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

May 24, 2019

Ms. Chrystal Locke, Administrator
St Johnsbury Health & Rehab
1248 Hospital Drive
Saint Johnsbury, VT 05819-9248

Dear Ms. Locke:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **April 24, 2019**. 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

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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 _____	04/24/2019

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
E 000	Initial Comments A re-certification survey of the Emergency Preparedness Program was completed by the Division of Licensing and Protection on 4/24/19. No regulatory deficiencies were identified.	E 000	St Johnsbury Health & Rehab provides this plan of correction without admitting or denying the validity or existence of the alleged deficiencies. The Plan of Correction is prepared and executed solely because it is required by federal and state law.	
F 000	INITIAL COMMENTS An unannounced onsite re-certification survey was completed by the Division of Licensing and Protection from 4/22-24/19. The following regulatory deficiencies were identified:	F 000	F554	
F 554 SS=D	Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7) §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure that 1 applicable resident in the sample of 23 had been evaluated by the Interdisciplinary Team (IDT) to determine if self-administration of medication was clinically appropriate, (Resident #232). Findings include: Per initial tour of the facility on 4/22/19, Resident #232 was found with two (2) partially used bottles of medication stored on the window sill. The resident explains that s/he takes Areds 2, two (2) capsules in the morning (AM) and one (1) in the evening (PM) and Macuelath one tablet (1) daily. The resident confirms that the medication is used to manage degeneration of his/her eyes.	F 554	Resident Number # 232 medication self-administration assessment and care plan are complete, the medication was placed in a locked container in the resident's room, and education was provided to the resident regarding the process. A review was completed of other residents who prefer self-administration of medication. Education for staff will be provided on resident medication self –administration. CNE or designee will audit residents preforming medication self-admiration to ensure appropriate practice. This will be reviewed weekly x 4 and monthly x 3. Findings will be reviewed at QAPI & recommendations will be made as needed. Completion Date 5/22/19	

accepted 5/23/19 Jane Hammond

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: CED | (X6) DATE: 5/17/19

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 554	Continued From page 1 Per review of the resident's medical record, physician progress notes dated 4/24/19 identifies, ["May administer own meds/vitamins for eyes"]. Per review of the resident's medical record, there is no evidence identifying that the resident had been evaluated for safe self-administration of medications. Confirmation was made by the Unit Manager on 4/23/19 at 2:30 PM that the resident has not been evaluated by the IDT for safe self-administration of medications. Per review of the facility policy titled Self-Administration of Medications, residents will be assessed for capability. If it is determined that the resident is able to self-administer: Self-administration must be care planned, residents must be provided with a secure locked area to maintain medications, the resident must be instructed in self-administration, and periodic evaluation must be performed. Confirmation was made by the Director of Nursing Services on 4/23/19 at approximately 11 AM, that the policy for self-administration of medication for resident #232 was not followed.	F 554		
F 584 SS=B	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	F 584		

accepted 5/23/19 Jane Hammond

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F 584	Continued From page 2 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 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 observation and staff interview, the facility failed to ensure each resident has a safe, clean, comfortable and homelike environment. Findings include: The following observations were made on 4/22/19 between 10:16 AM and 12:00 PM:	F 584	F584 The A1 hall wall mounted fan, A2 room fan, A6 room fan, & the dryer lint traps were all cleaned. An audit was completed of all fans and dryer lint traps in the facility and they have been cleaned. Education was provided for staff regarding the fan and lint trap cleaning schedule and process. Housekeeping/Laundry Manager or designee will audit fan and lint trap cleaning schedule and process to ensure cleanliness. This will be reviewed weekly x4 & monthly x3. Findings will be reviewed at QAPI & recommendations will be made as needed. Completion Date 5/22/19 accepted 5/23/19 Jane Hosmer RN	

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F 584	Continued From page 3 1. A wall mounted fan in operation on the A1 hallway wall was soiled with dust. 2. An operating fan in room A2 was soiled with dust. 3. An operating floor fan in room A6 was soiled with dust. These observations were confirmed by the Unit Manager on 4/22/19 at 3:05 PM 4. Per observation of laundry room on 4/23/19 at 9:11 AM, lint traps in dryers contained a large volume of lint. Per interview with the laundry Manager, the expectation is that lint traps are to be cleaned hourly. Per review of the hourly check sheets, the dryer lint traps had not been checked today, 4/23/2019. An entire day in February, 2019 had not been documented as checked. The Manager was present and confirmed that the checklist had not been completed, and that lint was present in the dryers at 9:11 AM.	F 584		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §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	F 656		

accepted 5/23/19 Jane Thomerson

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F 656	Continued From page 4 required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and 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. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure that the resident-centered care plan was developed for 3 of 23 residents sampled, (Residents # 75, #232, and #283). The findings include the following: 1. Per interview with Resident #75 on 4/22/19 at approximately 2:30 PM, s/he identified that s/he has a sore somewhere on his/her buttocks. Per interview with the Registered Nurse (RN) and review of the Treatment Administration Record	F 656	F656 Residents #75, #232, & #283 care plans were developed and revised to reflect resident #75 pressure ulcer, #232 self-administration of medication, and #283 ADL's. An audit was conducted on resident care plans to ensure they were developed and reflect identified areas of need. Education for staff was provided regarding care plan development and revision for pressure ulcers, self-administration of medication, and ADL's. CNE or designee will audit residents requiring care plan development and revision to ensure they reflect identified areas of need. This will be review weekly x4 and monthly x3. Findings will be reviewed at QAPI & recommendations will be made as needed. Completion Date 5/22/19 accepted 5/23/19 Jane Hamerman	

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F 656	Continued From page 5	F 656		

(TAR) for the month of April 2019, identified a physician order dated 4/16/19 for a Hydrocolloid dressing to left buttock, change every 3 days and as needed (PRN).

Per review of progress notes dated 4/15/19, the RN identifies a red area with dry skin on left buttocks, covered with Hydrocolloid dressing. Progress notes signed by the RN dated 4/17/19, identify open area to buttock, clean dressing in place. Confirmation was made by the Unit Manager on 4/22/19 that the resident-centered care plan does not identify a facility acquired pressure ulcer or the management of the pressure ulcer.

2. Per the initial tour of the facility on 4/22/19, Resident #232 was found with two (2) partially used medications stored on the window sill. The resident confirms that the medication is used to manage degeneration of his/her eyes. Per review of the resident's medical record, physician progress notes dated 4/24/19 identify "May administer own meds/vitamins for eyes".

Per review of the resident-centered care plan, there is no evidence identifying that the resident may self-administer medications. Confirmation was made by the Unit Manager on 4/23/19 at 2:30 PM that the resident-centered care plan has not been developed to direct staff that the resident may safely self-administer medications for the management of degenerative eye disease.

Per review of the facility policy entitled Self-Administration of Medications, residents must be care planned for self -administration of medication. The Director of Nursing Services confirmed on 4/23/19 at approximately 11 AM that

accepted 5/23/19 Jane Hosmer RN

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F 656	Continued From page 6 the policy for self-administration of medication for Resident #232 was not followed. 3. Per review of a physician's progress note from 4/12/19, Resident #283 has a history of peripheral vascular disease (blood circulating disorder) with bilateral claudication (pain or cramping in legs/arms) and (2) total hip replacements. Per interview on 4/23/19 at 4:00 PM with a Physical Therapist, s/he stated that the resident had bilateral hip and knee contractures and that the resident was receiving therapy to help with his/her positioning. Per review of the Activities of Daily Living (ADL's) care plan, the resident required a Hoyer mechanical lift for transfers. The care plan dated 4/12/19, for limited mobility read, "Resident/Patient requires assistance/is dependent for mobility related to: limited mobility; Interventions: Head of bed elevated as a mobility enabler". There was no evidence in the medical record that the care plan was developed to define the resident's mobility needs; the appropriate goals and interventions to follow; and a plan to reassess the resident's needs. Per interview on 4/24/19 at 10:58 AM with the Unit Manager, s/he confirmed that a care plan for limited mobility was not developed for Resident #283.	F 656		
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 staff interview and record review, the	F 658	accepted 5/23/19 Jane Hammond	

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F 658	Continued From page 7	F 658		

facility failed to ensure that professional standards were met for 1 of 5 applicable residents (Resident #49), regarding remaining free from unnecessary medications, for 1 of 3 applicable residents (Resident #75), for the managment of facility acquired pressure ulcers, and for 1 of 23 applicable residents (Resident #49), for following physician's orders. The findings include:

1. Per review of the Medication Administration Record (MAR), Resident # 49 was administered a medication that was outside of the prescribing physician's parameters for administration. Resident # 49 has a physician order for Diltiazem (a medication used to treat hypertension) 120 milligrams (mg), 1 capsule by mouth in the morning. The order stated to hold the medication for systolic blood pressure (bp) less that 100; dyastolic bp less than 60, and heart rate less than 60. There were 6 occasions between 1/3/19 - 4/23/19 where the medication was administered with a dyastolic bp less than 60. This was confirmed by the Center Nurse Executive on 4/24/19 at 10:20 AM.
2. Per review of the medical record, Resident #75 was admitted on 4/2/19. During interview on 4/22/19 at approximately 2:30 PM, Resident #75 identifies that s/he has a sore somewhere on his/her buttocks. Per interview with the Registered Nurse (RN) and review of the Treatment Administration Record (TAR) for the month of April 2019, a physician order exists for a Hydrocolloid dressing to left buttock, change every 3 days and as needed. The treatment began on 4/16/19.

Per review of progress notes dated 4/15/19, the RN identifies a red area with dry skin noted to left

F658

Resident # 49 had no negative effects from the alleged deficient practice. Resident #75 care plan was developed and an assessment completed to reflect the pressure ulcer. An audit was conducted of residents with pressure ulcers & ordered medication parameters to ensure appropriate measures are in place.

Education for staff was provided regarding administering medication with physician parameters & pressure ulcer car planning & assessment.

CNE or designee will audit residents with physician's parameters for administration of medication and residents with pressure ulcers. This will be reviewed weekly x4 and monthly x3.

Findings will be reviewed at QAPI & recommendations will be made as needed.

Completion Date 5/22/19

accepted 5/23/19
Jane Hosmer RN

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F 658	Continued From page 8	F 658		

buttocks, covered with Hydrocolloid dressing. Progress notes signed by the RN and dated 4/17/19, identify open area to buttock, clean dressing in place. Progress notes dated 4/19/19 for a care plan meeting show that the family questions the bed sore on his/her buttocks, and nursing explains why they think that the bed sore might have come about. (The documentation does not include the facility staff explanation.) The family voices they are concerned with the sore on his/her buttocks and would like an update from nursing in one week. Notes dated 4/20/19, signed by the RN, indicate an open area to buttock, clean dressing in place.

Per review of the medical record, a pressure ulcer assessment was not completed until 4/23/19, some eight (8) days after initially identified. The Skin-Pressure Ulcer assessment completed on 4/23/19, identifies a facility acquired, Stage 2 pressure ulcer on the left inner buttocks, measuring 0.5 centimeters (cm.) in length x 0.7 cm. in width, and a depth less than 0.1 cm. At the time of the assessment on 4/23/19 at approximately 4:30 PM, in the presence of the Unit Manager (UM), Director of Nurses (DNS) and the Clinical Quality Specialist, a second facility acquired pressure ulcer was identified on Resident #75's inner right buttocks. The area is identified as a facility acquired Stage 2 pressure ulcer, measuring 0.1 cm. in length x 0.2 cm. in width and a depth less than 0.1 cm. Dressings were applied to both wounds.

Per review of the Skin Integrity Management policy dated 11/28/16, according to Practice Standards, staff are instructed to perform wound observations and measurements and complete a Skin Integrity Report upon initial identification of

accepted 5/23/19 Jane Hosmer rn

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F 658	Continued From page 9	F 658		

altered skin integrity, weekly and with anticipated decline of the wound. The UM and the DNS both confirm that the wound to the left buttocks was never measured until 8 days after the wound had been identified. Confirmation was also made that the facility policy was not followed.

3. Per review of the Medication Administration Record (MAR) for Resident #49, a physician's order dated 1/4/19, read, "Finger stick blood glucose"; "Notify MD if blood sugar greater than 400"; "if blood glucose is below 70", "initiate hypoglycemia protocol"; "before meals for diabetes mellitus". Per observation during medication administration on 4/24/19 at 8:28 AM, a Licensed Practical Nurse (LPN) started to administer Resident #49's medications for the morning. Resident #49 stated that s/he had eaten his/her breakfast and was waiting for a second tray. Per interview on 4/24/19 with the LPN at that time, s/he confirmed that per the physician's order, the resident was to have his/her finger stick glucose checked prior to his/her meal; and that this was not done.

Lippincott Manual of Nursing Practice (9th Ed.). Wolters Kluwer Health/Lippincott Williams & Wilkins, pg. 17.

F 686 SS=G Treatment/Svcs to Prevent/Heal Pressure Ulcer
CFR(s): 483.25(b)(1)(i)(ii)

F 686

§483.25(b) Skin Integrity
§483.25(b)(1) Pressure ulcers.
Based on the comprehensive assessment of a resident, the facility must ensure that-
(i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure

accepted 5/23/19 Jane Kramer RN

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F 686	Continued From page 10	F 686		

ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing.
This REQUIREMENT is not met as evidenced by:
Based on observation, interview, and record review, the facility failed to ensure that 1 of 3 applicable residents did not develop pressure ulcers, and received treatment and services to promote healing and prevent new ulcers from developing (Resident #75). The findings include the following:

Per review of the medical record for Resident #75, was admitted on 4/2/19. During an interview on 4/22/19 at approximately 2:30 PM, Resident #75 identified that s/he has a sore somewhere on his/her buttocks. Per interview with the Registered Nurse (RN) and review of the Treatment Administration Record (TAR) for the month of April 2019, there is a physician's order for a Hydrocolloid dressing to left buttock, change every 3 days and as needed. The treatment began on 4/16/19.

Per review of progress notes dated 4/15/19, the RN identifies a red area with dry skin noted to left buttocks, covered with Hydrocolloid dressing. Progress notes signed by the RN and dated 4/17/19, identify open area to buttock clean dressing in place. Progress notes dated 4/19/19 care plan meeting show evidence that family questions the bed sore on his/her buttocks. Nursing explains why they think that the bed sore might have come about. (The documentation

F 686

The identified resident # 75 pressure ulcer assessment and care plan have been completed and developed. An audit was conducted of pressure ulcer assessments and care plans to ensure accuracy.

Education for staff was provided regarding pressure ulcer assessments and care planning to ensure completion of assessments & documentation.

CNE or designee will audit residents with pressure ulcers. This will be reviewed weekly x4 and monthly x3.

Findings will be reviewed at QAPI & recommendations will be made as needed.

Completion Date 5/22/19

accepted 5/23/19
Jane Hosmer RN

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 _____	04/24/2019

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 686	Continued From page 11	F 686		

does not include the facility staff explanation). The family voices they are concerned with the sore on his/her buttocks and would like an update from nursing in one week. Further notes dated 4/20/19, signed by the RN, identify an open area to buttock, clean and dressing in place.

Per review of the medical record, a pressure ulcer assessment was not completed until 4/23/19, some 8 days after the pressure ulcer was identified. The Skin-Pressure Ulcer assessment completed on 4/23/19 identifies a facility acquired, Stage 2 pressure ulcer on the left inner buttocks, measuring 0.5 centimeters (cm.) in length x 0.7 cm. in width and a depth less than 0.1 cm. At the time of the assessment on 4/23/10 at approximately 4:30 PM, in the presence of the Unit Manager (UM), Director of Nurses (DNS) and the Clinical Quality Specialist, a second facility acquired pressure ulcer was identified on Resident #75's inner right buttocks. The area is identified as a facility acquired Stage 2 pressure ulcer, measuring 0.1 cm. in length x 0.2 cm. in width and a depth less than 0.1 cm. Dressings were applied to both wounds.

Per review of the Skin Integrity Management policy dated 11/28/16, according to Practice Standards, staff are instructed to perform wound observations and measurements and complete a Skin Integrity Report upon initial identification of altered skin integrity, weekly and with anticipated decline of the wound.

The UM and the DNS both confirm that the wound to the left buttocks was not measured until 8 days after the wound had been identified. Confirmation was also made that the facility policy was not followed.

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Jane Hamer-RN

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F 695 SS=E	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure that respiratory equipment was properly maintained. Findings include: 1. Per observation on 4/22/19, oxygen concentrator machines in rooms A4, A9 and A27 W, were heavily soiled with dust. Additionally, the filters on the concentrators in rooms A9 and A27 were soiled/caked with dust. This was confirmed by the Unit Manager at 3:05 PM on 4/22/19. 2. Per observation on 4/22/19 at approximately 10 AM, Resident #6 was found to have nebulizer equipment, to include mouth piece and medication chamber, attached and left unprotected on the bedside table. 3. Per observation on 4/22/19 at approximately 11 AM, Resident #79 had a nebulizer machine with the tubing, mask and medication chamber attached, stored on the top of an oxygen concentrator, unprotected. Per interview on 4/22/19 at 3:30 PM with a Registered Nurse, s/he confirmed the above observations.	F 695	F695 Oxygen Concentrators in room's # A4, A9, & A27 were cleaned, as was, resident #282. Resident #6 & #79 nebulizer equipment was replaced and stored properly. Resident #80 tank was removed from the wheel chair and stored properly before continuing to go outside. An audit was conducted of residents who are having oxygen or nebulizer therapy to ensure concentrators are clean and oxygen tanks and nebulizer tubing are stored properly. Education for staff was provided regarding respiratory equipment storage, cleaning, and disinfection and storage of oxygen tanks. CNE or designee will audit respiratory equipment storage, cleaning, & disinfection of concentrators, and storage oxygen tanks. This will be reviewed weekly x4 and monthly x3. Findings will be reviewed at QAPI & recommendations will be made as needed. Completion Date 5/22/19 accepted 5/23/19 Jane Hammond	

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F 695	Continued From page 13	F 695		

Per review of the facility's policy titled Respiratory Equipment, dated 12/1/18, there will be routine cleaning of equipment in resident rooms. Oxygen concentrator filters will be rinsed and dried weekly and as needed (PRN) when visibly dusty. Small items will be placed in small plastic bags.

Confirmation was made by the Director of Nurses on 4/23/19, that the above identified items were stored improperly and not protected for contamination.

4. Per observation on 4/22/19 at 3:20 PM of Resident #80's room, s/he was receiving oxygen via nasal cannula (tubing used to deliver oxygen for breathing). The front of his/her oxygen concentrator machine was noted to be soiled; and the filters on the left and right side of the concentrator contained dirt/dust. During observation of Resident #282's room, a bottle of water, that provided humidification for oxygen delivery, had a date of 3/27. The oxygen concentrator machine was also soiled with dirt/dust. Per interview on 4/22/19 at 3:30 PM with a Registered Nurse, s/he confirmed the above observations.

5. Per observation on 4/23/19 at 1:13 PM, a Licensed Nursing Assistant (LNA) transported Resident #80 in a wheelchair outside to have a cigarette. The back of the wheelchair contained a cylinder of oxygen that was suspended in a canvas type bag. Per interview with the LNA at that time, s/he confirmed that the oxygen tank was off and that the oxygen tank had been in the canvas type bag each time s/he transported the resident to have a cigarette. Per interview on 4/23/19 at 1:43 PM with the Center Nurse Executive (CNE), s/he confirmed that the oxygen tank was stored improperly.

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F 695	Continued From page 14 Per review of the policy Oxygen: High Pressure Cylinders, revised 1/2/14, it read, "1.2 Cylinders must be properly secured to prevent accidental tipping of the tank and possible rupture causing high pressure release of gases. 1.2.1 Cylinders used for patient transport must be in a secured transport stand."	F 695		
F 757 SS=D	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility failed to ensure that 1 of 23 applicable residents (Resident #49) remained free from	F 757	F 757 Resident # 49 had no negative effects from the alleged deficient practice. An audit was conducted of residents with ordered medication parameters to ensure appropriate measures are in place and followed. Education for staff was provided regarding administering medication with physician parameters. CNE or designee will audit residents with physician's parameters for administration of medication. This will be reviewed weekly x4 and monthly x3. Findings will be reviewed at QAPI & recommendations will be made as needed. Completion Date 5/22/19 accepted 5/23/19 Jane Hosmer	

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F 757	Continued From page 15 unnecessary medications. Findings include: Per review of the Medication Administration Record (MAR), Resident # 49 was administered a medication that was outside of the prescribing physician's parameters for administration. Resident #49 has a physician order for Diltiazem (a medication used to treat hypertension) 120 milligrams (mg), 1 capsule by mouth in the morning. The order stated to hold the medication for systolic (top number) blood pressure (bp) less that 100; dyastolic (bottom number) bp less than 60, and heart rate less than 60. There were 6 occasions between 1/3/19 - 4/23/19 where the medication was administered with a dyastolic bp less than 60. The potential consequence of this is that the blood pressure might drop to an unsafe level. This was confirmed by the Center Nurse Executive on 4/24/19 at 10:20 AM.	F 757		
F 800 SS=E	Provided Diet Meets Needs of Each Resident CFR(s): 483.60 §483.60 Food and nutrition services. The facility must provide each resident with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs, taking into consideration the preferences of each resident. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to provide each resident with a nourishing, palatable, well-balanced diet that meets his/her daily nutritional and special dietary needs, taking into consideration the preferences of each resident. This has the potential to involve some aspect of most resident	F 800	accepted 5/23/19 Jane Hosmer RN	

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F 800	Continued From page 16 meals. The findings include the following: Per observation of the menu posted at the entrance of the dining room on 4/22/19, the lunch meal specials are listed as: Split Pea Soup with crackers, BBQ Pulled Pork on a Roll (Shredded pork baked in a zesty barbecue sauce and served on a fresh baked roll) with seasoned Potato Wedges; or (alternate meal) Chef Salad with French Dressing (Julienne meats and Swiss cheese, cucumbers, tomatoes and hard cooked egg on a bed of lettuce), a Dinner Roll, and Gelatin Cake. The following observations were identified during the 4/22/19 noon meal: The alternate meal being served to residents on both units and in the dining room was a chopped salad that included lettuce, tomatoes, cheese and unidentifiable meat. The food was chopped so fine, that the meat could not be identified and eggs did not appear to be present. No dinner rolls were provided; the Registered Dietician (RD) was offering saltines to those residents present in the dining room; No condiments were on the tables, and residents had to ask for salt/pepper and, in some instances, no salad dressing accompanied the salad; Resident #31 was not eating and commented to the surveyor that the food is very ["mushy and loose"], and wouldn't eat the puréed food. This was brought to the attention of the RD who offered the resident an ice cream and a mighty shake in place of the meal (a mighty shake is an option for adding calories and protein to a meal);	F 800	F800 Residents #31 & #19 had no negative effects as a result of the alleged deficient practice. An audit was conducted to ensure the posted menu is complete, correct, and being prepared and served as noted. Education to staff was provided regarding utilizing the menu system appropriately. Dietary Manager or designee will audit menus to ensure they are completed, correct, and being prepared and served as noted. This will be reviewed weekly x4 and monthly x3 Findings will be reviewed at QAPI & recommendations will be made as needed. Completion Date 5/22/19 accepted 5/23/19 Jane Hosmer RN	

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F 800	Continued From page 17	F 800		

Resident #19 [who has an order for an advanced dysphagia diet for a swallow problem or choking risk] reached over and took his/her tablemate's (Resident #11) vegetable, chunky soup of regular consistency, and ate it. This placed the resident at risk for aspiration;

Some residents were offered mashed potatoes with their salad in place of the rolls;

The BBQ pulled Pork was served on a hamburger roll, not a fresh baked roll as posted.

Confirmation was made on 4/22/19 at 4:30 PM by the District Manager of Health Care Services, the District Manager of the Vermont Division of Health Care Services and the facility Food Service Supervisor (FSS) that the alternate meal served was not as posted, nor did it contain the nutritional value as intended. The lettuce was shredded, the meat was not julienne, the cheese was grated. The cheese served was cheddar, not Swiss. The vegetables and eggs were chopped so fine they were unidentifiable. Mashed potatoes were offered in place of the potato wedges due to lack of supplies. Hamburger rolls were used in place of a fresh baked roll, also due to lack of supplies.

F 802 SS=E Sufficient Dietary Support Personnel
CFR(s): 483.60(a)(3)(b)

F 802

§483.60(a) Staffing
The facility must employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, taking into consideration resident assessments, individual plans of care and the number, acuity

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F 802	Continued From page 18 and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.60(a)(3) Support staff. The facility must provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service. §483.60(b) A member of the Food and Nutrition Services staff must participate on the interdisciplinary team as required in § 483.21(b)(2)(ii). This REQUIREMENT is not met as evidenced by: Based on observation and confirmed by staff interview, the facility failed to ensure that the facility had sufficient support personnel to safely and effectively carry out the functions of the food and nutrition services. The findings include the following: Per observation during the three days of survey (4/22/19-4/24/19), lunch is posted to begin at 11:30 AM through 1:00 PM, in the dining room and in resident rooms, based on their preference. Residents were observed migrating to the dining room at 11:30 AM. Twenty-eight (28) to thirty (30) residents are eating in the main dining room during the lunch service. A nurse aide (LNA) from each unit works with a dietary staff member preparing lunch trays for residents by reading tray cards, placing food and drinks on a tray, and then meals are delivered by the LNA. Another LNA is reviewing the meal with those residents eating in the dining room, enabling them to choose an entree of their liking. The LNA is also delivering and preparing drinks	F 802	F802 The dining process was changed: Dining carts are now served from the kitchen, which streamlined the flow of service in the dining room and allows staff to provide better oversight and direct supervision in the dining room. Education for staff was provided regarding following call coverage procedures and the new serving process. Dietary Manager or designee will audit meals times on the units and in the dining room to ensure timely meal service and appropriate staff coverage. Findings will be reviewed at QAPI & recommendations will be made as needed. Completion Date 5/22/19 accepted 5/23/19 Jane Hommerad	

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F 802	Continued From page 19	F 802		

(coffee/juice/milk/water) to all residents sitting at the table.

Observation during the survey identifies that Activity staff (who are LNA's), the dietician, and the District Manager of Health Care Services of Vermont are assisting with the meal service during the survey.

Food begins to be served to the dining room residents at approximately 12:30 PM, and the last plate of food is served at 1:00 PM. Residents waited 60-90 minutes in the dining room to receive their meal. During that period the surveyor over heard the following comments:

-I'm hungry;
-Why is food being taken out of the dining room;
-Do you think we will get lunch by supper time? I'm ready to eat now;
-Do you think we will eat before we go to bed;
-The radio is so loud I can't hear anything.

Per observation the room is chaotic, residents come and go, staff come and go, visitors enter to find their loved ones sittig at the table. Noise is made as plates are moved about and chairs adjusted to accommodate resident space. The food carts are moved in and out of the dining room as they are ready for delivery. Residents are attempting to socialize, staff speaking loudly so that those hard of hearing can comprehend what is being asked of them, and music is loud in the background. Resident #19 who has an order for an advanced dysphagia diet, reaches over and takes his/her tablemate's (Resident #11) vegetable chunky soup of regular consistency and eats it. This places him/her at risk for aspiration. Another resident removes his/her

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F 802	Continued From page 20 false teeth and places them on the table as he/she waits for lunch. Supervision by the LNA staff is inconsistent and there is no professional nurse presence. Per discussion with both the Director of Nurses (DNS) and the Food Service District Manager of the Vermont Division on 4/23/19, confirmation is made that the above identified observations are present. Administrative staff do have a plan in place to improve the dining service but this has not begun yet. The FSS director of the Vermont Division confirms that the dietary department has gone through numerous changes, has had some challenges with turnover of staff, and has been hiring new dietary workers. For the past two (2) days there have been call outs with no replacements available. Therefore, the food service supervisor and the District manager have been helping. The nursing department also has faced staffing challenges.	F 802		
F 804 SS=E	Nutritive Value/Appear, Palatable/Prefer Temp CFR(s): 483.60(d)(1)(2) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. This REQUIREMENT is not met as evidenced by: Based on observation and confirmed by staff interview, the facility failed to ensure that food and drink is palatable, attractive, and at a safe	F 804		

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F 804	Continued From page 21	F 804		

and appetizing temperature. The findings include the following:

1. State Surveyor requested a test tray to be served at the end of service for the lunch meal on 4/23/19. The test tray meal was delivered at 1:20 PM. Two State Surveyors checked the food temperatures with a calibrated thermometer. The findings were as follows:

-Cold fruit plate registered a temperature of 48 degrees Fahrenheit (F) ;
-Single serving of cottage cheese registered a temperature of 49.7 F;
-Pureed Potatoes registered a temperature of 120 degrees F;
-Pureed Chili Con Carne registered a temperature of 100 degrees F;
-Chocolate pudding registered a temperature of 53.5 degrees.

["According to food safety, cold foods must remain at 41 degrees Fahrenheit (F) or below and hot or reheated foods must remain at a minimum of 135 degrees F. Bacteria grow most rapidly in the range of temperatures between 40 degrees F to 140 degrees F. This range of temperatures is often called the "Danger Zone".']

The above test tray identified all five (5) of the foods served were at the "Danger Zone" temperatures. The above test results were reported to the Vermont Regional Manager by the State Surveyor.

2. Chocolate pudding tested at 12:58 PM on 4/23/19 was at 68 degrees F. The pudding was observed on a kitchen cart unrefrigerated since 11:30 AM.

F804

All foods will be held at appropriate temperatures for cold foods remaining at 41°F or below and hot foods remaining at a minimum of 135° F.

Education will be provided for the staff regarding maintaining temperatures and utilizing temperature logs.

Dietary Manager or designee will audit food temperatures to ensure parameters are met. This will be reviewed weekly x4 and monthly x3.

Findings will be reviewed at QAPI & recommendations will be made as needed.

Completion Date 5/22/19

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F 804	Continued From page 22 3. Per review of the daily temperature logs documented by the dietary staff dated 1/21/19 through 4/27/19, identify inconsistency in logged temperatures of both food and liquid. Policy requires documentation of temperatures of all foods and liquids prior to serving of all meals. Confirmation was made by the Vermont Regional Manager by the State Surveyor on 4/24/19 that the temperatures have not been checked/logged as required.	F 804		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and	F 880	F880 Resident #3 had no negative effects as a result of the alleged deficient practice and the nurse performing the dressing change was educated on aseptic wound dressing. An audit of residents that require dressing changes was completed. Education for staff was provided regarding aseptic wound dressing practices. CNE or designee will audit residents with wound dressing changes to ensure appropriate techniques are utilized. This will be reviewed weekly x4 and monthly x3. Findings will be reviewed at QAPI & recommendations will be made as needed. Completion Date 5/22/19 accepted 5/23/19 Jane Hosmer RN	

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 _____	04/24/2019

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 880	Continued From page 23	F 880		

procedures for the program, which must include, but are not limited to:
(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;
(ii) When and to whom possible incidents of communicable disease or infections should be reported;
(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;
(iv)When and how isolation should be used for a resident; including but not limited to:
(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.
(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and
(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.

§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.

§483.80(e) Linens.
Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.

§483.80(f) Annual review.
The facility will conduct an annual review of its

accepted 5/23/19
Jane Hosmer RN

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 _____	04/24/2019

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F 880	Continued From page 24 IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation and staff confirmation, the facility failed to maintain proper infection control practices for 1 of 23 applicable residents (Resident #3) during a dressing change. Findings include: Per observation on 04/23/19 at 10:59 AM, the Licensed Practical Nurse (LPN) entered Resident #3's room to perform a bilateral clean dressing change to the resident's feet. The LPN cleaned the overbed table and placed a clean barrier on the table and placed the supplies on the barrier. S/he had the resident raise the footrest on the recliner, s/he did not use any type of protective barrier on the footrest of the chair or on the floor underneath. S/he then donned gloves and removed the soiled dressing from the resident's right and then left foot and disposed of it in the nearby trash receptacle. The LPN then cleansed the wounds with a spray bottle of wound cleanser. The wound cleanser dripped from the resident's feet directly onto the bare floor. The LPN then redressed both wounds as per the physician's order, using proper hand hygiene and changing gloves appropriately. The LPN removed his/her gloves, gathered his/her supplies, removed the trash bag and left the room. When questioned afterwards about the contaminated liquid from the wound and the wound cleanser left on the floor, s/he confirmed a breach of infection control practices, and that a protective barrier should have been used to prevent the drainage from falling onto the bare floor.	F 880		
F 908 SS=E	Essential Equipment, Safe Operating Condition CFR(s): 483.90(d)(2)	F 908		

accepted 5/23/19 Jane Hosmer RN

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F 908	Continued From page 25 §483.90(d)(2) Maintain all mechanical, electrical, and patient care equipment in safe operating condition. This REQUIREMENT is not met as evidenced by: Based on observation and confirmed by staff interview, the facility failed to ensure that 7 of 8 resident bathrooms inspected (A17 (not occupied), A2, A10, A25, B12, B14, B27, and B218) were maintained in a safe condition. The findings include the following: Per facility tour in the presence of the Maintenance Director on 4/23/19 at 7:23 AM, resident bathrooms were identified with exposed pipes protruding from the wall. No protective covering was provided in place of the faucet handles that have been removed, leaving the butt end of the pipes exposed. These exposed pipes could lead to an injury if someone fell against them. Seven (7) of the eight (8) bathrooms listed, are occupied by residents who are either capable of using the bathroom with assistance or who toilet independently. The Director of Nurses confirms this information at approximately 10:00 AM on 4/23/19. Confirmation was made by the Maintenance Director at the time of the tour that the above numbered bathrooms have exposed pipes with ends unprotected. The Director also shares that many of the bathrooms have these exposed pipes, some have been removed and sheet rock applied, but many still have unprotected ends on the pipes that could lead to an injury.	F 908	F908 Bathrooms A2, A10, A17, A25, B12, & B14 have had pipes removed. B27 pipes will be removed the week of 5/19/19. An audit was completed to identify all other resident bathrooms that have pipes to ensure pipe removal. Education was provided to staff regarding the need for safe operating conditions. Maintenance Director or designee will audit the pipe removal process to ensure all bathrooms are complete and identify any other unsafe operating conditions through environmental rounds. This will be completed weekly x4 and monthly x3. Findings will be reviewed at QAPI & recommendations will be made as needed. Completion Date 5/22/19 accepted 5/23/19 Jane Hosmer RN	

Genesis HealthCare℠

POC No Request for IDR

Date: 5/17/19

To: Pamela Cota

Re: St Johnsbury Health & Rehab
Plan of Correction,
Credible Allegation of Compliance and
Request for Re-survey

Dear Pamela:

On April 24, 2019, surveyors from DAIL completed an inspection at St Johnsbury Health & Rehab. As a result of the inspection, the surveyors alleged that the Facility was not in substantial compliance with certain Medicare and Medicaid certification requirements. Enclosed you will find the Statement of Deficiencies (HCFA-2567) with the Facility's Plan of Correction for the alleged deficiencies. Preparation of the Plan of Correction does not constitute an admission by the Facility of the validity of the cited deficiencies or of the facts alleged to support the citation of the deficiencies.

Please also consider this letter and the Plan of Correction to be the Facility's credible allegation of compliance. The facility will achieve substantial compliance with the applicable certification requirements on or before May 24, 2019. Please notify me immediately if you do not find the Plan of Correction acceptable.

This letter is also our request for a re-survey, if one is necessary, to verify that the Facility achieved substantial compliance with the applicable requirements as of the dates set forth in the Plan of Correction and credible allegation of compliance.

Thank you for your assistance with this matter. Please call me if you have any questions.

Yours truly,

Thrystal Locke

Center Executive Director