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

July 5, 2023

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 complaint investigation conducted on **June 12, 2023.** 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 06/12/2023

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 The Division of Licensing and Protection conducted an unannounced, onsite investigation of 1 complaint on 6/8 and 6/12/23. There were regulatory violations identified as a result of the investigation.	F 000	F 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 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR 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	F 656	F 656 Resident #1 was transferred to the hospital and then discharged to home with her wish to continue chemotherapy treatment. Residents with lab orders have the potential to be affected by this alleged deficient practice. Education will be provided to the nurses regarding implementation of the comprehensive care planning of laboratory studies. Random audits of care plans regarding laboratory studies will be performed by the Director of Nursing and or her designee weekly x 4, then monthly x 4 or until substantial compliance has been achieved to assure that comprehensive care plans are implemented. Results of the audits will be reviewed during the QAA meeting x3 months at which time the committee will determine further frequency of the audits. Date of Compliance: July 12, 2023 **Tag F 656 POC accepted on 7/5/23 by H. Fox/P. Cota**	

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 _____	C 06/12/2023

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 656	Continued From page 1	F 656		

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.
§483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must-
(iii) Be culturally-competent and trauma-informed.
This REQUIREMENT is not met as evidenced by:
Based on interview and record review the facility failed to implement the comprehensive, person-centered care plan regarding laboratory studies for 1of 5 residents included in the sample (Resident#1).
Findings include:

The person-centered care plan for Resident #1 was not followed regarding laboratory studies. Per record review Resident #1 was admitted to the facility on 5/8/23 and has a diagnosis of a certain type of anemia (an autoimmune disease that can cause the destruction of the individual's blood cells). Resident #1 was admitted with physician's orders including CBC with differential (complete blood count with microscopic evaluation to determine the percentage of each kind of white blood cells present in the blood), a comprehensive metabolic panel (a panel of 14 blood tests) and a type and screen (blood test performed on persons who may need a transfusion of blood). These tests were ordered

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 06/12/2023

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 656	Continued From page 2 to be done every Monday and Thursday with the results to be faxed to the physician. A record review revealed that these tests were due on 5/11/23 and 5/15/23 but were not completed until 5/18/23 when the provider noted they had not been done. The care plan was noted to contain 3 separate problems with interventions containing actions regarding lab testing. The following problems were identified as having interventions related to laboratory studies: 1.Resident at risk for cardiovascular symptoms or complications related to hypertension. Intervention: Monitor labs and report abnormal results to physician. 2.Resident diagnosed with anemia diagnosis of cold agglutinin disease. Intervention: Lab work as ordered and notify physician of results per policy. 3.At risk for injury or complication related to anticoagulant therapy. Intervention: Labs as ordered. During an interview with the Director of Nursing on 6/12/23 at 9:15 AM s/he confirmed as labs had not been done as ordered, they were also not monitored, nor was the physician notified as ordered and per facility policy thus the care plan had not been followed.	F 656		
F 684 SS=E	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure	F 684		

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 06/12/2023

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 684	Continued From page 3 that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on interviews and record review the facility failed to provide care and follow physician orders for laboratory tests including the provision of results to the provider or pharmacy, as ordered for 2 of 5 sampled residents (Resident #1 and Resident #4) consistent with facility policy and professional standards of practice. Findings include: Record review and interview reveal that the facility had systemic failures in its management of laboratory orders; completing lab tests as ordered, obtaining, reviewing, monitoring and filing results of lab tests, reporting results of lab tests as ordered and accurately reporting critical results. 1. Per record review Resident #1 was admitted to the facility on 5/8/23 with a diagnosis of a certain type of anemia (an autoimmune disease that can cause the destruction of the individuals blood cells). Resident #1 was admitted with physicians orders including CBC with differential (complete blood count with microscopic evaluation), a CMP [comprehensive metabolic panel] (a panel of 14 blood tests) and a type and screen (blood test performed on persons who may need a transfusion of blood). These tests were ordered to be done every Monday and Thursday with the results to be faxed to the physician. A record review revealed that these tests were due on 5/11/23 and 5/15/23 but were not completed. On 5/18/23 the facility provider	F 684	F 684 Resident #1 was transferred to the hospital and then discharged to home to continue chemo therapy treatments per her plan of care. The lab results from resident # 4 & # 5 were placed in the resident's medical record. Residents with lab orders have the potential to be affected by this alleged deficient practice. Education will be provided to the nurses regarding policy and procedure on lab collection to include: following provider orders, obtaining results and notifying the provider of the lab results. Random audits of the center's system regarding laboratory studies will be performed by the Director of Nursing and or her designee weekly x 4, then monthly x 4 or until substantial compliance has been achieved to assure completion of labs tests as ordered, reporting results of lab tests as ordered, and accurately reporting critical results. Results of the audits will be reviewed during the QAA meeting x3 months at which time the committee will determine further frequency of the audits. Date of Compliance: July 12, 2023 **Tag F 684 POC accepted on 7/5/23 by H. Fox/P. Cota**	

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 06/12/2023

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 684	Continued From page 4	F 684		

noted the labs were not done and ordered them to be done immediately. Based on the results of the lab tests Resident #1 was transported to the emergency room and admitted to the hospital.

On 5/25/23 Resident #1 was readmitted to the facility with the same lab orders, now due on 5/29/23 and 6/1/23. On 5/29/23 the lab tests were drawn but the sample was hemolyzed (destruction of blood cells rendering the sample untestable) it was redrawn 5/30/23. The results of this test were significantly abnormal. They were not faxed to the physician as ordered, and there is no evidence the results were viewed by any provider, as they were not present in the record and had to be obtained from the lab by the facility at the request of the surveyor.

The lab tests due on 6/1/23 were done on 6/2/23. The critically abnormal results were telephonically received from the lab that processed the test and per the nurse's notes of 6/2/23 a call to the on-call provider was made during which the provider was notified (inaccurately) that Resident #1's Hemoglobin was 8 g/dL (grams per deciliter) and hematocrit was 18.3% (hemoglobin is the oxygen carrying capacity of red blood cells and hematocrit is the percentage of red blood cells in blood). Prior to these results, Resident #1 had a hemoglobin of 7.2 g/dL and a hematocrit of 20.4%. The report given by the nurse on 6/2/23 during which the hemoglobin was reported to be 8 g/dL represented an improvement. On 6/5/23 when the facility provider checked the results it was noted the hemoglobin result was 6 g/dL representative of a decline not an improvement, Resident #1 was again sent emergently to the hospital and again admitted.

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 06/12/2023

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 684	Continued From page 5 On 6/8/23 at approximately 10 AM during an interview with a unit manager, when asked why the lab tests had not been performed s/he stated, "the orders had not been transcribed into the medication administration record which is the process used to alert the nurse to obtain the lab tests". This unit manager was asked about the location of lab test results as the surveyor could not locate them in either the paper chart or the electronic health record. The unit manager stated lab results are kept in the paper chart in the section tab marked as laboratory results. The unit manager confirmed there was one page of lab results in the chart of Resident #1 containing one single page with results from 5/29 for a CBC and CMP, the CBC has no results as the tube was "clotted", there was no indication on this page noting if it had been seen or reviewed. It is noted there were no lab reports from the hospitalization of Resident #1 on which to base care and treatment and to use as a comparison for future results. Per the surveyors request the available lab studies pertaining to the dates during which Resident #1 was in the facility were obtained from the laboratory. The facility nurse practitioner was interviewed on 6/8/23 at approximately 11:15 AM regarding how lab results are obtained and reviewed. Per the nurse practitioner s/he does not have electronic access to the hospital records or lab results, instead s/he relies on results being provided to him/her in the facility. S/He noted there is no way to discern if s/he has reviewed the lab reports that are in the paper charts stating "maybe I should initial them when I review". On 6/8/23 at approximately 2 PM the lab director from the hospital that processed and reported the	F 684		

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 06/12/2023

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 684	Continued From page 6	F 684		

lab results on 6/2/23 was contacted to clarify how the abnormal results had been conveyed to the facility. Per the lab director, when results are considered critical, a phone call is placed with the information verbally conveyed and the receiver of the information reads back the critical results to confirm accuracy. This is documented by the hospital lab staff making the call. Per the lab director the documentation indicates the receiving nurse read back the results of the hemoglobin as 6 g/dL (not 8g/dL as was reported inaccurately to the provider).

Per email contact with the ordering physician and his/her nurse (emails dated June 6,7,8 and 9) the facility was called requesting updates on labs ordered and to request lab results be faxed to the provider. The nurse reports that he/she "never received results from St Albans H&R and had to request results from the hospital processing the labs in order to get them." Documentation of 11 calls placed was provided by the nurse working with the ordering physician. When the physician was asked about the impact on Resident #1 during the 3 days that lapsed between the receipt and inaccurate reporting of the results and the time the error was noted and the resident was hospitalized and treated, he/she noted " ...with a hemoglobin of 6 for 3 days [s/he] felt very weak with little energy...".

2. Resident #4 was admitted 5/19/23 with diagnosis including acute osteomyelitis, abscess of the psoas muscle, and discitis in the lumbar region (all are related to infections). Resident#5 was ordered an IV (intravenous) antibiotic for 8 weeks with the following orders: CBC with differential, CRP (C-reactive protein used to identify infection or inflammation), ESR

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 06/12/2023

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 684	Continued From page 7	F 684		

(erythrocyte sedimentation rate- related to coagulation), CMP to be every Monday and a CBC with differential and CMP to be done every Thursday. On 6/7/23 an ammonia level was added to both lab draws. There was also an order written on 5/29/23 as follows; monitor lab work as ordered and fax to pharmacy every evening shift Monday and Thursday until 6/24/23.

Per a review of the calendar there were 6 opportunities for these lab studies between the ordering date and the present date. A review of the electronic health record and the paper chart reveal the results from lab studies due on 5/22/23 were not present and the ammonia level from 6/1/23 was also not present. There was no evidence any of these results had been faxed to the pharmacy per the order. On 6/12/23 at approximately 12:30 PM the DON confirmed the missing lab reports, at approximately 1 PM the pharmacist confirmed no results had been faxed to the pharmacy.

On 6/12/23 at approximately 9:30 AM the DON was interviewed to ascertain the process by which the facility manages lab studies for a resident coming from a hospital setting. Per the DON the facility provider reviews the orders from the transition of care and if appropriate endorses those orders as well as adding anything else that is needed at the time, a nurse or unlicensed staff transcribes the orders for lab studies (facility policy states if an unlicensed person transcribes a licensed nurse will double check but there is no double check if a licensed nurse transcribes) into the electronic medication administration record on the dates/times due, labs are drawn on the dates due, results are faxed to the facility and put into the assigned nurse managers in-box to be

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 06/12/2023

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 684	Continued From page 8 reviewed with the provider, and the results are uploaded into the electronic health record by medical records or the unit manager. Paper copies of the lab studies are to be placed in the paper chart. There is not a policy regarding a way to determine if the provider has reviewed, if the report was faxed or if an outside ordering provider received any notification of abnormal results. There is not a system to track lab studies to confirm the receipt of results. There is no specific policy governing the receipt of critical results. Refer also to F773 and F775.	F 684		
F 732 SS=C	Posted Nurse Staffing Information CFR(s): 483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows:	F 732	The facility currently removed the MDS coordinator from the nursing form posted and has coded the MDS coordinator to nursing admin. The facility posted the total number of staff directly responsible for providing patient/resident care and actual hours worked on a daily basis. The LNHA, DON, HR and Scheduler have been educated on coding the MDS coordinator to nursing admin and only reporting those licensed staff responsible for providing patient/resident care and actual hours worked on a daily basis The DON, LNHA or designee will conduct Monday -Friday audits weekly x4 to validate the nursing form posted contains the correct staff. Results of the audits will be reviewed during the QAA meeting x3 months at which time the committee will determine further frequency of the audits. Date of Compliance: July 12, 2023	

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 06/12/2023

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 732	Continued From page 9 (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observations and interviews the facility failed to post the total number of staff directly responsible for providing patient/resident care and actual hours worked on a daily basis. Finding include: On June 8, 2023 during a complaint investigation, copies of the daily posted staffing sheets were requested for the dates during which the complaint being investigated occurred. The daily staffing sheets are required to be posted in a place available to the public to view for awareness of the number of residents and of staff that are scheduled to provide direct nursing care such as assisting residents with care and activities of daily living, giving medications and providing treatments. Including staff that are not providing direct resident care has the potential to mislead those viewing the schedule by inflating the numbers of direct care providers. During this brief review the scheduler/payroll	F 732	**Tag F 732 POC accepted on 7/5/23 by H. Fox/P. Cota**	

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 06/12/2023

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 732	Continued From page 10	F 732		

manager was asked if all of the nurses listed on the GenSTAR Daily Staffing Sheet were scheduled and expected to provide direct patient/resident care. The scheduler/payroll manager noted positions such as the infection control nurse, the MDS coordinator (referred to as the clinical reimbursement coordinator) and the wound care team leader are also included.

On June 12, 2023 during the second day of the investigation a copy of the previous weeks' GenSTAR Daily Staffing Sheets was requested and again the scheduler/payroll manager was asked about nurses on the schedule providing direct patient/resident care. On these daily posted schedules' dated 6/5/23-6/10/23 and 6/12/23 the scheduler/payroll manager noted there is a daily 8 hour position for the "clinical reimbursement coordinator". During an interview with the clinical reimbursement coordinator on 6/12/23 at approximately 10:45 AM s/he stated his/her job is to conduct assessments of residents which "per Genesis is direct care". The clinical reimbursement coordinator described his/her job as interviewing and completing required documentation for billing purposes. When asked specifically about his/her role when working as the clinical reimbursement coordinator s/he was asked if s/he provided any resident care, passed medications, provided treatments or anything that would be considered resident care. S/he stated if they were scheduled to work the floor they did, but when scheduled as the clinical reimbursement coordinator they did not. S/he confirmed on the dates listed above (6/5/23-6/10/23 and 6/12/23) s/he was scheduled as the clinical reimbursement coordinator therefore did not provide direct resident care.

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 06/12/2023

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 773 SS=E	Continued From page 11 Lab Srvcs Physician Order/Notify of Results CFR(s): 483.50(a)(2)(i)(ii) §483.50(a)(2) The facility must- (i) Provide or obtain laboratory services only when ordered by a physician; physician assistant; nurse practitioner or clinical nurse specialist in accordance with State law, including scope of practice laws. (ii) Promptly notify the ordering physician, physician assistant, nurse practitioner, or clinical nurse specialist of laboratory results that fall outside of clinical reference ranges in accordance with facility policies and procedures for notification of a practitioner or per the ordering physician's orders. This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to provide or obtain laboratory services when ordered by a physician and to promptly and/or accurately notify the physician or pharmacist of results as specifically ordered and per facility policy for 2 of 5 sampled residents (Resident's #1 and #4). Findings include: The facility did not obtain laboratory tests as ordered for Resident #1, did not notify the physician of the results when the ordered tests were completed as ordered, and when notification to a physician was made the results reported were inaccurate. The facility did not notify the pharmacy of the results of Resident #4's lab studies as ordered, nor did the facility obtain and include in the record complete results of lab studies done. 1. Per record review Resident #1 was admitted	F 773 F 773	Resident #1 was transferred to the hospital and then discharged to home to continue chemo therapy treatments per her plan of care. The lab results from resident # 4 & # 5 were placed in the resident's medical record. Residents with lab orders have the potential to be affected by this alleged deficient practice. Education will be provided to the nurses regarding policy and procedure on lab collection to include: following provider orders, obtaining results and notifying the provider of the lab results. Random audits of the center's system regarding laboratory studies will be performed by the Director of Nursing and or her designee weekly x 4, then monthly x 4 or until substantial compliance has been achieved to assure completion of labs tests as ordered, reporting results of lab tests as ordered, and accurately reporting critical results. Results of the audits will be reviewed during the QAA meeting x3 months at which time the committee will determine further frequency of the audits. Date of Compliance: July 12, 2023 **Tag F 773 POC accepted on 7/5/23 by H. Fox/P. Cota**	

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 06/12/2023

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 773	Continued From page 12	F 773		

to the facility on 5/8/23 with a diagnosis of a certain type of anemia (an autoimmune disease that can cause the destruction of the individuals blood cells). Resident #1 was admitted with physicians orders including CBC with differential (complete blood count with microscopic evaluation), a CMP [comprehensive metabolic panel] (a panel of 14 blood tests) and a type and screen (blood test performed on persons who may need a transfusion of blood). These tests were ordered to be done every Monday and Thursday with the results to be faxed to the physician. A record review revealed that these tests were due on 5/11/23 and 5/15/23 but were not completed. On 5/18/23 the facility provider noted the labs were not done and ordered them to be done immediately. Based on the results of the lab tests Resident #1 was transported to the emergency room and admitted to the hospital.

On 5/25/23 Resident #1 was readmitted to the facility with the same lab orders, now due on 5/29/23 and 6/1/23. On 5/29/23 the lab tests were drawn but the sample was hemolyzed (destruction of blood cells rendering the sample untestable) it was redrawn 5/30/23. The results of this test were significantly abnormal. They were not faxed to the physician as ordered, and there is no evidence the results were viewed by any provider, as they were not present in the record and had to be obtained from the lab by the facility at the request of the surveyor.

The lab tests due on 6/1/23 were done on 6/2/23. The critically abnormal results were telephonically received from the lab that processed the test and per the nurse's notes of 6/2/23 a call to the on-call provider was made during which the provider was notified (inaccurately) 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 _____	C 06/12/2023

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 773	Continued From page 13	F 773		

#1's Hemoglobin was 8 g/dL (grams per deciliter) and hematocrit was 18.3% (hemoglobin is the oxygen carrying capacity of red blood cells and hematocrit is the percentage of red blood cells in blood). Prior to these results, Resident #1 had a hemoglobin of 7.2 g/dL and a hematocrit of 20.4%. The report given by the nurse on 6/2/23 during which the hemoglobin was reported to be 8 g/dL represented an improvement. On 6/5/23 when the facility provider checked the results it was noted the hemoglobin result was 6 g/dL representative of a decline not an improvement, Resident #1 was again sent emergently to the hospital and again admitted.

On 6/8/23 at approximately 10 AM during an interview with a unit manager, when asked why the lab tests had not been performed s/he stated, "the orders had not been transcribed into the medication administration record which is the process used to alert the nurse to obtain the lab tests". This unit manager was asked about the location of lab test results as the surveyor could not locate them in either the paper chart or the electronic health record. The unit manager stated lab results are kept in the paper chart in the section tab marked as laboratory results. The unit manager confirmed there was one page of lab results in the chart of Resident #1 containing one single page with results from 5/29 for a CBC and CMP, the CBC has no results as the tube was "clotted", there was no indication on this page noting if it had been seen or reviewed. It is noted there were no lab reports from the hospitalization of Resident #1 on which to base care and treatment and to use as a comparison for future results. Per the surveyors request the available lab studies pertaining to the dates during which Resident #1 was in the facility were obtained from

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 06/12/2023

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 773	Continued From page 14 the laboratory. The facility nurse practitioner was interviewed on 6/8/23 at approximately 11:15 AM regarding how lab results are obtained and reviewed. Per the nurse practitioner s/he does not have electronic access to the hospital records or lab results, instead s/he relies on results being provided to him/her in the facility. S/He noted there is no way to discern if s/he has reviewed the lab reports that are in the paper charts stating "maybe I should initial them when I review". On 6/8/23 at approximately 2 PM the lab director from the hospital that processed and reported the lab results on 6/2/23 was contacted to clarify how the abnormal results had been conveyed to the facility. Per the lab director, when results are considered critical, a phone call is placed with the information verbally conveyed and the receiver of the information reads back the critical results to confirm accuracy. This is documented by the hospital lab staff making the call. Per the lab director the documentation indicates the receiving nurse read back the results of the hemoglobin as 6 g/dL (not 8g/dL as was reported inaccurately to the provider). Per email contact with the ordering physician and his/her nurse (emails dated June 6,7,8 and 9) the facility was called requesting updates on labs ordered and to request lab results be faxed to the provider. The nurse reports that he/she "never received results from St Albans H&R and had to request results from the hospital processing the labs in order to get them." Documentation of 11 calls placed was provided by the nurse working with the ordering physician. When the physician was asked about the impact on Resident #1	F 773		

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 06/12/2023

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 773	Continued From page 15	F 773		

during the 3 days that lapsed between the receipt and inaccurate reporting of the results and the time the error was noted and the resident was hospitalized and treated, he/she noted " ...with a hemoglobin of 6 for 3 days [s/he] felt very weak with little energy...".

2. Resident #4 was admitted 5/19/23 with diagnosis including acute osteomyelitis, abscess of the psoas muscle, and discitis in the lumbar region (all are related to infections). Resident#5 was ordered an IV (intravenous) antibiotic for 8 weeks with the following orders: CBC with differential, CRP (C-reactive protein used to identify infection or inflammation), ESR (erythrocyte sedimentation rate- related to coagulation), CMP to be every Monday and a CBC with differential and CMP to be done every Thursday. On 6/7/23 an ammonia level was added to both lab draws. There was also an order written on 5/29/23 as follows; monitor lab work as ordered and fax to pharmacy every evening shift Monday and Thursday until 6/24/23.

Per a review of the calendar there were 6 opportunities for these lab studies between the ordering date and the present date. A review of the electronic health record and the paper chart reveal the results from lab studies due on 5/22/23 were not present and the ammonia level from 6/1/23 was also not present. There was no evidence any of these results had been faxed to the pharmacy per the order. On 6/12/23 at approximately 12:30 PM the DON confirmed the missing lab reports, at approximately 1 PM the pharmacist confirmed no results had been faxed to the pharmacy.

Facility policy NSG115 Physician/Advanced

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 06/12/2023

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 773	Continued From page 16 Practice Provider (APP) Notification - with revision date of 12/01/21 states: upon identification of a patient who has a change in condition, abnormal laboratory values, or admnormal diagnostics, a licensed nurse will: Report to physiican/advanced practice provider. If unable to contact attending physician/APP, the Medical Director will be contacted. Practice standards include 3.1 Look up previous laboratory results and/or diagnostic results, date of previous laboratory/diagnostic results on the same lab value/diagnostic and notify the physician/APP.	F 773		
F 775 SS=E	Lab Reports in Record - Lab Name/Address CFR(s): 483.50(a)(2)(iv) §483.50(a)(2) The facility must- (iv) File in the resident's clinical record laboratory reports that are dated and contain the name and address of the testing laboratory. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to file in the resident's clinical record laboratory reports for two of five residents sampled (Residents #1 and #4). Findings include: 1. Per record review Resident #1 was admitted to the facility on 5/8/23 with a diagnosis of a certain type of anemia. Resident #1 was admitted with physicians orders including CBC with differential (complete blood count with microscopic evaluation to determine the percentage of each kind of white blood cells present in the blood), a comprehensive metabolic panel (a panel of 14 blood tests) and a type and screen (blood test	F 775	F 775 Resident #1 was transferred to the hospital and then discharged to home to continue chemo therapy treatments per her plan of care. The lab results from resident # 4 & # 5 were placed in the resident's medical record. Residents with lab orders have the potential to be affected by this alleged deficient practice. Education will be provided to the nurses regarding policy and procedure on lab collection to include: following provider orders, obtaining results and notifying the provider of the lab results. Labs will be filed into the resident's chart. Random audits of the center's system regarding laboratory studies will be performed by the Director of Nursing and or her designee weekly x 4, then monthly x 4 or until substantial compliance has been achieved to assure completion of labs tests as ordered, reporting results of lab tests as ordered, and accurately reporting critical results. Results of the audits will be reviewed during the QAA meeting x3 months at which time the committee will determine further frequency of the audits. Date of Compliance: July 12, 2023	

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 06/12/2023

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 775	Continued From page 17 performed on persons who may need a transfusion of blood), these tests were ordered to be done every Monday and Thursday with the results to be faxed to the physician. Both the electronic health record and the paper chart were reviewed for the results of these ordered tests. With the exception of one page of results dated 5/29/23 that indicated the CBC with differential could not be done due to clotting in the tube, there is no evidence the results were viewed by any provider as they were not present in the record and had to be obtained from the lab by the facility at the request of the surveyor. On 6/8/23 at approximately 10 AM a unit manager confirmed the absence of the lab reports. 2. Resident #4 was admitted 5/19/23 with diagnoses including infections. Resident#5 was ordered an IV (intravenous) antibiotic for 8 weeks with the following orders: CBC with differential, CRP (C-reactive protein used to identify infection or inflammation), ESR (erythrocyte sedimentation rate- related to coagulation), CMP to be every Monday and a CBC with differential and CMP to be done every Thursday. On 6/7/23 an ammonia level was added to both lab draws. There was also an order written on 5/29/23 as follows; monitor lab work as ordered and fax to pharmacy every evening shift Monday and Thursday until 6/24/23. Per a review of the calendar there were 6 opportunities for these lab studies between the ordering date and the present date. A review of the electronic health record and the paper chart reveal the results from lab studies due on 5/22/23 were not present and the ammonia level from 6/1/23 was also not present. On 6/12/23 at approximately 12:30 PM the DON confirmed the	F 775	**Tag F 775 POC accepted on 7/5/23 by H. Fox/P. Cota**	

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 06/12/2023

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 775	Continued From page 18 missing lab reports.	F 775		