

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 <u>http://www.dail.vermont.gov</u> 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,

Jamela Mcota RN

Pamela M. Cota, RN Licensing Chief

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C		·	(X3) DATE SURVEY COMPLETED C	
		475021	B. WING			06/12/2023	
ME OF PI	ROVIDER OR SUPPLIER		STR				
	BANS HEALTHCARE AN	ID REHABILITATION CENTER	596	SHELDON RO	DAD		
	DANG HEALINGARE AN		SA	INT 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 (X5 (EACH CORRECTIVE ACTION SHOULD BE COMPLE CROSS-REFERENCED TO THE APPROPRIATE DAT DEFICIENCY)			
F 000	of 1 complaint on 6/8		F 000	F 000	The filing of this plan of constitute an admission of forth in the statement of constitute and forth in the statement of constitute and for the statement of constitution of correction is preparely and for the facility's constitution of the facility's constitution of the statement of the facility's constitution of the statement	f the allegations set leficiencies. The ared and executed as	
F 656 SS=D	Develop/Implement C CFR(s): 483.21(b)(1) §483.21(b) Comprehe §483.21(b)(1) The fac implement a compreh care plan for each rea resident rights set for §483.10(c)(3), that in objectives and timefra medical, nursing, and needs that are identif assessment. The corr describe the following (i) The services that a or maintain the reside physical, mental, and required under §483. (ii) Any services that under §483.24, §483 provided due to the re under §483.10, include treatment under §483. (iii) Any specialized s rehabilitative services provide as a result of	ensive Care Plans cility must develop and hensive person-centered sident, consistent with the th at §483.10(c)(2) and cludes measurable ames to meet a resident's I mental and psychosocial ied in the comprehensive mprehensive care plan must Q- are to be furnished to attain ent's highest practicable psychosocial well-being as 24, §483.25 or §483.40; and would otherwise be required .25 or §483.40 but are not esident's exercise of rights ding the right to refuse 8.10(c)(6). ervices or specialized a the nursing facility will	F 656	F 656	Resident #1 was transferr and then discharged to he continue chemotherapy tr Residents with lab orders be affected by this alleged Education will be provided regarding implementation comprehensive care plan studies. Random audits of care plan laboratory studies will be Director of Nursing and of weekly x 4, then monthly substantial compliance ha assure that comprehensiv implemented. Results of the audits will be the QAA meeting x3 mont committee will determine the audits.	ome with her wish to eatment. have the potential to d deficient practice. d to the nurses of the ning of laboratory ans regarding performed by the r her designee x 4 or until is been achieved to ve care plans are one reviewed during ths at which time the	
	rationale in the reside	h the resident and the tive(s)		Tag F 6 H. Fox/	Date of Compliance: July 56 POC accepted on 7/5/2 P. Cota		
ORATORY	DIRECTOR'S OR PROVIDER	SUPPLIER REPRESENTATIVE'S SIGNATUR	1100	Ced	MIDIST	(X6) DATE	

program participation.

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

	MENT OF HEALTH AN S FOR MEDICARE & I					FORM	D: 06/20/2023 MAPPROVED D: 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD			(X3) DATE COMP	SURVEY
		475021	B. WING			1	C 12/2023
NAME OF P	ROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE		
		D REHABILITATION CENTER		:	596 SHELDON ROAD		
SAINT AL	DANS HEALINCARE AN	D REHABILITATION CENTER			SAINT ALBANS, VT 05478		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES (MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 656	future discharge. Faci whether the resident's community was assess local contact agencies entities, for this purpoo (C) Discharge plans in plan, as appropriate, in requirements set forth section. §483.21(b)(3) The set by the facility, as outlin care plan, must- (iii) Be culturally-comp This REQUIREMENT by: Based on interview at failed to implement the person-centered care studies for 1of 5 resid (Resident#1). Findings include: The person-centered was not followed rega Per record review Res the facility on 5/8/23 at certain type of anemia that can cause the de blood cells). Resident physician's orders incl (complete blood count evaluation to determint kind of white blood ce comprehensive metals blood tests) and a typ- performed on persons	ference and potential for lities must document a desire to return to the seed and any referrals to a and/or other appropriate se. In the comprehensive care in accordance with the in paragraph (c) of this vices provided or arranged ned by the comprehensive betent and trauma-informed. is not met as evidenced ind record review the facility e comprehensive, plan regarding laboratory ents included in the sample care plan for Resident #1 rding laboratory studies. sident #1 was admitted to and has a diagnosis of a a (an autoimmune disease struction of the individual's #1 was admitted with luding CBC with differential t with microscopic he the percentage of each lls present in the blood), a polic panel (a panel of 14 e and screen (blood test	F	656			

Event ID: TEKG11

Facility ID: 475021

If continuation sheet Page 2 of 19

		D HUMAN SERVICES MEDICAID SERVICES				FORM	0: 06/20/2023 APPROVED 0: 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE COMPI	SURVEY LET E D
		475021	B, WING			06/	C 12/2023
NAME OF PI	ROVIDER OR SUPPLIER			s	TREET ADDRESS, CITY, STATE, ZIP CODE		
SAINT AL		D REHABILITATION CENTER		5	96 SHELDON ROAD		
SAINT AL	DANS HEALTHCARE AN	D REHABILITATION CENTER		s	AINT ALBANS, VT 05478		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 656 F 684 SS=E	to be done every Mon results to be faxed to review revealed that the 5/11/23 and 5/15/23 b 5/18/23 when the prov- been done. The care is separate problems with actions regarding lab the separate problems with actions regarding lab the interventions related to 1.Resident at risk for of complications related to 1.Resident diagnosed cold agglutinin disease Intervention: Lab work physician of results per 3.At risk for injury or ca anticoagulant therapy. Intervention: Labs as of During an interview wi on 6/12/23 at 9:15 AM had not been done as monitored, nor was the ordered and per faciliti had not been followed Quality of Care CFR(s): 483.25 § 483.25 Quality of ca Quality of care is a fur applies to all treatmen facility residents. Base	day and Thursday with the the physician. A record hese tests were due on ut were not completed until vider noted they had not plan was noted to contain 3 th interventions containing testing. us were identified as having o laboratory studies: cardiovascular symptoms or to hypertension. abs and report abnormal with anemia diagnosis of e. cas ordered and notify er policy. omplication related to ordered. th the Director of Nursing I s/he confirmed as labs ordered, they were also not e physician notified as y policy thus the care plan I.		656			
FORM CMS-256	7(02-99) Previous Versions Obsc	Dete Event ID: TEKG11		Fa	sility ID: 475021 If continu	uation shoo	t Page 3 of 19

CENTER		ID HUMAN SERVICES MEDICAID SERVICES				MAPPROVI 0. 0938-03
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE	
		475021	B. WING			C 12/2023
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	1 00/	12/2025
				596 SHELDON ROAD		
SAINT AL	BANS HEALTHCARE AN	D REHABILITATION CENTER		SAINT ALBANS, VT 05478		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORR	ECTION	(X5)
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	IOULD BE	COMPLETIO
F 684	Continued From page that residents receive accordance with profe	treatment and care in	F 684	then discharged to ho	me to continue	chemo
	practice, the compreh	nensive person-centered		therapy treatments pe	·	
	care plan, and the res This REQUIREMENT by:	is not met as evidenced		The lab results from r placed in the residen		
	Based on interviews facility failed to provid orders for laboratory	and record review the le care and follow physician tests including the provision			ents with lab orders have the potenti- ected by this alleged deficient practic	
	for 2 of 5 sampled res	der or pharmacy, as ordered sidents (Resident #1 and		Education will be pr regarding policy and		
	Professional standard Findings include:	ent with facility policy and ls of practice.			e: following provider orders nd notifying the provider of	
	facility had systemic f laboratory orders; cor ordered, obtaining, re filing results of lab tes	terview reveal that the failures in its management of mpleting lab tests as viewing, monitoring and ets, reporting results of lab accurately reporting critical		Random audits of th regarding laborator by the Director of N weekly x 4, then mo substantial complia assure completion of	y studies will be ursing and or h onthly x 4 or unt nce has been a	performe er designe il chieved to
	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 diseaseI reporting results of lab t accurately reporting crit		critical results.			
	blood cells). Resident	struction of the individuals #1 was admitted with uding CBC with differential t with microscopic		Results of the audit the QAA meeting x committee will dete the audits.	3 months at whi	ch time th
	panel] (a panel of 14 screen (blood test per	comprehensive metabolic blood tests) and a type and formed on persons who on of blood). These tests		Date of Compliance	e: July 12, 2023	3
	were ordered to be do Thursday with the res physician. A record re tests were due on 5/1	bine every Monday and ults to be faxed to the eview revealed that these 1/23 and 5/15/23 but were 18/23 the facility provider		Tag F 684 POC accepted on H. Fox/P. Cota	7/5/23 by	

	S FOR MEDICARE &					IO. 0938-03
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 · ·	E CONSTRUCTION		TE SURVEY
			A. BUILDING			
		475021	B. WING			C
AME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		6/12/2023
				596 SHELDON ROAD		
AINT AL	BANS HEALTHCARE AN	ND REHABILITATION CENTER		SAINT ALBANS, VT 05478		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORI	RECTION	(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)		COMPLETIO
F 684	Continued From page	e 4	F 684	k		
	noted the labs were r	not done and ordered them				
		ely. Based on the results of				
		It #1 was transported to the				
	emergency room and	admitted to the hospital.				
	On 5/25/23 Resident	#1 was readmitted to the				
		lab orders, now due on				
		On 5/29/23 the lab tests were				
	drawn but the sample	-				
		cells rendering the sample				
		drawn 5/30/23. The results of antly abnormal. They were				
		ician as ordered, and there				
		sults were viewed by any				
		e not present in the record				
		ed 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 abnorm	al results were telephonically				
		that processed the test and				
		of 6/2/23 a call to the				
		made during which the (inaccurately) that Resident				
		s 8 g/dL (grams per deciliter)				
		18.3% (hemoglobin is the				
		acity of red blood cells and				
	hematocrit is the percent	centage of red blood cells in				
		results, Resident #1 had a				
		dL and a hematocrit of				
		ven by the nurse on 6/2/23 noglobin was reported to be				
	-	n improvement. On 6/5/23				
		ider checked the results it				
		globin result was 6 g/dL				
	representative of a de	ecline not an improvement,				
	Resident #1 was aga hospital and again ac	in sent emergently to the				

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CENTER	S FOR MEDICARE &	MEDICAID SERVICES					OMB NO	0.0938-0391
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1.	FIPLE CONS		_		E SURVEY PLETED
		475021	B. WING				1	C /12/2023
	ROVIDER OR SUPPLIER	ND REHABILITATION CENTER		596 SHE	ADDRESS, CITY, S ELDON ROAD ALBANS, VT 05		1 00	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	(EACH CORR	R'S PLAN OF CORRECTION ECTIVE ACTION SHOULD ENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 684	interview with a unit of the lab tests had not b "the orders had not b medication administr process used to alert tests". This unit man location of lab test re- not locate them in eit electronic health reco lab results are kept in section tab marked a manager confirmed to results in the chart of single page with result CMP, the CBC has n "clotted", there was r noting if it had been s there were no lab rep of Resident #1 on wh treatment and to use results. Per the surve lab studies pertaining Resident #1 was in the the laboratory. The facility nurse pra 6/8/23 at approximate instead s/he relies or him/her in the facility to discern if s/he has are in the paper char initial them when I re-	mately 10 AM during an manager, when asked why been performed s/he stated, eeen transcribed into the ation record which is the the nurse to obtain the lab ager was asked about the sults as the surveyor could her the paper chart or the ord. The unit manager stated the paper chart in the s laboratory results. The unit here was one page of lab f Resident #1 containing one ults from 5/29 for a CBC and to results as the tube was to indication on this page seen or reviewed. It is noted ports from the hospitalization nich to base care and as a comparison for future eyors request the available to the dates during which he facility were obtained from eld 11:15 AM regarding how ed and reviewed. Per the the does not have electronic al records or lab results, n results being provided to . S/He noted there is no way reviewed the lab reports that ts stating "maybe I should	F	684				

DEPARTMENT OF HEALTH AND HUMAN SERVICES

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Facility ID: 475021

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PRINTED: 06/20/2023

FORM APPROVED

		D HUMAN SERVICES MEDICAID SERVICES				FORM	D: 06/20/2023 MAPPROVED D: 0938-0391
STATEMENT O	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION	(X3) DATE	
		475021	B. WING			1	C 12/2023
NAME OF P	ROVIDER OR SUPPLIER			Γ	STREET ADDRESS, CITY, STATE, ZIP CODE		
SAINT ALI	BANS HEALTHCARE AN	D REHABILITATION CENTER			596 SHELDON ROAD SAINT ALBANS, VT 05478		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES 7 MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD F CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		(X5) COMPLETION DATE
F 684	the abnormal results if facility. Per the lab dir considered critical, a p information verbally of the information reads confirm accuracy. This hospital lab staff maki director the document nurse read back the re 6 g/dL (not 8g/dL as w the provider). Per email contact with his/her nurse (emails facility was called reques provider. The nurse re received results from the labs in order to get the calls placed was provid with the ordering phys was asked about the i during the 3 days that and inaccurate reporti- time the error was not hospitalized and treats hemoglobin of 6 for 3 with little energy". 2. Resident #4 was a diagnosis including ac of the psoas muscle, a region (all are related	was contacted to clarify how nad been conveyed to the ector, when results are ohone call is placed with the proveyed and the receiver of back the critical results to is is documented by the ing the call. Per the lab tation indicates the receiving esults of the hemoglobin as vas reported inaccurately to the ordering physician and dated June 6,7,8 and 9) the uesting updates on labs at lab results be faxed to the eports that he/she "never St Albans H&R and had to be hospital processing the em." Documentation of 11 ded by the nurse working itician. When the physician mpact on Resident #1 lapsed between the receipt ing of the results and the ed and the resident was ed, he/she noted "with a days [s/he] felt very weak dmitted 5/19/23 with cute osteomyelitis, abscess and discitis in the lumbar to infections). Resident#5 travenous) antibiotic for 8 ing orders: CBC with eactive protein used to	F	68	34		

Event ID: TEKG11

Facility ID: 475021

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		D HUMAN SERVICES MEDICAID SERVICES				FOR	D: 06/20/2023 MAPPROVED 0.0938-0391
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION	СОМ	E SURVEY PLETED
		475021	B. WING				C /12/2023
NAME OF P	ROVIDER OR SUPPLIER			Γ	STREET ADDRESS, CITY, STATE, ZIP CODE		
					596 SHELDON ROAD		1
SAINT AL	BANS HEALTHCARE AN	D REHABILITATION CENTER			SAINT ALBANS, VT 05478		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 684	CBC with differential a Thursday. On 6/7/23 a added to both lab draw written on 5/29/23 as ordered and fax to ph Monday and Thursday Per a review of the ca opportunities for these ordering date and the the electronic health reveal the results from were not present and 6/1/23 was also not previdence any of these the pharmacy per the approximately 12:30 F missing lab reports, at pharmacist confirmed to the pharmacy. On 6/12/23 at approxi was interviewed to as which the facility man resident coming from DON the facility provid the transition of care at those orders as well at is needed at the time, transcribes the orders policy states if an unlit licensed nurse will do double check if a licer the electronic medicat on the dates/times du dates due, results are	ation rate- related to be every Monday and a and CMP to be done every an ammonia level was ws. There was also an order follows; monitor lab work as armacy every evening shift y until 6/24/23. lendar there were 6 e lab studies between the present date. A review of ecord and the paper chart a lab studies due on 5/22/23 the ammonia level from resent. There was no e results had been faxed to order. On 6/12/23 at PM the DON confirmed the a approximately 1 PM the no results had been faxed	F	68	34		

Event ID: TEKG11

Facility ID: 475021

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	S FOR MEDICARE &		1			OMB NO. 093		
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING			(X3) DATE SURV COMPLETED		
						С		
		475021	B. WING	-		06/12/20	23	
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE			
SAINT AL	BANS HEALTHCARE AN	ID REHABILITATION CENTER			LDON ROAD 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)	BE COM	(X5) IPLETIO DATE	
F 684	Continued From page	9 8	F 684					
		vider, and the results are ctronic health record by						
	medical records or th	e unit manager. Paper						
	•	ies are to be placed in the not a policy regarding a						
		e provider has reviewed, if						
		or if an outside ordering						
		notification of abnormal						
		a system to track lab studies						
		of results. There is no ing the receipt of critical						
	results.			F 732	[
	roouno.				The facility currently removed the coordinator from the nursing form			
	Refer also to F773 ar	id F775.			has coded the MDS coordinator			
F 732	Posted Nurse Staffing	g Information	F 732		admin.			
SS=C	CFR(s): 483.35(g)(1)	-(4)						
					The facility posted the total numb directly responsible for	ber of staff		
	§483.35(g) Nurse Sta	•			providing patient/resident care a	nd actual		
		equirements. The facility ng information on a daily			hours worked on a daily basis.			
	(i) Facility name.				The LNHA, DON, HR and Scheo been educated on coding the MI			
	(ii) The current date.			1	coordinator to nursing admin an			
		and the actual hours worked			reporting those licensed staff res	ponsible for		
	-	aff directly responsible for			providing patient/resident care a hours worked on a daily basis	nd actual		
	resident care per shift (A) Registered nurses				The DON, LNHA or designee wil	l conduct		
	(B) Licensed practica				Monday -Friday audits weekly x4	to validate		
		defined under State law).			the nursing form posted contains	s the correct		
	(C) Certified nurse aid				staff.			
	(iv) Resident census.				Results of the audits will be revie	ewed during		
	\$402.2E(a)(0) Dectine	requiremente			the QAA meeting x3 months at v	-		
	§483.35(g)(2) Posting	st the nurse staffing data			committee will determine further	frequency of		
		n (g)(1) of this section on a			the audits.			
	daily basis at the beg				1			
	(ii) Data must be post	-		1	Date of Compliance: July 12, 20)23	1	

Facility ID: 475021

If continuation sheet Page 9 of 19

		MEDICAID SERVICES			1.
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE		(X3) DATE SURVEY COMPLETED
		475021	B. WING		C 06/12/2023
AME OF PI	ROVIDER OR SUPPLIER		ST	REET ADDRESS, CITY, STATE, ZIP CODE	
AINT AL	BANS HEALTHCARE AN	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 CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE COMPLET
F 732	Continued From page	e 9	F 732		
	(A) Clear and readab(B) In a prominent pla residents and visitors	ace readily accessible to		Tag F 732 POC accepted on H. Fox/P. Cota	7/5/23 by
	staffing data. The far written request, make	c for review at a cost not to			
	posted daily nurse st	y data retention acility must maintain the affing data for a minimum of uired by State law, whichever			
	by: Based on observation failed to post the tota	☐ is not met as evidenced ons and interviews the facility al number of staff directly ding patient/resident care ked on a daily basis.			
		ing a complaint investigation,			
	requested for the dat complaint being inves staffing sheets are re place available to the	stigated occurred. The daily equired to be posted in a			
	that are scheduled to such as assisting res activities of daily livin providing treatments.	provide direct nursing care idents with care and g, giving medications and Including staff that are not			
		ent care has the potential to g the schedule by inflating t care providers			

If continuation sheet Page 10 of 19

DEPARTMENT OF HEALTH	AND HUMAN SERVICES					06/20/2023 APPROVED
CENTERS FOR MEDICARE	& MEDICAID SERVICES				OMB NO	0.0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILDI		CONSTRUCTION		LETED
	475021	B. WING	_			C 12/2023
NAME OF PROVIDER OR SUPPLIER			STR	REET ADDRESS, CITY, STATE, ZIP CODE		
			596	SHELDON ROAD		
SAINT ALBANS HEALTHCARE	AND REHABILITATION CENTER		SA	INT ALBANS, VT 05478		
PREFIX (EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
the GenSTAR Daily scheduled and exp patient/resident car manager noted pos- control nurse, the f as the clinical reim the wound care tea On June 12, 2023 investigation a cop GenSTAR Daily St and again the sche asked about nurse direct patient/reside schedules' dated 6 schedules' dated 6 scheduler/payroll n hour position for th coordinator". Durin reimbursement coor approximately 10:4 to conduct assess Genesis is direct car reimbursement coor as interviewing and documentation for specifically about h the clinical reimbur asked if s/he provid would be considered they were schedule but when schedule reimbursement coor confirmed on the d (6/5/23-6/10/23 and as the clinical reim	d if all of the nurses listed on v Staffing Sheet were ected to provide direct e. The scheduler/payroll sitions such as the infection ADS coordinator (referred to bursement coordinator) and im leader are also included. during the second day of the y of the previous weeks' affing Sheets was requested duler/payroll manager was s on the schedule providing ent care. On these daily posted /5/23-6/10/23 and 6/12/23 the hanager noted there is a daily 8 e "clinical reimbursement g an interview with the clinical ordinator on 6/12/23 at 5 AM s/he stated his/her job is hents of residents which "per are". The clinical ordinator described his/her job I completing required billing purposes. When asked is/her role when working as sement coordinator s/he was led any resident care, passed led treatments or anything that ed resident care. S/he stated if ed to work the floor they did, d as the clinical ordinator they did not. S/he	F	732			

Facility ID: 475021

If continuation sheet Page 11 of 19

ATEMENT OF DEFICIENCIES D PLAN OF CORRECTION	RE & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			OMB NO. 0938-0 (X3) DATE SURVEY COMPLETED	
	475021	B. WING		C	
AME OF PROVIDER OR SUPPL			TREET ADDRESS, CITY, STATE, ZIP CODE	00/	12/2023
AINT ALBANS HEALTHCA	RE AND REHABILITATION CENTER		96 SHELDON ROAD GAINT ALBANS, VT 05478		
PREFIX (EACH DE	IARY STATEMENT OF DEFICIENCIES FICIENCY MUST BE PRECEDED BY FULL IRY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 773 Lab Srvcs Phy	 F 773 Continued From page 11 F 773 Lab Srvcs Physician Order/Notify of Results SS=E CFR(s): 483.50(a)(2)(i)(ii) 		Resident #1 was transferred to the hos then discharged to home to continue cl therapy treatments per her plan of care	nemo	
§483.50(a)(2) (i) Provide or or ordered by a p practitioner or or accordance with practice laws. (ii) Promptly no physician assis nurse specialis outside of clinic with facility poli notification of a physician's ord This REQUIRE by: Based on inter failed to provid when ordered I and/or accurate pharmacist of r per facility polio (Resident's #1 Findings includ) The facility did ordered for Res physician of the were complete to a physician of the were inaccurate pharmacy of th	The facility must- btain laboratory services only when hysician; physician assistant; nurse clinical nurse specialist in h State law, including scope of tify the ordering physician, tant, nurse practitioner, or clinical t of laboratory results that fall cal reference ranges in accordance cies and procedures for practitioner or per the ordering ers. MENT is not met as evidenced view and record review the facility e or obtain laboratory services by a physician and to promptly ely notify the physician or esults as specifically ordered and cy for 2 of 5 sampled residents and #4).		The lab results from resident # 4 & # 5 placed in the resident's medical record Residents with lab orders have the p be affected by this alleged deficient p Education will be provided to the nur regarding policy and procedure on la collection to include: following provid obtaining results and notifying the pr the lab results. Random audits of the center's system regarding laboratory studies will be p by the Director of Nursing and or her weekly x 4, then monthly x 4 or until substantial compliance has been act assure completion of labs tests as or reporting results of lab tests as order accurately reporting critical results. Results of the audits will be reviewed the QAA meeting x3 months at which committee will determine further free the audits. Date of Compliance: July 12, 2023	otential to practice. ses b ler orders, ovider of m performed designee hieved to rdered, red, and d during h time the quency of	

		ND HUMAN SERVICES				PRINTED: 06 FORM APF	PROVED
STATEMENT	S FOR MEDICARE &	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	_	OMB NO. 093 (X3) DATE SURV COMPLETED	'EY
		475021	B. WING			С	
				STREET ADDRESS, CITY,		06/12/20	023
NAME OF P	ROVIDER OR SUPPLIER			596 SHELDON ROAD	STATE, ZIF CODE		
SAINT AL	BANS HEALTHCARE AN	ID REHABILITATION CENTER		SAINT ALBANS, VT	05478		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID		R'S PLAN OF CORRECTION		(X5)
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH COR	RECTIVE ACTION SHOULD BI RENCED TO THE APPROPRIA DEFICIENCY)		DATE
F 773	Continued From page	e 12	F 7	73			
		3 with a diagnosis of a					
	•	a (an autoimmune disease					
	••	estruction of the individuals					
		t #1 was admitted with					
	physicians orders inc	luding 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						
		1/23 and 5/15/23 but were					
	not completed. On 5/	18/23 the facility provider					
		not done and ordered them					
		ely. Based on the results of					
		t #1 was transported to the					
	emergency room and	admitted to the hospital.					
	On 5/25/23 Resident	#1 was readmitted to the	1				
		lab orders, now due on	1			2	
		On 5/29/23 the lab tests were					
	drawn but the sample	•					
		cells rendering the sample					
		Irawn 5/30/23. The results of antly abnormal. They were					
		ician as ordered, and there					
		sults were viewed by any					
		e not present in the record					
		ed from the lab by the facility					
	at the request of the s	surveyor.					
	The lab tests due on	6/1/23 were done on 6/2/23.					
	The critically abnorma	al results were telephonically					
	-	that processed the test and					
		of 6/2/23 a call to the					
	-	made during which the					
	provider was notified	(inaccurately) that Resident					_
ORM CMS-256	7(02-99) Previous Versions Obs	solete Event ID: TEKG	511	Facility ID: 475021	If continua	ation sheet Page	13 of 19

		D HUMAN SERVICES MEDICAID SERVICES				PRINTED: 06/20/2023 FORM APPROVED OMB NO. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED
		475021	B. WING			C 06/12/2023
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STA	TE, ZIP CODE	
				596 SHELDON ROAD		
SAINT AL	BANS HEALTHCARE AN	D REHABILITATION CENTER		SAINT ALBANS, VT 0547	78	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	X (EACH CORRECT CROSS-REFERENCE	PLAN OF CORRECTION TIVE ACTION SHOULD BE CED TO THE APPROPRIAT EFICIENCY)	(X5) COMPLETION E DATE
F 773	#1's Hemoglobin was and hematocrit was 1 oxygen carrying capachematocrit is the perce- blood). Prior to these hemoglobin of 7.2 g/d 20.4%. The report give during which the hemog- egresented are when the facility provi- was noted the hemog- representative of a de Resident #1 was again hospital and again add On 6/8/23 at approxim- interview with a unit me the lab tests had not be medication administration process used to alert a tests". This unit mana- location of lab test res- not locate them in either electronic health recor- lab results are kept in section tab marked as manager confirmed the results in the chart of single page with resul- CMP, the CBC has no "clotted", there was no noting if it had been set there were no lab repo- of Resident #1 on white treatment and to use a results. Per the survey- lab studies pertaining Resident #1 was in the	8 g/dL (grams per deciliter) 8.3% (hemoglobin is the city of red blood cells and entage of red blood cells in results, Resident #1 had a L and a hematocrit of en by the nurse on 6/2/23 oglobin was reported to be a improvement. On 6/5/23 der checked the results it lobin result was 6 g/dL cline not an improvement, n sent emergently to the mitted. hately 10 AM during an hanager, when asked why been performed s/he stated, en transcribed into the tion record which is the the nurse to obtain the lab ger was asked about the utts as the surveyor could her the paper chart or the rd. The unit manager stated the paper chart in the a laboratory results. The unit ere was one page of lab Resident #1 containing one ts from 5/29 for a CBC and o results as the tube was o indication on this page een or reviewed. It is noted orts from the hospitalization ch to base care and as a comparison for future yors request the available to the dates during which e facility were obtained from		773		
ORM CMS-256	7(02-99) Previous Versions Obso	Event ID: TEKG	11	Facility ID: 475021	If continuat	ion sheet Page 14 of 19

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVE AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING		S FOR MEDICARE &	MEDICAID SERVICES				O. 0938-0391
	STATEMENT OF	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA			(X3) DAT	E SURVEY IPLETED
			475021	B. WING		00	6/12/2023
	NAME OF PRO	ROVIDER OR SUPPLIER	t.		STREET ADDRESS, CITY, STATE, ZIP CODE		
SAINT ALBANS HEALTHCARE AND REHABILITATION CENTER					596 SHELDON ROAD		
SAINT ALBANS HEALTHCARE AND REHABILITATION CENTER SAINT ALBANS, VT 05478	SAINT ALD	DANS HEALTHCARE AN	D REHABILITATION CENTER		SAINT ALBANS, VT 05478		
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMP	PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A	HOULD BE	(X5) COMPLETION DATE
F 773 Continued From page 14 the laboratory. F 773 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 she does not have electronic access to the hospital records or lab results, instead she 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 tactors of lab is placed with the information verbally conveyed and the receiver of the information verbally conveyed and the receiver of the information verbally conveyed and the receiver of the information verbally conveyed and the receiving nurse read back the results of the heads the receiving nurse read back the results of the headglobin 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, as d) 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 Abans 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.		the laboratory. The facility nurse prace 6/8/23 at approximate lab results are obtain nurse practitioner s/ha access to the hospital instead s/he relies on him/her in the facility. to discern if s/he has are in the paper chart initial them when I rev On 6/8/23 at approxim from the hospital that lab results on 6/2/23 the abnormal results of facility. Per the lab dir considered critical, a information verbally c the information reads confirm accuracy. This hospital lab staff make director the document nurse read back the r 6 g/dL (not 8g/dL as v the provider). Per email contact with his/her nurse (emails facility was called req ordered and to request provider. The nurse re- received results from tr labs in order to get the calls placed was prov	ctitioner was interviewed on ely 11:15 AM regarding how ed and reviewed. Per the e does not have electronic I records or lab results, results being provided to S/He noted there is no way reviewed the lab reports that is stating "maybe I should view". nately 2 PM the lab director processed and reported the was contacted to clarify how had been conveyed to the rector, when results are phone call is placed with the onveyed and the receiver of back the critical results to is is documented by the ing the call. Per the lab tation indicates the receiving esults of the hemoglobin as was reported inaccurately to n the ordering physician and dated June 6,7,8 and 9) the uesting updates on labs st lab results be faxed to the eports that he/she "never St Albans H&R and had to he hospital processing the em." Documentation of 11 ided by the nurse working	F 7			

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Facility ID: 475021

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PRINTED: 06/20/2023

		D HUMAN SERVICES				FOF	RM APPROVED
CENTER	S FOR MEDICARE & I	MEDICAID SERVICES					<u>IO. 0938-0391</u>
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN		(X3) DATE SURVEY COMPLETED C		
		475021	B. WING	_		0	6/12/2023
NAME OF PF	ROVIDER OR SUPPLIER			STR	EET ADDRESS, CITY, STATE, ZIP CODE		
SAINT ALI	BANS HEALTHCARE AN	D REHABILITATION CENTER			SHELDON ROAD 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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 773	and inaccurate report time the error was not hospitalized and treat hemoglobin of 6 for 3 with little energy". 2. Resident #4 was a diagnosis including ac of the psoas muscle, a region (all are related was ordered an IV (in weeks with the follow differential, CRP (C-re- identify infection or int (erythrocyte sediment coagulation), CMP to CBC with differential a Thursday. On 6/7/23 as ordered and fax to ph Monday and Thursday Per a review of the ca opportunities for these ordering date and the the electronic health r reveal the results from were not present and 6/1/23 was also not p evidence any of these the pharmacy per the approximately 12:30 f missing lab reports, a pharmacist confirmed to the pharmacy.	a lapsed between the receipt ing of the results and the ted and the resident was ed, he/she noted "with a days [s/he] felt very weak dmitted 5/19/23 with cute osteomyelitis, abscess and discitis in the lumbar to infections). Resident#5 travenous) antibiotic for 8 ing orders: CBC with eactive protein used to flammation), ESR tation rate- related to be every Monday and a and CMP to be done every an ammonia level was ws. There was also an order follows; monitor lab work as armacy every evening shift y until 6/24/23. Idendar there were 6 e lab studies between the present date. A review of record and the paper chart in lab studies due on 5/22/23 the ammonia level from resent. There was no e results had been faxed to order. On 6/12/23 at PM the DON confirmed the t approximately 1 PM the no results had been faxed	F 7	73			
	Facility policy NSG11	5 Physician/Advanced					

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PRINTED: 06/20/2023

OLIVIER	STOR MEDICARE a	MEDICAID SERVICES			DMB NO. 0938-03
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A, BUILDING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		(=====			С
		475021	B. WING		06/12/2023
NAME OF P	ROVIDER OR SUPPLIER			REET ADDRESS, CITY, STATE, ZIP CODE	
SAINT AL	BANS HEALTHCARE AN	D REHABILITATION CENTER		SHELDON ROAD INT 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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	
F 773	Continued From page	9 16	F 773		
	Practice Provider (AP revision date of 12/01	P) Notification - with /21 states: upon ent who has a change in		r	
	admnormal diagnostic Report to physiican/a	cs, a licensed nurse will: dvanced practice provider. If nding physician/APP, the	F 775	Resident #1 was transferred to the hosp then discharged to home to continue ch therapy treatments per her plan of care.	emo
		/or diagnostic results, date /diagnostic results on the		The lab results from resident # 4 & # 5 w placed in the resident's medical record.	
F 775	physician/APP.	d - Lab Name/Address	F 775	Residents with lab orders have the po be affected by this alleged deficient p	
	CFR(s): 483.50(a)(2)			Education will be provided to the nurs	
	reports that are dated address of the testing	t's clinical record laboratory and contain the name and		regarding policy and procedure on lab collection to include: following provide obtaining results and notifying the pro the lab results. Labs will be filed into t resident's chart.	er orders, vider of
	review the facility faile	n, interview and record ed to file in the resident's ory reports for two of five esidents #1 and #4).		Random audits of the center's system regarding laboratory studies will be pe by the Director of Nursing and or her weekly x 4, then monthly x 4 or until substantial compliance has been achi	erformed designee
	Findings include:	Resident #1 was admitted to		assure completion of labs tests as ord reporting results of lab tests as ordere accurately reporting critical results.	lered,
	the facility on 5/8/23 v	vith a diagnosis of a certain lent #1 was admitted with		Results of the audits will be reviewed	during
	physicians orders incl (complete blood coun evaluation to determin	uding CBC with differential t with microscopic ne the percentage of each		the QAA meeting x3 months at which committee will determine further freque the audits.	time the
		Ils present in the blood), a polic panel (a panel of 14		Date of Compliance: July 12, 2023	

Facility ID: 475021

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CENTER	S FOR MEDICARE & I	D HUMAN SERVICES MEDICAID SERVICES	1			FORM OMB NO	D: 06/20/2023 MAPPROVED D: 0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			ONSTRUCTION		LETED
		475021	B. WING			1	C 12/2023
NAME OF PF	ROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
SAINT ALE	BANS HEALTHCARE AN	D REHABILITATION CENTER			SHELDON ROAD INT ALBANS, VT 05478		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 775	be done every Mondares ults to be faxed to electronic health recorreviewed for the result With the exception of 5/29/23 that indicated could not be done due there is no evidence that any provider as they were cord and had to be facility at the request of approximately 10 AM the absence of the late 2. Resident #4 was act diagnoses including in ordered an IV (intraver with the following order CRP (C-reactive proteor inflammation), ESR rate- related to coagul Monday and a CBC were done every Thursd level was added to bo also an order written of monitor lab work as one every evening shift Me 6/24/23. Per a review of the cat opportunities for these ordering date and the the electronic health reveal the results from were not present and 6/1/23 was also not protect and point of the cat opport and the the electronic health reveal the results from were not present and 6/1/23 was also not protect and point or present and 6/1/23 was also not protect and point or present and 6/1/23 was also not protect and point or present and for the present	a who may need a these tests were ordered to y and Thursday with the the physician. Both the rd and the paper chart were ts of these ordered tests. one page of results dated the CBC with differential e to clotting in the tube, he results were viewed by were not present in the obtained from the lab by the of the surveyor. On 6/8/23 at a unit manager confirmed o reports. Amitted 5/19/23 with effections. Resident#5 was nous) antibiotic for 8 weeks ers: CBC with differential, in used to identify infection a (erythrocyte sedimentation ation), CMP to be every ith differential and CMP to ay. On 6/7/23 an ammonia th lab draws. There was on 5/29/23 as follows; rdered and fax to pharmacy onday and Thursday until lendar there were 6 e lab studies between the present date. A review of ecord and the paper chart o lab studies due on 5/22/23 the ammonia level from	F 7	775	Tag F 775 POC accepted on 7/5/23 h H. Fox/P. Cota	ЪУ	

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		MEDICAID SERVICES			OMB	RM APPROVEI 10. 0938-0391
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION		TE SURVEY MPLETED
		475021	B, WING			C
NAME OF PE	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STA		6/12/2023
SAINT ALI	BANS HEALTHCARE AN	D REHABILITATION CENTER		596 SHELDON ROAD SAINT ALBANS, VT 0547	78	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	IX (EACH CORRECT CROSS-REFERENCE	PLAN OF CORRECTION TIVE ACTION SHOULD BE CED TO THE APPROPRIATE EFICIENCY)	(X5) COMPLETION DATE
F 775	Continued From page missing lab reports.	9 18	F	775		
OPM CMS 256	7(02-99) Previous Versions Obs	olete Event ID:TEK(Facility ID: 475021	If continuation she	