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

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,

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 _____	10/26/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAINT ALBANS HEALTHCARE AND REHABILITATION CENTER	596 SHELDON ROAD SAINT ALBANS, VT 05478

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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 identified.	E 000	The filing of this plan of correction does not constitute an admission of the allegations set forth in the statement of deficiencies. The plan of correction is prepared and executed as evidence of the facility's continued compliance with applicable law.	
F 000	INITIAL COMMENTS An unannounced, on-site re-certification survey and staff vaccination requirement review was conducted by the Division of Licensing and Protection on 10/24/22 through 10/26/22. The following regulatory violations were identified:	F 000		
F 584 SS=E	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior;	F 584	1. In room #27 on the East Wing, the missing 12"x12" tile has been replaced. 2. In room #23 on the East Wing, the bathroom is without bedpans on the floor. 3. In room #6 on the East Wing, the wall mounted dispenser has been fixed to the wall. 4. In rooms #15, #19, #20 on the East Wing, the handrails in the bathroom have been tightened. 5. The interior wall of the ice machine located in a room in the back hallway was cleaned the day of survey. 6. The West Wing Shower Room ceiling has been painted. The insects inside the ceiling light fixture have been removed. The middle shower room stall has had its water shut off and a quote is being obtained for a capital project to repair the tiles. The construction paraphernalia on the floor in the corner near the tub has been removed. 7. The facility will be purchasing monthly night stands to replace the old stands. This process will start with room #9 on the West Unit.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Rebecca Fleming	Administrator	11/22/22

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 584	Continued From page 1 §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); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §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 §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure there was a safe, clean, comfortable and homelike environment. Findings include: 1. In room # 27 on the East wing, there is a missing 12" x 12" tile on the floor near the window. 2. In room # 23 on the East wing, there are multiple bedpans piled on the floor in the bathroom. 3. In room # 6 on the East wing, the wall mounted bathroom soap dispenser is hanging askew. 4. In rooms #15, #19, #20 on the East wing, the handrails in the bathrooms are loose. 5. The interior wall of an ice machine located in an open room off the rear hallway between East and West units had a gray viscous substance on it. The substance was easily wiped away with a fingertip.	F 584	All residents that reside in the center have the potential to be affected by this alleged deficient practice. Education will be provided to all staff regarding providing a safe, clean, and home like environment to maintain a sanitary, orderly, and comfortable center. Random audits will be performed weekly times 4, then monthly x 4 or until substantial compliance has been achieved. The Maintenance Director/Administrator is responsible for ensuring housekeeping/maintenance services are maintained. Date of Compliance: November 26, 2022 Tag F584 POC Accepted on 12/1/2022 by S.Stem/P.Cota	

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F 584	Continued From page 2 6. The following was observed in the West wing shower room on 10/26/22 at 10:45 AM: - The ceiling is peeling and stained - There are insects inside the ceiling light fixtures. - The middle shower stall has multiple missing, broken or stained tiles. - There is construction paraphernalia on the floor in the corner near the tub.. The above is clearly visible to residents passing in the hallway. The door was propped open with a bedside table piled with linen. Residents and staff were observed using this shower room throughout the 3 days of survey. 7. In room #9 on the West wing, a nightstand is significantly peeled on the top and sides, exposing bare wood. The above observations were confirmed with the Maintenance Director (MD) on 10/26/22 at 1:05 PM. Regarding the ice machine, the MD stated that there was a mold issue in the room that h/she believed had been resolved.	F 584		
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	F 656	An order was obtained on 10/27/2022 for resident #23 to be assessed by Meditele. This resident's primary physician also intitiated an anti-depressant. An order of Meditele was ordered for resident #55 on 10/27/2022. Behavior monitoring and interventions were added to tasks for all residents to ensure behavior documentation. Behaviors will be reviewed with the interdisciplinary team during CAR (Customer at Risk) Meetings with referrals made appropriately.	

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F 656	Continued From page 3 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 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 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: 1. Per record review, Resident #23 was admitted to the facility on 8/5/2022 with diagnoses that include history of traumatic brain injury, cerebral vascular accident [stroke] and diabetes. Review of Resident #23's care plan reveals "resident	F 656	All residents with behaviors have the potential to be affected by this alleged deficient practice. Education will be provided to the nursing staff regarding documentation of behaviors and referrals for mental health. Random audits of residents with behaviors will be performed weekly x 4, then monthly x 4 or until substantial compliance has been achieved to assure that appropriate documentation is completed and mental health referrals made. The Director of Nursing or her designee is responsible for ensuring that comprehensive care plans are implemented. Date of compliance: November 26, 2022 Tag F656 POC Accepted on 12/1/2022 by S.Stem/P.Cota	

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F 656	Continued From page 4	F 656		

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 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 s/he does not document or report Resident #23's behaviors to anyone as indicated in his/her care plan because 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 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

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F 656	Continued From page 5 referrals for mental health services have not been made for Resident #23. Per interview on 10/26/22 at 11:17 AM, a Licensed Practical Nurse that s/he does not document Resident #23's behaviors or make the referrals to the mental health services as outlined on Resident #23's care plan. Per interview on 10/26/22 at 12:46 PM, Resident #23 tearfully communicated that s/he was sad a lot and would like to talk to someone about his/her sadness. By the end of this interview, Resident #23 was groaning with tears flowing down his/her face. 2. Per record review, Resident #55 was admitted to the facility's rehabilitation unit with post fall injuries on 9/27/2022 with diagnoses that include adjustment disorder with mixed anxiety and depressive mood and depression. Review of Resident #55's care plan reveals "resident is experiencing adjustment issues related to: DX [diagnosis] Depression," with interventions to "evaluate need for Psych/Behavioral Health consult," and "evaluate mood state or behavioral symptoms impacting social isolation." There was no evidence that behaviors were documented in Resident #55's record. Per observations and interview on 10/24/22 at 10:48 AM, Resident #55 was visibly sad and stated that s/he doesn't know who to turn to for help. S/he confirmed that s/he does not go to therapy but that s/he would like to. Per interview on 10/26/22 at 9:30 AM, the Director of Social Services (DSS) confirmed that a referral for mental health services has not been	F 656		

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F 656	Continued From page 6 made for Resident #55. Per interview on 10/26/22 at 12:53 PM, the Director of Nursing stated that behaviors for Residents #23 and #55 have not been documented because they are not on any medications that trigger for observations of behaviors and confirmed that referrals for mental health services have not been made for either resident as indicated in their care plans.	F 656		
F 725 SS=E	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must	F 725	Recruitment efforts are in progress with 4 LNAs 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 the potential to be affected by this alleged deficient practice. The administrator will update residents regarding staffing during monthly resident council meetings. Random audits will be performed weekly x 4 and then monthly x 4 or until substantial compliance has been achieved to assure that residents are receiving care timely. The Director of Nursing/Administrator is responsible for ensuring services are provided by sufficient numbers per state regulations. Date of Compliance: November 26, 2022. Tag F725 POC Accepted on 12/1/2022 by S.Stem/P.Cota	

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F 725	Continued From page 7 designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on observation and staff, resident, and resident representative interviews, the facility failed to ensure there are a sufficient number of skilled licensed nurses, nurse aides, and other nursing personnel to provide care and respond to each resident's need for assistance for activities of daily living (ADLs) [ADLs include bathing, dressing, toileting, hygiene, eating, and transfer] for 4 of 18 sampled residents [Residents #22, 24, 28, and 61]. Findings include: 1. Record review shows that Resident #61 requires a two person assist for ADLs. Per observation and interview on 10/24/22 at 9:40 AM, Resident #61 was in bed wearing a johnny. S/he stated that s/he still hasn't been cleaned up today yet. S/he said "it takes staff a long time to get to me. Yesterday I didn't get out of bed until 11:30." S/he stated that s/he would like to be out of bed earlier. 2. Record Review shows that Resident #24 requires a two person assist for ADLs. Per interview on 10/24/22 at 9:52 AM, Resident #24's representative stated that s/he is there most days, and the facility is short staffed, especially on the weekend. S/he said that Resident #24 "can go 6 hours without someone checking to see if [s/he] is soiled." 3. Record Review shows that Resident #24 requires assistance for some ADLs, including transfers. Per interview on 10/24/22 at 10:11 AM, Resident #28 said "it takes forever for someone to come to help me go to the bathroom.	F 725		

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F 725	Continued From page 8 Weekends are harder. I can only hold it for so long." S/he stated that s/he has fallen trying to go to the bathroom on his/her own and once had soiled himself/herself with diarrhea because staff took too long to help him/her. 4. Record Review shows that Resident #22 requires a two person assist for ADLs. Per interview on 10/24/22 at 1:50 PM, Resident #22's representative stated that s/he is visiting most days and s/he observes that Resident #22 has to wait a long time for his/her care to be done because they are short staffed. 5. Per interview on 10/25/2022 at 2:45 PM, a Licensed Practical Nurse stated that s/he has to work through his/her breaks and will have to stay late to get things done because there are a lot of care needs on the unit, and s/he can't get it done in 8 hours.	F 725		
F 742 SS=E	Treatment/Srvcs Mental/Psychoscial Concerns CFR(s): 483.40(b)(1) §483.40(b) Based on the comprehensive assessment of a resident, the facility must ensure that- §483.40(b)(1) A resident who displays or is diagnosed with mental disorder or psychosocial adjustment difficulty, or who has a history of trauma and/or post-traumatic stress disorder, receives appropriate treatment and services to correct the assessed problem or to attain the highest practicable mental and psychosocial well-being; This REQUIREMENT is not met as evidenced by: Based on observations, record review, and interviews, the facility failed to provide appropriate	F 742	An order was obtained on 10/27/2022 for resident #23 to be assessed by Meditele. This resident's primary physician also initiated an anti-depressant. An order for Meditele was ordered for resident #55 on 10/27/2022. Behavior monitoring and interventions were added to tasks for all residents to ensure behavior documentation.	

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F 742	Continued From page 9 services or collect data to evaluate the effectiveness of care plans to residents that display or are diagnosed with mental disorder or psychosocial adjustment difficulty for 2 of 19 sampled residents [Residents #23 and #55]. Findings include: 1. Per record review, Resident #23 was admitted to the facility on 8/5/2022 with diagnoses that include history of traumatic brain injury, cerebral vascular accident [stroke], and diabetes. Review of Resident #23's care plan reveals "resident exhibits distressed mood symptoms related to: changes in whom/where 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." The care plan also reveals that Resident #23 has impaired communication. Interventions to help Resident #23 make themself understood include asking short yes or no questions and repeating answers to verify accuracy. Per observation and interview on 10/24/22 at 3:00 PM, Resident #23 was able to answer yes or no questions calmly for a couple minutes talking to this surveyor. The resident became visibly distressed (sobbing and putting his/her face in their hands) when asked about how their stay has been so far and began pointing to the facility. This surveyor was unable to understand what the resident was trying to relay. Per interview on 10/25/22 at 11:54 PM with Resident #23 and their representative, Resident #23's representative stated that Resident #23 was pointing to his/her old room. Resident #23	F 742	Behaviors will be reviewed with the interdisciplinary team during CAR (Customer at Risk) Meetings with referrals made appropriately. All residents with behaviors have the potential to be affected by this alleged deficient practice. Education will be provided to the nursing staff regarding documentation of behaviors and referrals for mental health. Random audits of residents with behaviors will be performed weekly x 4, then monthly x 4 or until substantial compliance has been achieved to assure that appropriate documentation is completed and mental health referrals made. The Director of Nursing or her designee is responsible for ensuring that comprehensive care plans are implemented. Date of compliance: November 26, 2022 Tag F742 POC Accepted on 12/1/2022 by S.Stem/P.Cota	

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F 742	Continued From page 10	F 742		

was initially in a room by the road when s/he was admitted and is upset that s/he was moved out of the room. The resident representative explained that it was a hard adjustment for Resident #23 to come to the nursing home and being able to watch the road is comforting to him/her. Resident #23 began crying again when the representative was talking. The representative said they don't believe anyone has assessed [him/her] 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."

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's behaviors to anyone because Resident #23 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 patient care] does not include monitoring behaviors.

Per interview on 10/26/22 at 9:30 AM, the Director of Social Services (DSS) stated s/he would make a referral for mental health services based on what was reported to him/her from other staff and his/her own judgment as the DSS. Staff have not reported concerns to him/her about Resident #23's behavior. S/he confirmed that a referral for mental health services has not been made for Resident #23.

Per interview on 10/26/22 at 11:17 AM, a Licensed Practical Nurse stated that Resident

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 _____	10/26/2022

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 742	Continued From page 11 #23 is sad because of the transition here. The LNA stated that they do not document his/her behaviors because they are regular. S/he stated that s/he does not make the referrals to mental health services as outlined on Resident #23's care plan because the provider would, and they would know to do that based on notes about his/her behaviors. S/he confirmed that s/he does not document Resident #23's behaviors. Per interview on 10/26/22 at 12:46 PM, Resident #23, when asked, chose being sad rather than happy, being sad a lot rather than being sad a little, and would like to talk to someone about his/her sadness rather than not talking to someone about it. When the answers were repeated back to him/her, s/he confirmed the above. Resident #23 was groaning with tears flowing down his/her face by the end of this interview. 2. Per record review, Resident #55 was admitted to the facility's rehabilitation unit with post fall injuries on 9/27/2022 with diagnoses that include adjustment disorder with mixed anxiety and depressive mood and depression. Review of Resident #55's care plan reveals "resident is experiencing adjustment issues related to: DX [diagnosis] Depression," with interventions to "evaluate need for Psych/Behavioral Health consult," and "evaluate mood state or behavioral symptoms impacting social isolation." There is no documentation about Resident #55's behaviors or mood in their medical record. Per observations and interview on 10/24/22 at 10:48 AM, Resident #55 stated that she wants to go home and began to cry. S/he said that s/he does not have an appetite. S/he stated that s/he	F 742		

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	475021	A. BUILDING _____ B. WING _____	10/26/2022

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F 742	Continued From page 12 doesn't know where to turn for help, and s/he hopes s/he doesn't live long. S/he confirmed that she does not go to therapy but that s/he would like to. Per interview on 10/26/22 at 9:30 AM, the Director of Social Services (DSS) stated that Resident #55 has been staying in their room and voicing that they are sad. The DSS stated s/he is unsure how care staff track improvement or decline for care plan goals. S/he stated s/he would make a referral based on her own judgment and what clinical staff reported to him/her. The DSS confirmed that a referral for mental health services has not been made for Resident #55. Per observations and interview on 10/25/22 at approximately 3:30 PM, Resident # 55 stated that s/he was so sad and began to cry and whimpered "I don't know what to do." Per review of the job description for Director of Social Services (DSS) the following specific educational/vocational requirements for the position include: "Bachelor's degree in Social Work or human service required and three to five years of supervised Social Service experience in healthcare setting working directly in long-term care". On 10/26/22 at approximately 12:30 PM, while reviewing the DSS's qualifications and the DDS job description, the Administrator confirmed that based on DSS's education and professional experience, s/he does not meet the job requirements of the position. Per interview on 10/26/22 at 12:53 PM, the Director of Nursing stated that behaviors for Residents #23 and #55 have not been	F 742		

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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.	F 742		