

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

December 1, 2022

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 October 26, 2022. 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,

Jamela McotaRN

Pamela M. Cota, RN Licensing Chief

TEMENT	OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED	
		475021	B. WING			10/26/2022	
				STREET ADDRESS, CITY, STATE, ZIP CODE 596 SHELDON ROAD			
SAINT AL	BANS HEALTHCARE AN	D REHABILITATION CENTER		SAINT ALBANS, VT 05478			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
E 000	Initial Comments The Division of Licensing and Protection conducted an emergency preparedness review during the annual recertification survey on 10/26/2022. There were no regulatory violations		E 00	The filing of this plan of corre constitute an admission of the forth in the statement of defic of correction is prepared and evidence of the facility's cont with applicable law.	e allegations set iencies. The plan executed as		
F 000	identified.		F 00	0			
	and staff vaccination conducted by the Div Protection on 10/24/2 following regulatory v Safe/Clean/Comforta CFR(s): 483.10(i)(1) §483.10(i) Safe Envir The resident has a ric comfortable and hom but not limited to rece supports for daily livir The facility must prov §483.10(i)(1) A safe, homelike environmer use his or her person possible. (i) This includes ensur receive care and serv physical layout of the independence and do (ii) The facility shall end the protection of the in or theft. §483.10(i)(2) Housek services necessary to and comfortable inter	2 through 10/26/22. The iolations were identified: ble/Homelike Environment (7) onment. ght to a safe, clean, elike environment, including eiving treatment and ng safely. ide- clean, comfortable, and it, allowing the resident to al belongings to the extent tring that the resident can vices safely and that the facility maximizes resident bes not pose a safety risk. xercise reasonable care for resident's property from loss	F 58	 In room #27 on the Eamissing 12"x12" tile ha In room #23 on the Eabathroom is without be floor. In room #6 on the Easmounted dispenser hat the wall. In rooms #15, #19, #20Wing, the handrails in have been tightened. The interior wall of the located in a room in the was cleaned the day on The West Wing Showe has been painted. The the ceiling light fixture removed. The middle stall has had its water quote is being obtained project to repair the tile construction parapherr in the corner near the foremoved. The facility will be purch night stands to replace This process will start the West Unit. 	s been replaced. st Wing, the edpans on the t Wing, the wall s been fixed to 0 on the East the bathroom ice machine e back hallway f survey. er Room ceiling a insects inside have been shower room shut off and a d for a capital es. The halia on the floor ub has been hasing monthly the old stands.	(X6) DATE	

Any derictency statement ending with an asterior (derictes a deriver any month and asterior by content and asterior by the statement ending with an asterior of the patients. (See it structions.) 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.

		D HUMAN SERVICES MEDICAID SERVICES				FORM): 11/11/2022 I APPROVED . 0938-0391
STATEMENT O	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED	
		475021	B. WING	_		10/26/2022	
NAME OF PR	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
SAINT ALI	BANS HEALTHCARE AN	D REHABILITATION CENTER			96 SHELDON ROAD AINT ALBANS, VT 05478		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIJ TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)		(X5) COMPLETION DATE
F 584			F 584 All residents that reside in the center have the potential to be affected by this alleged defici practice.				
	 §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); 				Education will be provided to all staff rega providing a safe, clean, and home like environment to maintain a sanitary, order comfortable center.	g a safe, clean, and home like nent to maintain a sanitary, orderly, and	
	§483.10(i)(5) Adequat levels in all areas;	83.10(i)(5) Adequate and comfortable lighting vels in all areas;			Random audits will be performed weekly then monthly x 4 or until substantial compli		
	§483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and				has been achieved. The Maintenance Director/Administrator is responsible for ensuring housekeeping/maintenance services are		
	sound levels.	naintenance of comfortable is not met as evidenced			maintained. Date of Compliance: November 26, 2022		
	Based on observation facility failed to ensure	and staff interview, the there was a safe, clean, like environment. Findings			Tag F584 POC Accepted on 12/1/2022 by S.Stem/P.Cota		
	1. In room # 27 on the missing 12" x 12" tile o window. 2. In room # 23 on the	on the floor near the		÷ ž	39.1		
	multiple bedpans piled bathroom.			یه. ۲۰			
	bathroom soap dispen	ser is hanging askew. #20 on the East wing, the					
	an open room off the r and West units had a g	an ice machine located in ear hallway between East gray viscous substance on easily wiped away with a		-			

Event ID: P64L11

Facility ID: 475021

If continuation sheet Page 2 of 14

±1

	S FOR MEDICARE &	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
	F DEFICIENCIES CORRECTION	IDENTIFICATION NUMBER:			COMPLETED	
		475021	B. WING		10/26/2022	
AME OF PF	OVIDER OR SUPPLIER		ST	REET ADDRESS, CITY, STATE, ZIP CODE		
		ND REHABILITATION CENTER		6 SHELDON ROAD AINT ALBANS, VT 05478		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)		
F 584	Continued From pag	e 2	F 584			
		observed in the West wing				
	shower room on 10/2					
	- The ceiling is peeli					
		nside the ceiling light fixtures.				
	 The middle shower broken or stained tile 	stall has multiple missing,				
		on paraphernalia on the floor				
	in the corner near th	e tub				
	The above is clearly	visible to residents passing				
		loor was propped open with a				
		vith linen. Residents and using this shower room				
	throughout the 3 day					
		West wing, a nightstand is				
	significantly peeled of	on the top and sides,				
	exposing bare wood					
		tions were confirmed with the or (MD) on 10/26/22 at 1:05				
		ice machine, the MD stated				
		d issue in the room that				
	h/she believed had l	been resolved.		An order was obtained on 10/27/2022 for	_	
F 656 SS=E	Develop/Implement CFR(s): 483.21(b)(1	Comprehensive Care Plan)	F 656	An order was obtained on 10/27/2022 for resident #23 to be assessed by Meditele resident's primary physician also intitiate	e. This	
	§483.21(b) Comprel			anti-depressant.		
		acility must develop and	· /=	An order of Meditele was ordered for res	sident	
		hensive person-centered esident, consistent with the		#55 on 10/27/2022.		
		orth at §483.10(c)(2) and		Pabovier monitorian and interventions	1070	
		ncludes measurable		Behavior monitoring and interventions w added to tasks for all residents to ensure		
	objectives and timef	rames to meet a resident's	Pag 44	behavior documentation,		
		d mental and psychosocial				
		ified in the comprehensive mprehensive care plan must		Behaviors will be reviewed with the		
	describe the following			interdisciplinary team during CAR (Custo		
		are to be furnished to attain		Risk) Meetings with referrals made appr	opriately.	
	or maintain the resid	lent's highest practicable				
	متعاملات المراجع	d psychosocial well-being as				

Facility ID: 475021

If continuation sheet Page 3 of 14

1

TATEMENT	OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		475021	B. WING		10/26/2022	
	ROVIDER OR SUPPLIER BANS HEALTHCARE AN	ID REHABILITATION CENTER	5	TREET ADDRESS, CITY, STATE, ZIP CODE 96 SHELDON ROAD AINT ALBANS, VT 05478		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETIO DATE
F 656	Continued From page 3 required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required		F 656	All residents with behaviors have the be affected by this alleged deficient p	practice.	
	under §483.24, §483 provided due to the re under §483.10, includer	.25 or §483.40 but are not esident's exercise of rights ling the right to refuse		Education will be provided to the nurs regarding documentation of behavior referrals for mental health.		
	treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its			Random audits of residents with beha be performed weekly x 4, then month until substantial compliance has been to assure that appropriate documenta completed and mental health referral	nly x 4 or n achieved ation is	
	resident's representat (A) The resident's goa	h the resident and the tive(s)-		The Director of Nursing or her design responsible for ensuring that compre care plans are implemented.	hensive	
	future discharge. Fact whether the resident's community was asses local contact agencies	s desire to return to the ssed and any referrals to s and/or other appropriate		Date of compliance: November 26, 2	2022	
	 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 observations, record review, and staff and resident interview, the facility failed to implement the plan of care related to behavioral health for 2 of 18 sampled residents [Residents #23 and #55]. Findings include: 			Tag F656 POC Accepted on 12/1/2022 by S.Stem/P.Cota	2°	:
						-990
-				94 - C	× . .,	
	to the facility on 8/5/20 include history of trau	Resident #23 was admitted 022 with diagnoses that matic brain injury, cerebral oke] and diabetes. Review				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) IDENTIFICATION INJURCE: DENTIFICATION INJURCE: A BUILDING (X2) MUTTIFIE CONSTRUCTION A BUILDING (X3) DATE SUPPOY COMPLETED AND PLAN OF CORRECTION A BUILDING 47501 D.WING 10/26/2022 NAME OF PROVIDER OR SUPPLIER SAINT ALBANS HEALTHCARE AND REHABILITATION CENTER STREET ADDRESS, CITY, STATE, 2P COOLE S6 SHIT ALBANS, VT 05478 000000000000000000000000000000000000		MENT OF HEALTH AN S FOR MEDICARE & I					FOF	ED: 11/11/2022 MAPPROVED O. 0938-0391
NMLE OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE SANT ALBANS HEALTHCARE AND REHABILITATION CENTER STREET ADDRESS, CITY, STATE, ZIP CODE SANT ALBANS HEALTHCARE AND REHABILITATION CENTER SANT ALBANS, VT 05473 (X) ID PRETX REGULATORY OR LSC (DENTRYING INFORMATION) PROVIDERS (MULT OF PROVIDENT OF DESICIPANCE) (CAS) EXPERIENCED TO THE APPROPRIATE DEFICIENCY PROVIDERS (MULT OF CASECDED BY FUL REGULATORY OR LSC (DENTRYING INFORMATION) PROVIDERS (MULT OF CASECDED BY FUL REGULATORY OR LSC (DENTRYING INFORMATION) PROVIDERS (MULT OF CASECDED BY FUL REGULATORY OR LSC (DENTRYING INFORMATION) PROVIDERS (MULT OF CASECDED BY FUL REGULATORY OR LSC (DENTRYING INFORMATION) PROVIDERS (MULT OF CASECDED BY FUL REGULATORY OR LSC (DENTRYING INFORMATION) PROVIDERS (MULT OF CASECDED BY FUL REGULATORY OR LSC (DENTRYING INFORMATION) PROVIDERS (MULT OF CASECDED BY FUL REGULATORY OR LSC (DENTRYING INFORMATION) PROVIDERS (MULT OF CASECDED BY FUL REGULATORY OR LSC (DENTRYING INFORMATION) PROVIDERS (MULT OF CASECDED BY FUL REGULATORY OR LSC (DENTRYING INFORMATION) PROVIDERS (MULT OF CASECDED BY FUL REGULATORY OR LSC (DENTRYING INFORMATION) PROVIDERS (MULT OF CASECDED BY FUL REGULATORY OR LSC (DENTRYING INFORMATION) F666 F666 F 655 Continued From page 4 exhibits distressed mood symptoms related to: changes in whom Where [shihe] lives, unable to communicate verbar out distressed (SobDing and putting his/her faces in the related has the adding. F 656 Per interview on 10/26/22 at 9:07 AM, a Certified Nurse Adde (CNA) stated that she does not document or report Resident #23 is behaviors to anyone as indicated in his/hor c	STATEMENT C	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA					E SURVEY
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CIT, SITH, 2 JP CODE SANT ALBANS HEALTHCARE AND REHABILITATION CENTER STREET ADDRESS, CIT, SITH, 2 JP CODE 0(1)D BUMMARY STATEMENT OF DEFICIENCIES DE PREFIX REGULATORY OR LSC DENTIFYING INFORMATION) PROVIDERS IN AN OF CORRECTION PEERK (EACH OERICINY UMITS ERFECEDED BY FULL REGULATORY OR LSC DENTIFYING INFORMATION) PROVIDER STAND & CORRECTION F 656 Continued From page 4 PE exhibits distressed mood symptoms related to: changes in whom/where [shine] lives, unable to communicate verbal wants/needs, changes in mobility," with interventions to Trefer to Behavioral Health Specialist as needed," and "observe for signs/symptoms of worsening sadness/depression/anxiety/fear/anger/agitation." Per observation on 10/2/422 at 3:00 PM, Resident #23 and their representative, Resident #23's representative, stated that they don't believe anyone has assessed Resident #23 for mental health, depression, or services since she has been here but "hinks it is important because I think s/he is depressed and has had a hard time transitioning to a nusing home." Resident #23 began crying again when the representative was taking. Per interview on 10/26/22 at 9:07 AM, a Certified Nurse Aide (CNA) stated that s/he does not document or report Resident #23 is behaviors to anyone as indicated in his/her care plan because s/he is normally always sad. This CNA demonstrated where s/he would becount assigned monitoring behaviors as a task and confirmed that Resident #23 id not have behaviors for a resident if the record if they were assigned monitoring behaviors as a task and confirmed hat Resident #23			475021	B. WING			10	/26/2022
SANT ALBANS HEALTHCARE AND REHABILITATION CENTER SANT ALBANS, VT 05478 (X) D PREFX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH CORRECTVE ACTION SHOULD BE (EACH CORRECTVE ACTION SHOULD BE CROSS-HEERENCED TO THE APPROPRIATE DEFICIENCY) D PROVIDE (EACH CORRECTVE ACTION SHOULD BE CROSS-HEERENCED TO THE APPROPRIATE DEFICIENCY) 00% DATE F 656 Continued From page 4 exhibits distressed mood symptoms related to: changes in whom/where [s/he] lives, unable to communicate verbal wants/needs, changes in mobility, "with interventions to "refer to Behavioral Health Specialist as needed," and "observe for signs/symptoms of worsening sadness/depression/anxie//fear/anger/agitation." F 656 Per observation on 10/24/22 at 3:00 PM, Resident #23 was visibly distressed (sobbing and putting his/her face in their hands). Fer interview on 10/25/22 at 1:54 PM with Resident #23 sor mental the able depressed dana had a hard time transitioning to a norsing home." Resident #23 began crying again when the representative, Resident #23's representative stated that they don't believe anyone has assessed Resident #23's behaviors to document or report Resident #23's behaviors to document or report Resident #23's behaviors to anyone as indicated th his/her care plan because s/he is normally always sad. This CNA demonstrated where s/he would document behaviors for a resident the record if they were assigned monitoring behaviors as a task and confirmed that Resident #23's did not have behaviors for a resident #23's did not have behaviors for a resident the record flow were assigned monitoring behaviors as a task and confirmed hak Resident #23's did not have behaviors for a resident flow of Resident #25's Kardex Report [quick reference of individual	NAME OF PF	ROVIDER OR SUPPLIER			Г	STREET ADDRESS, CITY, STATE, ZIP CODE		
(A) ID PREFIX SUMMARY STREMENT OF DEFICIENCES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULTORY OR LSC DEFITIFING INFORMATION) ID PREFIX TAG PROVIDER'S FLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULTORY OR LSC DEFITIFING INFORMATION) D PREFIX F 656 Continued From page 4 exhibits distressed mood symptoms related to: changes in whom/where [s/he] lives, unable to communicate verbal wants/needs, changes in mobility, "with interventions to "refer to Behavioral Health Specialist as needed," and "observe for signs/symptoms of worsening sadress/depression/axxiety/fear/anger/agitation." F 656 Per observation on 10/25/22 at 11:54 PM with Resident #23 was visibly distressed (sobbing and putting his/her face in their hands). F Per interview on 10/25/22 at 12:50 PM, Resident #23 are systed that they don't believe anyone has assessed Resident #23 for mental health, depression, or services since s/he has been here but "thinks it is important because I thinks. Ne is depressed and has had a hard time transitioning to a nursing home." Resident #23 began crying again when the representative was taking. Per interview on 10/25/22 at 9:07 AM, a Certified Nurse Aide (CNA) stated that s/he does not document or report Resident #23 is behaviors to anyone as indicated in his/her care pian because s/he is normally always sat. This CNA demonstrated where s/he would document behaviors for a resident #23 did not have behaviors for a projent [quick reference of individual	SAINT ALBANS HEALTHCARE AND REHABILITATION CENTER				L 1			
 exhibits distressed mood symptoms related to: changes in whom/where [s/he] lives, unable to communicate verbal wants/needs, changes in mobility," with interventions to "refer to Behavioral Health Specialist as needed," and "observe for signs/symptoms of worsening sadness/depression/anxiety/fear/anger/agitation." Per observation on 10/24/22 at 3:00 PM, Resident #23 was visibly distressed (sobbing and putting his/her face in their hands). Per interview on 10/25/22 at 11:54 PM with Resident #23 was visibly distressed (sobbing and putting his/her face in their hands). Per interview on 10/25/22 at 3:00 PM, Resident #23 and their representative, Resident #23's representative stated that they don't believe anyone has assessed Resident #23 for mental health, depression, or services since s/he has been here but "thinks it is important because I think s/he is depressed and has had a hard time transitioning to a nursing home." Resident #23 began crying again when the representative was talking. Per interview on 10/26/22 at 9:07 AM, a Certified Nurse Aide (CNA) stated that she does not document or report Resident #23's behaviors to anyone as indicated in his/her care plan because e s/he is normally always sad. This CNA demonstrated where s/he would document behaviors for a resident in the record if they were assigned monitoring behaviors as a task and confirmed that Resident #23 did not have behaviors as a CNA task. Review of Resident #23's Kardex Report [quick reference of individual 	PREFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREF	ix	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR	3E	COMPLETION
patient care] does not include monitoring behaviors. Per interview on 10/26/22 at 9:30 AM, the Director of Social Services (DSS) confirmed that		exhibits distressed mo changes in whom/whe communicate verbal w mobility," with interven Health Specialist as no signs/symptoms of wo sadness/depression/al Per observation on 10. Resident #23 was visil putting his/her face in the Per interview on 10/25. Resident #23 and their #23's representative st anyone has assessed health, depression, or been here but "thinks i think s/he is depressed transitioning to a nursit began crying again wh talking. Per interview on 10/26. Nurse Aide (CNA) state document or report Re anyone as indicated in s/he is normally always demonstrated where si behaviors for a residen assigned monitoring be confirmed that Resider behaviors as a CNA ta #23's Kardex Report [o patient care] does not i behaviors. Per interview on 10/26/	 and symptoms related to: tre [s/he] lives, unable to vants/needs, changes in tions to "refer to Behavioral eeded," and "observe for rsening nxiety/fear/anger/agitation." //24/22 at 3:00 PM, oly distressed (sobbing and their hands). //22 at 11:54 PM with representative, Resident tated that they don't believe Resident #23 for mental services since s/he has t is important because I d and has had a hard time ng home." Resident #23 en the representative was //22 at 9:07 AM, a Certified ed that s/he does not sident #23's behaviors to his/her care plan because as ad. This CNA //he would document tin the record if they were ehaviors as a task and the table of Resident muck reference of individual nclude monitoring //22 at 9:30 AM, the 	F	656			

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Event ID: P64L11

Facility ID: 475021

If continuation sheet Page 5 of 14

		ID HUMAN SERVICES MEDICAID SERVICES				FOR	D: 11/11/2022 M APPROVED D. 0938-0391
STATEMENT C	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			E SURVEY PLETED
		475021	B. WING			10	/26/2022
NAME OF PF	ROVIDER OR SUPPLIER			STRE	ET ADDRESS, CITY, STATE, ZIP CODE		
SAINT ALE	BANS HEALTHCARE AN	ID REHABILITATION CENTER			SHELDON ROAD IT ALBANS, VT 05478		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFi TAG	x	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 656	Continued From page	ə 5	F	656			
	referrals for mental he made for Resident #2	ealth services have not been 23.					
	Per interview on 10/2 Licensed Practical No	6/22 at 11:17 AM, a urse that s/he does not					
		23's behaviors or make the al health services as outlined re plan.					
	#23 tearfully communities to the second seco	26/22 at 12:46 PM, Resident nicated that s/he was sad a talk to someone about the end of this interview, oaning with tears flowing					
	to the facility's rehabilinjuries on 9/27/2022 adjustment disorder of depressive mood and Resident #55's care of experiencing adjustm [diagnosis] Depression "evaluate need for Per- consult," and "evaluate symptoms impacting	Resident #55 was admitted litation unit with post fall with diagnoses that include with mixed anxiety and d depression. Review of plan reveals "resident is nent issues related to: DX on," with interventions to sych/Behavioral Health ate mood state or behavioral social isolation." There was naviors were documented in d.					
	10:48 AM, Resident stated that s/he does	d interview on 10/24/22 at. #55 was visibly sad and sn't know who to turn to for d that s/he does not go to would like to.					
	Director of Social Se	26/22 at 9:30 AM, the rvices (DSS) confirmed that health services has not been					

Event ID: P64L11

Facility ID: 475021

If continuation sheet Page 6 of 14

7

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		D HUMAN SERVICES MEDICAID SERVICES			FORM	D: 11/11/2022 MAPPROVED D: 0938-0391	
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE		
		475021	B. WING		10/	26/2022	
NAME OF P	ROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP CODE			
SAINT AL	BANS HEALTHCARE AN	D REHABILITATION CENTER	596 SHELDON ROAD SAINT ALBANS, VT 05478				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ITEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 656	Continued From page made for Resident #5		F 656				
F 725 SS=E	Residents #23 and #5 documented because medications that trigge behaviors and confirm health services have r resident as indicated i Sufficient Nursing Stat CFR(s): 483.35(a)(1)(§483.35(a) Sufficient 3 The facility must have the appropriate compe provide nursing and re- resident safety and att practicable physical, m well-being of each res resident assessments and considering the m diagnoses of the faciliti accordance with the fa at §483.70(e). §483.35(a)(1) The faci- by sufficient numbers types of personnel on nursing care to all resi resident care plans: (i) Except when waive this section, licensed r (ii) Other nursing perso- limited to nurse aides. §483.35(a)(2) Except to	ated that behaviors for 5 have not been they are not on any er for observations of the that referrals for mental not been made for either in their care plans. ff 2) Staff. sufficient nursing staff with betencies and skills sets to blated services to assure tain or maintain the highest nental, and psychosocial ident, as determined by and individual plans of care umber, acuity and ty's resident population in acility assessment required lity must provide services of each of the following a 24-hour basis to provide dents in accordance with d under paragraph (e) of surses; and onnel, including but not		Recruitment efforts are in progress with 4 hired since survey. An LNA class has been scheduled for 11/14/2022 with 5 students registered. Traveling contracts have been opened to supplement staffing positions. All residents that reside in the center have potential to be affected by this alleged defi- practice. The administrator will update residents registaffing during monthly resident council meetings. Random audits will be performed weekly x then monthly x 4 or until substantial compli- has been achieved to assure that residents receiving care timely. The Director of Nursing/Administrator is responsible for ensuring services are provi- sufficient numbers per state regulations. Date of Compliance: November 26, 2022. Tag F725 POC Accepted on 12/1/ S.Stem/P.Cota	the cient garding 4 and iance s are	Ţ	

Event ID: P64L11

Facility ID: 475021

If continuation sheet Page 7 of 14

		D HUMAN SERVICES			FORM APPROVED OMB NO. 0938-0391
		MEDICAID SERVICES			(X3) DATE SURVEY
STATEMENT OF	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C		COMPLETED
		475021	B. WING		10/26/2022
NAME OF P	ROVIDER OR SUPPLIER			EET ADDRESS, CITY, STATE, ZIP CODE	
	RANS HEALTHCARE AN	D REHABILITATION CENTER		SHELDON ROAD	
SAINT AL	BANG IICAEIIIOANE AN		SAI	NT ALBANS, VT 05478	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE COMPLETION
F 725	designate a licensed nurse on each tour of This REQUIREMENT by: Based on observatio resident representative failed to ensure there skilled licensed nurse nursing personnel to each resident's need of daily living (ADLs) dressing, toileting, hy for 4 of 18 sampled ro 28, and 61]. Findings 1. Record review sho requires a two person observation and inter AM, Resident #61 wa S/he stated that s/he today yet. S/he said	nurse to serve as a charge duty. is not met as evidenced n and staff, resident, and ve interviews, the facility are a sufficient number of es, nurse aides, and other provide care and respond to for assistance for activities [ADLs include bathing, giene, eating, and transfer] esidents [Residents #22, 24,	F 725	8	
	11:30." S/he stated the of bed earlier.	nat s/he would like to be out		ă.	
	requires a two person interview on 10/24/22 representative stated days, and the facility on the weekend. S/h	ows that Resident #24 n assist for ADLs. Per 2 at 9:52 AM, Resident #24's I that s/he is there most is short staffed, especially e said that Resident #24 but someone checking to see		r ** *	
	requires assistance f transfers. Per intervie		4L11 Facil	ity ID: 475021	f continuation sheet Page 8 of 14

PRINTED: 11/11/2022

		D HUMAN SERVICES			FORM	D: 11/11/2022 APPROVED 0. 0938-0391
STATEMENT C	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		475021	B. WING		10/	26/2022
NAME OF PF	OVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP CODE		
SAINT ALE	BANS HEALTHCARE AN	D REHABILITATION CENTER		96 SHELDON ROAD AINT ALBANS, VT 05478		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 725 F 742 SS=E	long." S/he stated that to the bathroom on his soiled himself/herself took too long to help h 4. Record Review sho requires a two person interview on 10/24/22 representative stated days and s/he observ wait a long time for his because they are sho 5. Per interview on 10 Licensed Practical Nu- work through his/her late to get things done care needs on the un- in 8 hours. Treatment/Srvcs Men CFR(s): 483.40(b)(1) §483.40(b) Based on assessment of a resid that- §483.40(b)(1) A resident who displa mental disorder or ps difficulty, or who has post-traumatic stress appropriate treatment assessed problem or practicable mental an This REQUIREMENT	 I can only hold it for so t s/he has fallen trying to go s/her own and once had with diarrhea because staff nim/her. bws that Resident #22 assist for ADLs. Per at 1:50 PM, Resident #22's that s/he is visiting most es that Resident #22 has to s/her care to be done rt staffed. b/25/2022 at 2:45 PM, a urse stated that s/he has to breaks and will have to stay e because there are a lot of it, and s/he can't get it done ttal/Psychoscial Concerns the comprehensive dent, the facility must ensure so is diagnosed with ychosocial adjustment a history of trauma and/or disorder, receives t and services to correct the 	F 725	An order was obtained on 10/27/2022 resident #23 to be assessed by Medit resident's primary physician also initia depressant. An order for Meditele was ordered for #55 on 10/27/2022. Behavior monitoring and interventions added to tasks for all residents to ensi- behavior documentation.	ele. This ated an anti- resident	
		ns, record review, and rfailed to provide appropriate				

Facility ID: 475021

If continuation sheet Page 9 of 14

TATEMENT	OF DEFICIENCIES F CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	CONSTRUCTION	OMB NO. 0938-03 (X3) DATE SURVEY COMPLETED		
		475021	B. WING		10/26/2022		
	ROVIDER OR SUPPLIER BANS HEALTHCARE AN	ID REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 596 SHELDON ROAD SAINT ALBANS, VT 05478				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETIO DATE	
F 742	display or are diagnor psychosocial adjustm sampled residents [R Findings include: 1. Per record review, to the facility on 8/5/2 include history of trau vascular accident [str of Resident #23's car exhibits distressed m changes in whom/wh communicate verbal w mobility," with interve Health Specialist as r signs/symptoms of w sadness/depression/a The care plan also re impaired communicat Resident #23 make th asking short yes or no answers to verify acco Per observation and i PM, Resident #23 wa questions calmly for a this surveyor. The residistressed (sobbing a their hands) when asib been so far and bega surveyor was unable resident was trying to Per interview on 10/22 Resident #23 and the	ta to evaluate the plans to residents that sed with mental disorder or lent difficulty for 2 of 19 esidents #23 and #55]. Resident #23 was admitted 022 with diagnoses that imatic brain injury, cerebral oke], and diabetes. Review e plan reveals "resident ood symptoms related to: ere he lives, unable to wants/needs, changes in ntions to "refer to Behavioral needed," and "observe for orsening anxiety/fear/anger/agitation." veals that Resident #23 has ion. Interventions to help nemself understood include o questions and repeating uracy. Interview on 10/24/22 at 3:00 s able to answer yes or no a couple minutes talking to ident became visibly ind putting his/her face in ked about how their stay has in pointing to the facility. This to understand what the relay. 5/22 at 11:54 PM with ir representative, Resident stated that Resident #23	F 742	Behaviors will be reviewed with the interdisciplinary team during CAR (Cust Risk) Meetings with referrals made appr All residents with behaviors have the po be affected by this alleged deficient prace Education will be provided to the nursing regarding documentation of behaviors a referrals for mental health. Random audits of residents with behavi be performed weekly x 4, then monthly until substantial compliance has been a to assure that appropriate documentation completed and mental health referrals for The Director of Nursing or her designee responsible for ensuring that comprehe care plans are implemented. Date of compliance: November 26, 202 Tag F742 POC Accepted on 12/ by S.Stem/P.Cota	ropriately. tential to ctice. g staff ind ors will x 4 or chieved on is nade. is nsive		

F

		D HUMAN SERVICES				FOR	D: 11/11/2022 M APPROVED D. 0938-0391
STATEMENT C	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' <i>'</i>		ONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		475021	B. WING			10	26/2022
NAME OF PF	ROVIDER OR SUPPLIER			STF	REET ADDRESS, CITY, STATE, ZIP CODE		
				596	SHELDON ROAD		
SAINT ALI	BANS HEALTHCARE AN	D REHABILITATION CENTER		SA	INT ALBANS, VT 05478		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 742	admitted and is upset the room. The resider that it was a hard adju come to the nursing h watch the road is com #23 began crying aga was talking. The repro- believe anyone has a health, depression or been here but "thinks think s/he is depresse transitioning to a nurs Per interview on 10/2 Nurse Aide (CNA) sta document or report R anyone because Res sad. This CNA demon document behaviors they were assigned n task and confirmed th have behaviors as a	by the road when s/he was that s/he was moved out of at representative explained ustment for Resident #23 to nome and being able to nforting to him/her. Resident in when the representative esentative said they don't ssessed [him/her] for mental services since s/he has it is important because I ed and has had a hard time ing home." 6/22 at 9:07 AM, a Certified ted that s/he does not esident #23's behaviors to ident #23 is normally always nstrated where s/he would for a resident in the record if nonitoring behaviors as a nat Resident #23 did not CNA task. Review of ex Report [quick reference of e] does not include	F	742			
	would make a referrate based on what was re- other staff and his/he Staff have not reporte Resident #23's behave	vices (DSS) stated s/he I for mental health services eported to him/her from r own judgment as the DSS. ed concerns to him/her about vior. S/he confirmed that a alth services has not been		1000 1000			
FORM CMS-256	Per interview on 10/2 Licensed Practical N 57(02-99) Previous Versions Ob	urse stated that Resident	L11 5.	Faci	lity ID: 475021 If co	ntinuation she	et Page 11 of 14

		ID HUMAN SERVICES				FORM APPROVED
CENTER	S FOR MEDICARE &	MEDICAID SERVICES				OMB NO. 0938-0391
STATEMENT OF	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED
		475021	B. WING			10/26/2022
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CI		
SAINT AL	BANS HEALTHCARE AN	ID REHABILITATION CENTER		596 SHELDON ROAD		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH C	IDER'S PLAN OF CORRECTION ORRECTIVE ACTION SHOULD FERENCED TO THE APPROPS DEFICIENCY)	BE COMPLETION
F 742	 #23 is sad because of LNA stated that they behaviors because the that s/he does not may health services as our care plan because the would know to do that his/her behaviors. S/l not document Resider Per interview on 10/2 #23, when asked, che happy, being sad a look little, and would like the his/her sadness rather someone about it. We repeated back to him above. Resident #23 flowing down his/her interview. 2. Per record review, to the facility's rehabilinguities on 9/27/2022 adjustment disorder to depressive mood and Resident #55's care experiencing adjustment gall between the facility of the facility's rehabilinguities on 9/27/2022 adjustment disorder to depressive mood and Resident #55's care experiencing adjustment for the facility and "evaluate need for Perconsult," and "evaluate symptoms impacting documentation about mood in their medicate per observations and 10:48 AM, Resident #55's care and the section of the	of the transition here. The do not document his/her ney are regular. S/he stated ake the referrals to mental tilined on Resident #23's e provider would, and they it based on notes about he confirmed that s/he does ent #23's behaviors. 26/22 at 12:46 PM, Resident ose being sad rather than ot rather than being sad a o talk to someone about er than not talking to hen the answers were lifter that he confirmed the was groaning with tears face by the end of this Resident #55 was admitted ilitation unit with post fall with diagnoses that include with mixed anxiety and d depression. Review of plan reveals "resident is nent issues related to: DX on," with interventions to sych/Behavioral Health ate mood state or behavioral social isolation." There is no t Resident #55's behaviors or al record.	F 74	2	ŗ	
		to cry. S/he said that s/he petite. S/he stated that s/he				
FORM CMS-25	67(02-99) Previous Versions Ob	solete Event ID: P64	L11	Facility ID: 475021	lf con	linuation sheet Page 12 of 14

PRINTED: 11/11/2022

		D HUMAN SERVICES				F OME	NTED: 11/11/2022 ORM APPROVED 3 NO. 0938-0391		
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (X2) M		IULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED		
		475021	B. WING	3			10/26/2022		
NAME OF PF	OVIDER OR SUPPLIER			STREE	T 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)		II PRE TA	FIX	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE	(X5) COMPLETION DATE		
F 742	doesn't know where to hopes s/he doesn't liv she does not go to the like to. Per interview on 10/20 Director of Social Ser Resident #55 has bee voicing that they are s unsure how care staff decline for care plan g would make a referra judgment and what cl him/her. The DSS con mental health service Resident #55. Per observations and approximately 3:30 P s/he was so sad and "I don't know what to Per review of the job Social Services (DSS educational/vocationa position include: "Bac Work or human service years of supervised S healthcare setting wo care". On 10/26/22 at while reviewing the D	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ued From page 12 t know where to turn for help, and s/he s/he doesn't live long. S/he confirmed that bes not go to therapy but that s/he would erview on 10/26/22 at 9:30 AM, the or of Social Services (DSS) stated that ent #55 has been staying in their room and g that they are sad. The DSS stated s/he is e how care staff track improvement or e for care plan goals. S/he stated s/he make a referral based on her own ent and what clinical staff reported to er. The DSS confirmed that a referral for I health services has not been made for ent #55.		- 742					
	DDS job description, that based on DSS's experience, s/he doe requirements of the p Per interview on 10/2	the Administrator confirmed education and professional s not meet the job							
FORM CMS-25	Residents #23 and #	55 have not been	4L11	Facility	ID: 475021	If continuation	n sheet Page 13 of 14		

		ID HUMAN SERVICES MEDICAID SERVICES					ORM APPROVE NO. 0938-039		
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) E C	(X3) DATE SURVEY COMPLETED		
		475021		B. WING		10/26/2022			
NAME OF PROVIDER OR SUPPLIER SAINT ALBANS HEALTHCARE AND REHABILITATION CENTER					STREET ADDRESS, CITY, STATE, ZIP CODE 596 SHELDON ROAD SAINT ALBANS, VT 05478				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		(X5) COMPLETION DATE		
F 742	Continued From page 13 documented because they are not on any medications that trigger for observations of behaviors and confirmed that referral for mental health services have not been made for either resident.		al	F 742					

Event ID: P64L11

Facility ID: 475021

If continuation sheet Page 14 of 14

PRINTED: 11/11/2022