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

October 26, 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 recertification survey conducted on **October 4, 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,

PamelaMCotaRN
Pamela M. Cota, RN
Licensing Chief

Enclosure

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	475021	A. BUILDING _____ B. WING _____	10/04/2023

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

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E 000	Initial Comments The Division of Licensing and Protection conducted an unannounced, onsite Emergency Preparedness survey in conjunction with the annual recertification survey from 10/2/2023-10/4/2023 to determine compliance with 42 CFR Part 483 requirements for Long Term Care Facilities. As a result of this survey, the Facility was determined to be in substantial compliance with these requirements.	E 000	St. Albans Health & Rehabilitation Center provides this plan of correction without admitting or denying the validity or existence of the alleged deficiency. The plan of correction is prepared and executed solely because it is required by federal and state law.	
F 000	INITIAL COMMENTS The Division of Licensing and Protection conducted an unannounced, onsite recertification survey from10/2/2023 through 10/4/2023 to determine compliance with 42 CFR Part 483 requirements for Long Term Care Facilities. Deficiencies were cited as a result of this survey	F 000	F584 1. In room # 25 the cove base was reapplied. The Center has obtained a contractor to provide a quote to repair/replace and paint in resident rooms, and sand/stain doors. Ceiling tiles will be replaced. Baseboard heating in the hall near the kitchen/west hall will be painted/replaced. The center has hired a Maintenance Assistant with carpentry experience to start October 30th.	
F 584 SS=E	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss	F 584	2. The Unit Manager emptied the commode of resident #33 and obtained a cover for the commode. All residents have the potential to be affected by this alleged deficient practice. Education will be provided to staff regarding residents having the right to a safe, clean, comfortable homelike environment and use of TELS. Education will be provided to the nursing staff regarding the center's policy for Considerate Treatment.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

Rebecca Jennings, Administrator 10/24/23

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 584	Continued From page 1 or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observations and interviews, the facility failed to provide necessary maintenance services to ensure residents have a safe, clean, comfortable, and homelike environment. The facility also failed to ensure the environment was cared for in a sanitary manner by cleaning and properly storing a resident commode for 1 of 21 (Resident #33) residents in the sample. 1. During observations on 10/2/23 in the rooms on the East and West units, the following environmental concerns were identified: Room #25 had a cove base (used as a transition material from floor to wall) peeling from the	F 584	Random audits will be completed weekly x 4 and Monthly x 4 by the Director of Nursing and or her Designee to assure that commodes are clean and have a cover. An Environmental audit of the center was completed to identify all work to be completed in resident living Areas. Ceiling tiles audits will be completed weekly x 4 and then Monthly x 4. Administrator will update original environmental audit as tasks are completed. Results of the audits will be reviewed during CQI for further evaluation and recommendations. Date of compliance: November 3, 2023 **Tag F 584 POC accepted on 10/26/23 by D. Hoffman/P. Cota**	

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F 584	Continued From page 2 corner of the wall, exposing broken plaster pieces. In room #20, the walls were scratched, and sheet rock exposed. Room #19 the entrance door, closet doors, and bathroom door all have scratched wood, and the register needs painting. Walls and door and closet doors are scratched. Ceiling tiles throughout the East and West units were chipped, broken, and stained. One ceiling tile on the West unit between the nurse station and the dining area had an orange-sized spot of black mold. Baseboard heating in the hall near the kitchen and in the West Hall was in disrepair with missing paint, rust, dents, and missing fins. On 10/4/23 at approximately 11:30 AM, during an environmental walk-through with the Center Executive Director (CED), Director of Maintenance, and the Senior Administrator, the CED confirmed the above findings. 2. Per observation on 10/2/23 at 1:30 PM, Resident #33 was sitting in their room in a wheelchair. A food tray left over from the lunch meal was on the overbed table. A commode with urine was located at the head of the bed approximately 2 feet from the resident; when asked if s/he had used the commode after lunch, Resident #33 said they had not. At 3:25 PM, the lunch tray had been removed, and the commode was still at the head of the bed and still contained urine. When Resident #33 was asked if staff had emptied it before lunch, s/he said no, they hadn't.	F 584		

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F 584	Continued From page 3 On 10/3/23 at 1:45 PM, Resident #33 was observed eating lunch in her/his room. The commode was again noted to have urine in it. S/he was asked if it bothered her/him to have the used commode right next to them when they ate s/he stated it did not bother them, but it would be nice if they could at least have a cover for it. Per interview on 10/3/23 at approximately 4:15 PM with the Unit Manager staff are expected to empty resident's commode after use. On 10/4/23, the unit manager obtained a cover for the commode and confirmed that urine was left in the commode.	F 584		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to assure that services provided by the facility are provided according to professional standards regarding documentation, assessment, obtaining physician orders, and creating a plan of care regarding the use of a splint for 1 of 21 sampled residents (Resident #3). Findings include: Per record review, Resident #3 was admitted to the facility on 9/12/23 for physical therapy with diagnoses that include left ankle sprain, difficulty in walking, and need for assistance with personal	F 658	F658 The Unit Manager followed up with Resident #3's orthopedist who confirmed that the splint was not needed. The splint was removed immediately and a skin assessment was completed with no alteration in skin integrity. Residents with a prosthetic or orthopedic device have the potential to be affected by this alleged deficient practice. The nurses will be educated on the center's Policy for Prosthetics and Orthopedics. Random audits will be completed by the Director of Nursing and or her designee weekly x 4 and then monthly x 4 or until substantial compliance has been achieved to assure services provided meet professional standards. Results of the audits will be reviewed during CQI for further evaluation and recommendations. Date of compliance: November 3, 2023	

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F 658	Continued From page 4 care. Per interview on 10/2/2023 at approximately 11:30 AM, Resident #3 stated she/he had difficulty walking to the bathroom by him/herself as the "thing" (splint) was still on her/his leg. It had been there since he/ she got there (21 days earlier), and staff have not done anything with it, including removing it to assess or wash the skin underneath the splint. Per observation on 10/3/2023 at approximately 11:00 AM, a split was observed on Resident # 3's left lower extremity, encasing her/his ankle while s/he was assisted with personal care by an LNA (Licensed Nursing Assistant). The LNA assisting Resident #3 with care confirmed that the staff do not remove the splint during care, including washing the skin under it. Per review of Resident #3's medical record, there is no documentation that Resident #3 was admitted with a splint or that care related to wearing a splint was completed. A 9/12/23 admission nursing assessment performed by the Unit Manager does not include documentation that Resident #3 was wearing a leg splint or that the skin surrounding the splint was assessed. Resident #3 did not have physician orders to wear a leg splint from 9/12/23 through 10/4/2023. There is no documentation that the splint was applied or removed on Resident #3's Medication Administration Record and Treatment Administration Record. Resident #3's care plan does not include goals or interventions that address the use of the splint, including assessing the extremity for swelling, neurovascular status, and skin integrity. Physician visit notes dated 9/13/2023 and 9/25/23 do not address splint use.	F 658	**Tag F 658 POC accepted on 10/26/23 by D. Hoffman/P. Cota**	

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F 658	Continued From page 5 Per interview on 10/4/2023 at approximately 11:00 AM, the Unit Manager stated that they did not notice or document the splint on Resident #3's left leg while performing the admission assessment and did not obtain a physician's order to use it. He/she confirmed that the splint should have been documented on the assessment, the skin underneath the splint should have been assessed, and a physician's order to apply and remove the splint should have been obtained. On 10/4/2023 at approximately 11:30 AM, the Director of Nursing confirmed that Resident #3 did not have a physician's order to use a splint. There is no evidence that care was performed related to the use of a splint, including assessments of the area, and a care plan was not developed to include the use of the splint. Ref: Lippincott Manual of Nursing Practice (11th Edition) Lippincott Williams & Wilkins.	F 658		
F 756 SS=D	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon.	F 756	F756 Resident #58's MRR was reviewed with the Center's NP and an order was obtained to perform a gradual dose reduction for resident's Aripiprazole. All residents that receive medications have the potential to be affected by this alleged deficient practice. RN/LPN's will be educated regarding the center's policy for Medication Regimen Review. Random audits of Medication Regimen Reviews from the pharmacy will be performed by the Director of Nursing and or designee weekly x 4 and then monthly X 4 or until substantial compliance has been achieved to assure pharmacy recommendations are acted on.	

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F 756	Continued From page 6 (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on record review and interviews, the facility failed to ensure that the recommendations on a Medication Review Recommendations (MRR) made by the pharmacists, were acted on for 1 of 5 sampled residents (Resident #58). Findings include: Per record review, a pharmacy document dated 4/13/2023, indicated a review of Resident #58's medication regime. The pharmacist made the following recommendations: "Please attempt a gradual dose reduction (GDR)	F 756	Results of the audits will be reviewed during CQI for further evaluation and recommendations. Date of compliance: November 3, 2023 **Tag F 756 POC accepted on 10/26/23 by D. Hoffman/P. Cota**	

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F 756	Continued From page 7 of Aripiprazole (a medication used to treat Schizophrenia, bipolar disorder, depression, and Tourette Syndrome) at this time. Or please provide additional documentation in the medical record that describes why a gradual dose reduction (GDR) at this time would likely cause the resident distress, worsen the medical condition, or impair function (i.e., why a GDR may be clinically contraindicated.)." There was no evidence that the physician had reviewed the document and/or followed up on the suggestion for dose reduction. An interview on 10/4/2023 at approximately 10:00 A.M. with the Director of Nursing and the Unit Manager, they confirmed that a GDR had not been attempted and there was no evidence in Resident 58's medical record from the physician documenting why a GDR would be clinically contraindicated.	F 756		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents	F 812		

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F 812	Continued From page 8	F 812		

from consuming foods not procured by the facility.

§483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety.
This REQUIREMENT is not met as evidenced by:
Based on observation and staff interview, the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety. Findings include:

During a tour of the facility kitchen accompanied by the Food Service District Manager (FSDM) at approximately 10:15 AM on 10/2/23 the canned food shelf was noted to contain two dented cans. When asked about the process for inspecting and removing dented cans the FSDM stated that staff are trained to remove all dented cans before placing for use. The FSDM removed the dented cans, and confirmed that they should not have been placed on the shelf for use.

On 10/4/23 at 8:04 AM, during observations of the breakfast meal tray line located in the main dining room, the serving area was noted to be unclean. The following issues were observed:

1. The clean plate dispenser was noted to be dirty with food particles, crumbs, and buildup of old grease along the insides of the dispenser.
2. The steam table area floor and sidewall were noted to have food debris, spilled liquid that had dried, and cobwebs. The cobwebs were located between the area of the steam table that held the food and the sidewall and had old, dried food hanging in them.
4. The floor in the storage closet had loose

1. The clean plate dispenser was cleaned.
2. The steam table area floor and sidewalls were cleaned.
3. The floor in the storage closet was cleaned.
4. Meal Trays have been ordered for replacement.
5. The open package of hotdogs without a date was discarded.
6. The transport carts for meal trays were cleaned.
7. The dented cans have been discarded.
8. The food was removed from the cardboard boxes, placed on shelf, labeled and dated.
9. The mentioned ceiling in the dish room is part of a capital project for asbestos abatement with a quote obtained for removal.
10. The items without a resident name and/or date were discarded from the refrigerator on the East Wing.

The kitchen staff will be educated on the following policies: Cleaning Standards, Cleaning Schedule, Pantry/Nourishment Room Sanitation, Department Sanitation, Food Brought in for Patients/Residents, Dry Storage, and Refrigerated/Frozen Storage.

The nursing staff will be educated on the center's policy for Food Brought in for Patient/Residents.

All residents have the potential to be affected by this alleged deficient practice.

Random audits of for Food Procurement, Storage, Sanitation will be performed by the Administrator and or designee weekly x 4 and then monthly X 4 or until substantial compliance has been achieved to assure food safety.

Results of the audits will be reviewed during CQI for further evaluation and recommendations.

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F 812	Continued From page 9 Cheerios, buildup of debris, and dried spillage. 5. Meal trays being used to transport and serve meals to residents were cracked, peeling, and some had sharp edges. 6. There was an open package of hot dogs on the door of the refrigerator without a date to indicate when they were opened. 7. A food cart used to transport meal trays to the units had a dried red substance on the inner walls, which appeared to be juice. At 8:35 AM on 10/4/23 the Dietary Manager (DM) was shown and confirmed the above issues identified during observation of tray service. At this time the steam table was being emptied by staff and the water in the basin that is used to create steam had peas and other pieces of food in it. The DM stated that the water should be emptied out at least daily after the evening meal, and that the food that was in it must be left from the evening meal on 10/3/23. S/he also confirmed that that the main dining service area should be cleaned after each shift and that it was not being done consistently. The DM stated that s/he was creating schedules and systems to ensure the tasks were being done; however, these had not been implemented yet. On 10/4/23 at 12:30 PM, observations during a repeat visit to the kitchen revealed that there were again two dented cans that had been placed for use. One can was dented at the top seam which increases the risk of compromise. The walk-in refrigerator was noted to have cardboard boxes of food that had been delivered that morning and placed on the floor, where the floor was still noted to have debris and dirt under the shelves. The ceiling area located between the dish room and the pan sinks was noted to have	F 812	Date of compliance: November 3, 2023 **Tag F 812 POC accepted on 10/26/23 by D. Hoffman/P. Cota**	

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SAINT ALBANS HEALTHCARE AND REHABILITATION CENTER	596 SHELDON ROAD SAINT ALBANS, VT 05478

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F 812	Continued From page 10 cracked, peeling paint and areas of what appeared to be black mold. This was confirmed by the FSDM at the time of the finding. Per observation on October 2, 2023, at 1:55 PM, during a tour of the East Wing dining area the following observations were made in the refrigerator which was accessible by staff, residents, and visitors: A 68 oz. hazelnut coffee creamer labeled with a resident's name but no date, and an 18 oz squeeze container of mayonnaise with a resident's name and note saying "for everyone" without a date. The following items were found in the freezer without names and dates: Lean Cuisine personal frozen pizza, Jimmy Dean breakfast bowl and a single serve package of Ore-Ida crisp fries. Posted on the front of the refrigerator was a printed form stating: State law requires all food to be labeled and dated before being put in the refrigerator. Add resident name and date brought with an expiration of 7 days of food being put in refrigerator. At 2PM of the same day a unit Licensed Nursing Assistant confirmed the lack of dates on the noted items as well as (except for the coffee creamer and mayonnaise), the lack of resident names on the remaining items. A review of the facility policy regarding resident food storage confirmed the requirement of all items being stored must be labeled with the name of the resident and the date the item is stored.	F 812		