| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 475021 | A. Building<br>B. Wing | 07/22/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Saint Albans Healthcare and Rehabilitation Center | 596 Sheldon Road<br>Saint Albans, VT 05478 |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
|---|---|
| F 0689<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.<br><br>(continued on next page) |

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.

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
|---|---|---|
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| F 0689<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Based on observation, interview, and record review, the facility failed to assess and identify individual risks and implement measures to provide supervision to prevent accidents resulting in harm to 1 of the 3 sampled residents (Resident #1). Findings include: Per record review, Resident #1 has the following diagnoses: adjustment disorder, borderline personality disorder, anxiety, and major depressive disorder. A review of the initial Minimum Data Set (a standardized, comprehensive assessment of an adult's functional, medical, psychosocial, and cognitive status) indicates a BIMS (brief interview for Mental Status) of 15, suggesting that Resident #1 is cognitively intact. Resident #1 had been living in a group home until a short time ago when she/he was found to require more assistance with Activities of Daily and was admitted to the facility for rehabilitation. The State Agency received a report from the facility Administrator regarding an incident that occurred on 6/10/2025. The report reveals that Resident #1 was found in his/her room with deep wounds to his/her left forearm and thumb area. Two pairs of Scissors were found at the bedside. When asked what happened, S/he stated, I cut myself with scissors because I wanted to kill myself. Resident #1's room was searched, and a single knitting needle was found. Additional reporting was provided to the State Agency regarding a second incident, dated 6/15/2025, in which Resident #1 was found to have removed all the sutures from the laceration. Per the Facility Assessment, with a review date of 7/11/2024, We are able to provide care to residents with depression, anxiety, manic depression, and psychiatric disorders. Staff are trained upon hire and annually on trauma-informed care, which includes trauma symptoms, triggers, and how to provide support in the long-term care setting. In-house providers- our medical director and NP provide treatment of mental/behavioral health services as applicable. Person-centered care planning occurs, which supports the cognitive and mental health needs of the residents.Per record review, an emergency room note dated 12/21/24 reveals that Resident #1 presents for self-injury to his/her finger and suicide ideation, stating s/he is overwhelmed by the change in his/her living situation. Per a Case Management Progress Note with a date of 12/23/24, reveals Resident #1 held a butter knife to his/her throat and then harmed themselves by tearing off a fingernail at the nail bed, indicating s/he was overwhelmed by his/her transfer to a different facility. At the time, Resident #1 was endorsing suicidal ideation, stating she/he would find a way to act on it. Per Trauma Informed Care policy effective 5/1/2024, The Center will identify triggers which may re-traumatize patients with a history of trauma. Trigger-specific interventions will identify ways to decrease the patient's exposure to triggers that re-traumatize the patient, as well as identify ways to mitigate or decrease the effect of the trigger on the patient and will be added to the patient's care plan. Trauma-specific care plan interventions will recognize the interrelation between trauma and symptoms of trauma such as substance abuse, eating disorders, depression, and anxiety. In situations where a trauma survivor is reluctant to share their history, the Center will still try to identify triggers which may re-traumatize the patient and develop care plan interventions which minimize or eliminate the effect of the trigger on the patient.Per review of Resident #1's care plan, an entry dated 5/7/25 reveals that Resident #1 is at risk for suicidal ideations and self-harm Pt [patient] had held a butter knife to [his/her] throat and made a self-injury to her fingernail, with goals that include asking resident to share suicidal history and monitor any behavioral changes. The care plan does not contain safety interventions related to preventing self-harm until 6/10, when Resident #1 cut his/her arm. Per Transition of Care Report, dated 5/6/2025, a physical therapy entry indicates that a few months ago at his/her baseline, Resident #1 was able to ambulate around his/her home and used a wheelchair for longer distances. S/he was able to perform personal hygiene without assistance. She is now requiring more assistance with transfers and self-care and has limited mobility that requires more assistance. Today [s/he] is well below previous baseline level of functional mobility, at high risk for falling. Per Minimum Data Set (A standardized, comprehensive assessment of an adult's functional, medical, psychosocial, and cognitive status) dated 5/21/2025, Resident #1 is dependent on staff (dependent is defined as helper does all the effort, resident does none of the effort to complete the activity for toileting hygiene, defined as the ability to maintain perineal hygiene, adjust clothes before and after voiding or having a bowel movement, s/he is dependent on staff to dress both upper and lower body, s/he cannot turn self in bed, or come to a standing position from sitting in a chair, wheelchair, or on the side of the bed. Additionally, s/he is dependent on being able to get on and off a toilet or commode. A review of Social Service and Documentation dated 5/9/2027, there is an entry in the Mood category that Resident #1 has a history of behaviors, depression, and self-harming, she/he has had the recent experience of a change in residence |

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| F 0742<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Provide the appropriate treatment and services to a resident who displays or is diagnosed with mental disorder or psychosocial adjustment difficulty, or who has a history of trauma and/or post-traumatic stress disorder.<br><br>Based on interview and record review, the facility failed to acknowledge and assess the underlying causes of the resident's expression of distress and failed to develop and implement a care plan that addressed this distress, resulting in deterioration of the resident's mental and psychosocial well-being and resulting in the resident harming self for 1 of 3 (Resident #1) of the applicable sample and failed to revise care plans for triggers related to trauma for 9 or 12 residents (Residents #1, #2, #3, #4, #5, #6, #7, and #8). This is a repeat deficiency for this facility, with the violation cited during the previous recertification survey, dated 1/28/25. Findings include: 1.) Per record review, Resident #1 has the following diagnoses: adjustment disorder, borderline personality disorder, anxiety, and major depressive disorder. A review of the Brief Interview for Mental Status Evaluation (A test for cognitive function) dated 5/28/25 provides a score of 15, suggesting that Resident #1 is cognitively intact. Resident #1 had been living in a group home until recently when she/he was found to require more assistance than the group home could provide. The State Agency received a report from the facility Administrator regarding an incident that occurred on 6/10/2025. The report reveals that Resident #1 was found in her room with deep wounds to her left forearm and thumb area. Scissors were found at the bedside. When asked what happened, s/he stated, I cut myself with scissors because I wanted to kill myself. Resident #1's room was searched, and a single knitting needle was found. Additional reporting was provided to the State Agency on 6/15/2025, indicating that Resident #1 removed all sutures from the laceration.<br><br>Per the Facility Assessment with a review date of 7/11/2024, We are able to provide care to residents with depression, anxiety, manic depression, and psychiatric disorders. Staff are trained upon hire and annually on trauma-informed care, which includes trauma symptoms, triggers, and how to provide support in the long-term care setting. In-house providers- our medical director and NP provide treatment of mental/behavioral health services as applicable. Person-centered care planning occurs, which supports the cognitive and mental health needs of the resident.<br><br>Per record review, an emergency room note dated 12/21/24 reveals that Resident # 1 presents for self-injury to his/her finger and suicide ideation, stating s/he is overwhelmed by the change in his/her living situation.<br><br>Per a Case Management Progress Note with a date of 12/23/24, reveals that Resident #1 held a butter knife to his/her throat and then harmed themselves by tearing off a fingernail at the nail bed, indicating s/he was overwhelmed by his/her transfer to a different facility. At the time, Resident # 1 was endorsing suicidal ideation, stating she/he would find a way to act on it. Resident #1 was residing in a group home, with admittance to a long-term care facility for the purpose of rehabilitation to improve mobility.<br><br>According to the Transition of Care Report dated 5/6/2025, a physical therapy entry indicates that a few months ago, at baseline, Resident #1 was able to ambulate around their home and used a wheelchair for longer distances. S/he was able to perform personal hygiene without assistance. S/he is now requiring more assistance with transfers and self-care, and has limited mobility that requires more assistance. Today [s/he] is well below previous baseline level of functional mobility, at high risk for falling.<br><br>(continued on next page) |

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| F 0742<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Per review of Progress Notes, there are multiple entries (5/7/25 hitting face, 5/21/25 hitting self, spitting at staff, 5/22/25 hitting self, throwing self, 6/4/25 kicked Licensed Nursing Assistant, hitting self in face, 6/6/25 rocking chair, throwing self out, 6/7/25 threatened to hurt self) demonstrating ongoing self -harm or threats to self harm.<br><br>Per Psychiatric Evaluation & Consultation dated 5/9/2025 reveals this is the initial consult with Resident #1, outside records indicate a diagnosis of PTSD; however, the medical chart does not reflect the diagnosis. With the history of borderline personality disorder, s/he could easily become unstable, and she would follow up in 7 days.<br><br>A review of Social Service and Documentation dated 5/9/2027, has an entry in the Mood category that Resident #1 has a history of behaviors, depression, and self-harming and has had the recent experience of a change in residence, and a change in persons lived with. Under the Mental Health section, it is indicated that Resident #1 has a diagnosis of a major mental illness, listing them as Depression, Anxiety Disorder, and personality disorder, and displays symptoms of psychosocial adjustment difficulty that are described as became upset during incontinence episode, slapping self and crying after admission. In the section Mental Health Treatment History, it is entered that Resident #1 has received mental health treatment and that this consists of outpatient psychiatry, and treatment is ongoing. In the Trauma History section, it is indicated that Resident #1 has a history of trauma/Post Traumatic Stress Disorder ( PTSD). There is an entry that states per mental health case worker, Resident #1 has a history of self-harm and frequent trips to the Emergency Department for self-cutting, slapping self in face and head when upset or needs are not met.<br><br>Per Psychiatric Evaluation Consultation 5/19/2025, reveals that Resident #1 is keeping busy with various arts and crafts, including making tissue paper. It is discussed that Resident #1 will have a weekly follow-up with the Behavioral Health Provider. Plan to follow up in 7 days. There are no further visits until 6/13/2025. Per Progress Notes on 6/10, Resident # 1 is found with a large deep laceration to his/her arm and two pairs of bloody scissors by his/her bed. When the staff asked what happened, she/he stated, I cut myself with the scissors because I wanted to kill myself, because the night shift left me wet.<br><br>Per record review of an email to the Social Service Director dated 6/12/2025, Resident #1's mental health case worker indicates a long-time history of behaviors that include self-harm when triggered by an external event or personal interaction, or needs are not met immediately .[she/he] has the potential to become extremely anxious and verbal /yelling in addition to [his/her] self-harming behaviors and voicing suicidal intentions.<br><br>Per Psychiatric Evaluation 6/13/2025 reveals that Resident #1 has diagnoses of borderline personality disorder, depression, and anxiety, takes medications for PTSD, and mood. It reveals she/he cut his/her arm because the nighttime staff were not being nice to him/her, s/he was told that they would not return as s/he had urinated too many times, causing frustration and so s/he cut her arm, as s/he wanted to remove him/herself from the situation. The self-injury was related to a specific incident of feeling helpless and maladaptive coping skills. The evaluation notes that medical records indicate Resident #1 has a history of this behavior when s/he is not feeling listened to or feels helpless. The therapist notes chronic enduring condition with high risk of destabilization.<br><br>(continued on next page) |

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| F 0742<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Per Provider Note dated 6/15/2025, reveals Resident # 1 removed the sutures, opening the deep wound on his/her arm. When Resident #1 was asked why she/he removed the sutures/they indicated a desire for the wound to become infected before she/he dies.<br><br>Per Trauma Informed Care policy effective 5/1/2024, The Center will identify triggers which may re-traumatize patients with a history of trauma. Trigger-specific interventions will identify ways to decrease the patient's exposure to triggers that re-traumatize the patient, as well as identify ways to mitigate or reduce the effect of the trigger on the patient and will be added to the patient's care plan.Trauma-specific care plan interventions will recognize the interrelation between trauma and symptoms of trauma, such as substance abuse, eating disorders, depression, and anxiety. In situations where a trauma survivor is reluctant to share their history, the Center will still try to identify triggers which may re-traumatize the patient and develop care plan interventions which minimize or eliminate the effect of the trigger on the patient.<br><br>The medical record contains multiple entries of a history of self-harming behaviors that are attributed to psychosocial adjustment difficulty. The admission assessments (the MDS and the Social Service and Documentation) contain information indicating that Resident #1 has an adjustment disorder and requires additional assistance from staff. Behavioral Health notes indicate there is a high risk of destabilization if the resident feels helpless or is not listened to. Additionally, there was a lapse in Behavioral Health services from 5/19/2025 to 6/13/2025. The medical record has evidence of multiple entries describing self-harming behavior that is related to adjustment disorder, a change in environment, and increased dependence on staff for Activities of Daily Living.<br><br>On 6/30/2025 at 1:54 PM, an interview with the Social Service Director and the DON revealed that Resident #1 was not asked about his/her trauma or triggers; Resident #1's case workers provided information, identifying triggers that result in self-harming behavior and suicidal ideation.<br><br>Per interview by phone on 7/2/2025 at 10:50 AM, the DON confirmed that the facility did not adequately acknowledge Resident # 1's distress, by identifying and mitigating triggers of trauma, ensuring that Mental Health Services were available, and by keeping Resident # 1 free from accidents, and did not follow their internal policy.<br><br>2.) Per record review, seven residents (Residents #2, #3, #4, #5, #6, #7, and #8), who have diagnoses of trauma and/or PTSD [Post-Traumatic Stress Disorder], did not have their care plans updated with triggers associated with their trauma.<br><br>An interview was conducted with the Social Worker on 7/21/25 at 11:57 AM. The Social Worker confirmed the care plans did not have triggers identified that were associated with the residents’ history of trauma.<br><br>On 7/21/25 at 3:34 PM it was confirmed with the Administrator and Social Services Director that the triggers had not been added to the residents’ care plans until 7/21/25. |