. Admission progress notes indicate that Resident #1 was admitted with an unstageable wound to the left buttocks, and an unstageable deep tissue injury to the left heel. Resident had a care plan developed that included turning and repositioning every 2 to 3 hours for pressure relief, and dressing changes every 3 days to the left buttocks. The doctor's order for dressings on 3/17/2021 was "Cleanse wound with wound cleanser, pack with impregnated gauze, and cover with Optifoam dressing every day shift every 3 days". This was documented as being completed. On 3/20/2021 the progress note stated that the wound was unchanged. On 3/25/2021, the wound was noted to have enlarged due to necrotic tissue lifting, and had new granulation tissue forming. A wound sheet dated 3/25/21 had the measurements and status of the wound documented. This prompted a new order for "Cleanse wound with wound cleanser, pack with Max-sorb AG, and cover with Sacral optifoam. Change QOD" (every other day). The documentation from the TAR (Treatment Administration Record) showed the dressing changed on 3/26, 3/28, and 3/30/21. There were no notes regarding the status of the wound to monitor and evaluate the impact of the interventions. Per interview on 5/11/2021 at 12:28 PM, the Nurse Unit Manager stated that they changed the dressing on 3/26, 3/28, and 3/30, but unless there had been a notable change there was not an expectation of a detailed assessment and documentation until a week from 3/25/21, which made it due on 4/1/21. On 3/30/2021, the Unit	F 686		

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F 686	Continued From page 2 Manager stated s/he changed the dressing, took measurements and examined the wound, however did not document the wound dimensions or any other status of the wound in the resident's chart. The Unit Manager stated that they had written it on a piece of paper that did not end being transferred to the medical record. The nurse also stated in this interview that the dressing did not get changed on 4/1/2021 before the resident was discharged to their home that day at about 11:00 AM. The last documentation of wound status was on 3/25/21 on a paper wound sheet which included measurements. The home health nurse was not scheduled to go into the resident's home until 4/2/2021, which left the dressing in place for three days rather than the two days as ordered. Per interview on 4/20/2021 at 2:10 PM, the Director of Nursing confirmed that there was no documentation available to indicate that the staff had turned and repositioned the resident every 2 to 3 hours during the nursing home admission, and that they do not have a process to document the repositioning schedule or ensure it was completed.	F 686		

F686 Plan of Correction:

The St. Albans Healthcare and Rehabilitation Center provides this plan of correction without admitting or denying the validity or existence of the alleged deficiencies. The plan of correction is prepared and executed solely because it is required by federal and state law.

Resident number 1 discharged home prior to this survey. Residents residing in the facility had no negative effects as a result of the alleged deficient practice.

Residents residing in the facility that have wounds and treatment orders in place have the potential to be affected by the alleged deficient practice.

Residents residing in the facility that require turning and positioning have the potential to be affected by the alleged deficient practice. LNA's will be educated the on turning and reposition process.

Education is currently being provided to the licensed nursing staff on skin integrity management policy and procedure.

Audits will be conducted weekly X4 and then monthly X3 by CNE or designee to monitor the effectiveness of the plan.

Results of the audit will be reported to the QAPI committee X3 months at which time the committee will evaluate the data and act on the information as indicated.

Date of compliance June 10, 2021.