VERMONT

AGENCY OF HUMAN SERVICES
DEPARTMENT OF DISABILITIES, AGING AND INDEPENDENT LIVING

Division of Licensing and Protection
HC 2 South, 280 State Drive
Waterbury, VT 05671-2060
http://www.dail.vermont.gov
Survey and Certification Voice/TTY (802) 241-0480
Survey and Certification Fax (802) 241-0343
Survey and Certification Reporting Line: (888) 700-5330
To Report Adult Abuse: (800) 564-1612

December 22, 2023

Mr. Dennis Carlson, Administrator
St Johnsbury Health & Rehab
1248 Hospital Drive
Saint Johnsbury, VT 05819-9248

Dear Mr. Carlson:

Enclosed is a copy of your acceptable plans of correction for the complaint investigation conducted on **November 21, 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
Licensing Chief

Enclosure

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	475019	A. BUILDING _____ B. WING _____	C 11/21/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST JOHNSBURY HEALTH & REHAB	1248 HOSPITAL DRIVE SAINT JOHNSBURY, VT 05819

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F 000	INITIAL COMMENTS The Division of Licensing and Protection conducted an onsite, unannounced investigation of three complaints and one facility reported incident (ACTS #22250, #22255, #22373, and #22443) on 11/20/23, with additional offsite record review that ensued through 11/21/23, to determine compliance with 42 CFR Part 483 requirements for Long Term Care Facilities. The following regulatory deficiencies were identified:	F 000	This plan of correction was written to follow state and federal guidelines. It is not an admission of noncompliance. However, it is the facility's commitment to demonstrate and maintain compliance.	
F 585 SS=F	Grievances CFR(s): 483.10(j)(1)-(4) §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay. §483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph. §483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident. §483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the	F 585	F585 Specific Corrective Action 1.OPS204 Grievances/Concerns has been updated to address the documentation requirements for written grievances The 2 identified Grievances happened in the past and can't be corrected, the resident expired at the facility on 11/14/2023. 2. An audit of grievances in the last 30 days was completed to validate the documentation requirements for written grievances has been met.	12/20/23

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: ADMINISTRATOR | (X6) DATE: 12/15/23

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 585	Continued From page 1 provider must give a copy of the grievance policy to the resident. The grievance policy must include: (i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system; (ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations; (iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated; (iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source,	F 585	F585 continued... 3. The facility ensures that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident/representitives's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued. NHA, SS Director, and DON will be re-educated to this process. 4. NHA/Designee will complete audits of grievances to validate that a written resolution was provided to the resident and/or representative. These audits will be weekly x 4 weeks, bi-weekly x 4 weeks, and then monthly x 3 months. Results of these audits will be brought to the monthly QAPI Committee for further review and recommendations. Date of Compliance 12/20/2023 **Tag F 585 POC accepted on 12/22/23 by S. Stem/P. Cota**	

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F 585	Continued From page 2	F 585		

and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law;
(v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued;
(vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and
(vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision.
This REQUIREMENT is not met as evidenced by:
Based on staff interview, record review, and review of facility policy, the facility failed to establish a grievance policy that ensures written grievance decisions meet documentation requirements, potentially impacting all residents in the facility. Findings include:

Review of facility policy titled OPS204 Grievance/Concern, last revised 7/19/23, reveals that the policy does not address the documentation requirements for written grievance

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F 585	Continued From page 3 decisions. Although the policy does discuss the initiation of documenting the receipt of a grievance, it does not address that all written grievance decisions include the following: date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued. 2 of 2 grievance forms sampled do not include the required elements for a written grievance decision. The forms do not include documentation of the steps taken to investigate the grievance, a statement as to whether the grievance was confirmed or not confirmed, or a date that the written decision was issued. On 11/20/23 at approximately 2 PM, the Market Operations Advisor confirmed that the two sampled grievance forms were not complete.	F 585		
F 655 SS=G	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must-	F 655	F655 Specific Corrective Action 1. Resident #1 has a revised care plan, specific to the person-centered care related to Elopement that includes risk and intervention to prevent further elopement.	12/20/23

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F 655	Continued From page 4 (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to develop and revise a baseline care plan, specific to the person-centered care related to elopement for 1 applicable resident (Resident	F 655	F655 Continued... 2. An audit of resident's baseline care plans were completed to validate care plans are in place that include the minimum healthcare information necessary to properly care for a resident including identified risk for elopement and intervention in place to prevent the resident from leaving the facility. 3. The facility developed baseline care plans within 48 hours of a resident's admission and includes the minimum healthcare information necessary to properly care for a resident including, identified risk for elopement and intervention in place to prevent the resident from leaving the facility. Licensed staff/IDT will be re-educated to this process.	

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F 655	Continued From page 5 #1), who left the facility undetected, was found on the road by a local citizen and brought to the Emergency Department with multiple lacerations. Findings include: Record review reveals that Resident #1 was admitted to the facility on 8/29/23 with diagnoses that include Wernicke's encephalopathy (a neurological disorder that presents with confusion, muscle movement coordination disorder, and vision problems), dementia, orthostatic hypotension (low blood pressure after standing that can cause dizziness or lightheadedness), and history of falling. An 8/31/23 progress note reveals that an elopement assessment determined that Resident #1 is at high risk for elopement as evidenced by Resident #1's verbalizing the desire to leave the facility, reported family history of elopement, and recent general cognitive decline. A physician order was created on 8/31/23 for a WanderGuard Device (a bracelet that residents wear that sets off an alarm when a resident approaches a monitored door). A comprehensive Minimum Data Set (MDS; a comprehensive assessment used as a care-planning tool) dated 9/4/23 reveals that Resident #1 is independent with locomotion on and off the unit, does not require a mobility device, and exhibits behaviors of wandering daily. Resident #1 was determined to have a BIMS of 11 (brief interview for mental status; a cognitive assessment score indicating moderate cognitive impairment). Progress notes reveal Resident #1 has repeated	F 655	F655 Continued... 4. DON/Designee will complete random weekly audits of resident's CP to validate that they are in place within 48hrs of admission, this will include residents at risk for elopement. Results of these audits will be brought to the monthly QAPI Committee for further review and recommendations. Date of compliance 12/20/23 **Tag F 655 POC accepted on 12/22/23 by S. Stem/P. Cota**	

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F 655	Continued From page 6	F 655		

behavior of wandering, desire to remove his/her WanderGuard, and success with removing his/her WanderGuard putting him/her at increased risk for elopement. An 8/31 note states, "Resident often asks where the door is to go home, and stated to staff 'I'm all done here, I'm ready to go home to my dog.' [S/he] is pleasantly confused." A 9/3/23 note states, "Resident noted to be in hallway attempting to open glass doors to fire extinguisher, assisted and redirected back to room where LNA had given [her/him] coffee [s/he] had asked for, upon entering room, noted wander guard bracelet in 2 pieces laying on dresser, resident states 'Oh it fell off.'" A 9/4/23 note states, "[Resident #1 is] alert but noted with confusion but pleasant with staff. Resident ambulates about facility and in [his/her] room. Resident did not voice any complaints. Staff noted [s/he] attempted to pull off wander guard x1 [once] this shift. will continue to monitor." A 9/6/23 note, created at 3:32 PM states, "resident is alert and confused looking for a way home, easily redirected. denies pain or discomfort ... Wandering occurs daily or almost daily [Resident #1] is experiencing anxiety about surroundings. [Resident #1] is experiencing delusions."

Resident #1's baseline care plan includes the following care plan focus, "Resident is at risk for elopement related to: Cognitive Loss/Dementia," created on 8/31/23. Although the baseline care plan had a few interventions, the interventions did not address known behaviors such as Resident #1's multiple attempts to remove his/her WanderGuard, active exit seeking, or wandering behaviors as described in the progress notes above prior to 9/7/23.

Per review of a facility incident report dated

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F 655	Continued From page 7 9/6/23, Resident #1 eloped from the facility on 9/6/23. The report describes that a visitor overheard the staff discussing the missing resident and the visitor stated that "[s/he] saw the resident walking down the hill with a duffel bag. [S/He] went on to say that [s/he] saw that the resident's wrists were bloody so [s/he] picked [him/her] up and took [him/her] to the ED [Emergency Department] (NVRH)." Incident report notes reveal that an LNA observed Resident #1 after dinner with a duffle bag and s/he was redirected back to his/her room. The LNA stated that Resident #1 is known to remove his/her WanderGuard and the "resident was repeatedly asking 'when can I leave?' [The LNA] says that [s/he] had never seen [him/her] wander like [s/he] did tonight." The incident report does not reveal the time when Resident #1 was noticed missing at the facility or the time that the visitors reported to staff that they took a person to the ED. Per an Emergency Department visit Physician note dated 9/6/23, initiated at 6:47 PM, Resident #1 was confused when they arrived at the hospital. Resident #1 reported inaccurately that s/he was on his/her way back from Maine and was headed to South Royalton, VT. S/He was unsure how s/he arrived in St. Johnsbury and was planning on taking a bus home. Resident #1 reported that s/he slipped and fell on the pavement. The Physician's exam reveals that Resident #1 has 3 lacerations on his/her left hand and fingers, a right hand abrasion, and a right hand laceration requiring two sutures. This note reveals that the facility contacted the ED at 7:42 PM to report that Resident #1 had eloped from the facility.	F 655		

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F 655	Continued From page 8 Per interview on 11/20/23 at 5:04 PM, the Director of Nursing confirmed that Resident #1's baseline care plan for risk for elopement did not include interventions that addressed known risk factors for elopement such as wandering, desire to return home, and his/her repeated attempts to remove the WanderGuard, and should have. Per interview on 11/21/23 at 2:24 PM, the Administrator was unable to determine the exact times events took place on 9/6/23. S/He confirmed that Resident #1 was last seen in the facility after dinner, which is served at 4:30 PM, and that the facility investigation into the event revealed that staff did not hear the alarm go off on the evening of 9/6/23.	F 655		
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	F 656	F656 Specific Corrective Action 1. Resident #1 has orders in place to check secure bracelets for placement and function. 2. An audit of residents, at risk for elopement, has been completed to validate that the CP intervention in place for prevention of elopement are being followed. This includes observation that the secure bracelets are being checked for placement and function.	12/20/23

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F 656	Continued From page 9 treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §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 interviews and record reviews, the facility failed to implement a comprehensive care plan in relation to wandering and elopement for 1 of 3 sampled residents (Resident #1). Findings include: Record review reveals that Resident #1 was admitted to the facility on 8/29/23 with diagnoses that include Wernicke's encephalopathy (a neurological disorder that presents with confusion, muscle movement coordination disorder, and vision problems), dementia,	F 656	F656 continued... 3. The facility has interventions in place to prevent elopement for those residents at risk based on assessment and identified behaviors. This includes orders for checking a secure care bracelet for both function and placement. Licensed staff will be re-educated to this process. 4. The DON/Designee will complete weekly observation/audits x3, monthly x3 to validate that the resident at risk for elopement have their care plan intervention followed. This includes observation that the secure care bracelets are checked for placement and function. Results of these audits will be reviewed at the Monthly QAPI Committee meeting. Date of Compliance 12/20/23 **Tag F 656 POC accepted on 12/22/23 by S. Stem/P. Cota**	

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orthostatic hypotension (low blood pressure after standing that can cause dizziness or lightheadedness), and history of falling.

Progress notes reveal an elopement assessment on 8/31/2023 which determined that Resident #1 is at high risk for elopement and a Wanderguard (a monitoring device that utilizes an alarm system) would be implemented for safety.

Progress notes reveal Resident #1 has repeated behavior of wandering, success with removing his/her WanderGuard, exit-seeking behavior, and a history of an actual elopement with injury resulting. A 9/3/23 note states, "Resident noted to be in hallway attempting to open glass doors to a fire extinguisher, assisted and redirected back to the room where LNA had given [him/her] coffee [s/he] had asked for, upon entering room, noted wander guard bracelet in 2 pieces laying on the dresser, resident states 'Oh it fell off'". A 9/6/23 change of condition evaluation states "Resident eloped from facility and fell as [s/he] was making [his/her] way down Hospital Hill." A 11/1/23 change of condition evaluation reveals that Resident attempted to leave the facility and was found "between front door and outside door." A 11/17/23 note states, "Wandering occurs up to 5 days a week and poses significant risk and is intruding on others."

Resident #1's care plan reveals the following focus, "Resident is at risk for elopement related to Cognitive Loss/Dementia". Interventions include "Check Wanderguard - expiration Jan. 2024," created on 9/7/23, and "Utilize and monitor security bracelet per protocol," created on 8/31/2023. An 11/7/23 interdisciplinary team meeting note reveals that "elopement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	475019	A. BUILDING _____ B. WING _____	C 11/21/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST JOHNSBURY HEALTH & REHAB	1248 HOSPITAL DRIVE SAINT JOHNSBURY, VT 05819

(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 11	F 656		

interventions will remain in place per care plan as a resident is still identified as a risk for elopement."

A review of the Facility Policy titled Patient Security Bracelet NSG121 states, "Resident/Patient (hereinafter "patient") security bracelets (e.g., Wanderguard) will be inspected per manufacturer's recommendations but at a minimum of every shift for placement and daily for function. The expiration date, placement checks, and function inspections of the bracelet will be documented in the medical record."

A review of the physician's orders reveals that orders for a Wanderguard, hourly monitoring, and check for daily function were discontinued on 10/4/2023. There was no documentation in Resident #1's medical record that s/he had an order for a Wanderguard or documentation that placement was checked three times daily and function was checked daily per facility policy and Resident #1's care plan from 10/5/23 through 11/20/23.

Per interview on 11/20/23 at approximately 4:20 PM with the Director of Nursing, she/he stated that Resident #1 still had a Wanderguard and was unsure why the orders for the Wanderguard and monitoring placement and function were discontinued. S/He confirmed there was no evidence of a physician's order or documentation that the Wanderguard was checked for placement and function after 10/4/2023 in Resident #1's medical record and should be.