



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

June 28, 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 **June 4, 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,

A handwritten signature in black ink that reads "Pamela M. Cota RN".

Pamela M. Cota, RN
Licensing Chief

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

PRINTED: 06/17/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 475019	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 06/04/2019
NAME OF PROVIDER OR SUPPLIER ST JOHNSBURY HEALTH & REHAB			STREET ADDRESS, CITY, STATE, ZIP CODE 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 000}	INITIAL COMMENTS The Division of Licensing and Protection conducted an unannounced onsite follow-up survey on 6/04/19 and the following regulatory violations remain uncorrected.	{F 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 802}	Sufficient Dietary Support Personnel SS=E CFR(s): 483.60(a)(3)(b) §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 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 personnel with appropriate competencies and skill sets to safely and effectively carry out the functions of the food and nutrition services. The findings include the following: Per observation on 6/4/19, lunch is posted to	{F 802}	F802 The dining process in the Kitchen was changed and new meal times in the Dining Room were posted. New Kitchen equipment was purchased and rearranged to streamline the flow of service in the Kitchen to enhance time efficiency. Education for staff was provided regarding updated Dining Room meal times, tray line service, and use of new equipment. Dietary Manager or designee will audit meal times to ensure the timeliness of meal service and staff work flow. This will be reviewed weekly x4 and monthly x3. Findings will be reviewed at QAPI & recommendations will be made as needed.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Completion Date 7/2/19

FBO2 POC accepted 6/27/19 covered by POC

(X6) DATE

CED

6/26/19

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.

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

PRINTED: 06/17/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 475019	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 06/04/2019
NAME OF PROVIDER OR SUPPLIER ST JOHNSBURY HEALTH & REHAB			STREET ADDRESS, CITY, STATE, ZIP CODE 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 802}	Continued From page 1 begin at 11:30 AM, in the dining room and in resident rooms, based on their preference. Residents were observed migrating into the dining room around 11:30 AM. The Plan of Correction with a completion date of 5/22/19, indicated that the dining process was changed and that dining carts are now being served from the kitchen which they indicate has streamlined the flow of services in the dining room. However, on 6/4/19 during observation of the lunch time meal the residents in the dining room still did not receive their meals until close to 12:30 PM and beyond when the last resident was served. The meals for units A & B are now plated in the kitchen and taken to each unit by cart. The surveyor observed this process in the kitchen, and it was quite chaotic, and it did not run smoothly. At 11:34 AM temps were being taken and then at 11:41AM the 1st plate was served and placed onto the metal cart to go to the B unit. At 12:12 PM the last plate for the A unit was served and placed on the metal cart to be taken to the unit. The food was then transported into the dining room so that food service could begin in there. The meal on 6/4/19 offered the choices of Shepard's Pie or an Italian Chef Salad, Mashed Potatoes along with a dinner roll, and Bean Soup and pineapple crisp for dessert. During observation in the kitchen there was one dietary aide plating the hot food onto plates and then moving to the cart where the salad ingredients were and using a separate pair of tongs for each item, picking up lettuce, tomato, onion, cheese, ham, and salami. After completing each plate, it	{F 802}			

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

PRINTED: 06/17/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 475019	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 06/04/2019
NAME OF PROVIDER OR SUPPLIER ST JOHNSBURY HEALTH & REHAB		STREET ADDRESS, CITY, STATE, ZIP CODE 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 802}	Continued From page 2 was placed on the top of the cart where another dietary aide covered the food and placed it onto a metal cart. Although the 1st metal cart had doors that could be closed to keep the food warm, they were left open during this process. The other carts that were used for transport did not have doors that could be closed and were just open carts. Before and during the serving process s/he had to ask several times for serving utensils to be provided as there were not enough to serve the food. At one point this surveyor spoke with the dietary aide and ask if this was the norm on a daily basis for serving food. S/he replied that most of the time the salad ingredients were already mixed together, and it would then take less time. The Senior District Food Service Manager reported that the cook for the dayshift had to leave for a family emergency and was unable to mix the ingredients for the Chef Salad together. The Dietary Manager who was not in the kitchen at this time, was located and upon prompting did eventually step in and plate all the salad ingredients for the Chef Salads. Per discussion with both the Food Service District Manager and the Administrator on 6/4/19, confirmation is made that the above identified observations are present. They report that the new system seemed to be running smoothly until today and felt this was related to being short-staffed due to the cook leaving. They report that the kitchen is at full staff, but feel that perhaps issues around time management, poor planning, organizational skills, and inexperienced staff contributed to the situation.	{F 802}		
{F 804}	Nutritive Value/Appear, Palatable/Prefer Temp SS=E CFR(s): 483.60(d)(1)(2)	{F 804}		

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

PRINTED: 06/17/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 475019	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 06/04/2019
NAME OF PROVIDER OR SUPPLIER ST JOHNSBURY HEALTH & REHAB			STREET ADDRESS, CITY, STATE, ZIP CODE 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 804}	Continued From page 3 §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 and appetizing temperature. The findings include the following: The State Surveyor requested a test tray to be served at the end of service for the lunch meal on 6/4/19. The test tray meal was delivered at approximately 12:25 PM after all the trays for both units were served, but before the dining room was served, as the dining room service comes directly from the steam table and would not provide accurate temperatures. The State Surveyor checked the food temperatures with a calibrated thermometer. The Food Service District Manager came into the room during the testing. The finding were as follows: -Bean Soup registered a temperature of 120 degrees Fahrenheit (F); -Shepard's Pie registered a temperature of 103 degrees F; -Mashed Potatoes registered a temperature of 103 degrees F; -Italian Chef Salad registered a temperature of 56	{F 804}	F804 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. New equipment was purchased to aide holding tray temps. Education will be provided for the staff regarding the use of the new equipment and utilizing test tray temperature sheets. Dietary Manager or designee will test tray 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 7/2/19 F804 POC accepted 6/27/19 Llovell RN/PMC		

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

PRINTED: 06/17/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 475019	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 06/04/2019
NAME OF PROVIDER OR SUPPLIER ST JOHNSBURY HEALTH & REHAB		STREET ADDRESS, CITY, STATE, ZIP CODE 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 804}	Continued From page 4 degrees F; -Pineapple crisp registered a temperature of 55 degrees F; ["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 confirmed by the Senior District Manager who was present and who along with the surveyor tasted the food and found the Shepard's Pie especially to be unpalatable.	{F 804}		