

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 25, 2021

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

Dear Mr. Farnsworth:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **April 28, 2021**. 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

PRINTED: 05/05/2021
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 C 04/28/2021
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	F 000	F000	
F 583 SS=D	<p>The Division of Licensing and Protection conducted unannounced onsite investigations of 3 complaints 4/27/21 - 4/28/21. The following regulatory deficiencies were cited as a result:</p> <p>Personal Privacy/Confidentiality of Records CFR(s): 483.10(h)(1)-(3)(i)(ii)</p> <p>§483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records.</p> <p>§483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident.</p> <p>§483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service.</p> <p>§483.10(h)(3) The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(i)(2) or other applicable federal or state laws. (ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman</p>	F 583	<p>The filing of this plan of correction does not constitute an admission of the allegations set forth in the statements of deficiencies. has prepared and executed a plan of correction as evidence of the facilities' continued compliance with applicable federal and state laws.</p> <p>The discharge process of medication removal was reviewed, house wide audit of medication cart was completed. All medication carts currently only house medication of those active residents. Discharging residents medication list will be reviewed by two nurses and signed off.</p> <p><i>Ross Farnsworth</i></p> <p>Education for staff was provided regarding updating the discharge check list to ensure two nurses are signing off medication list upon discharge.</p> <p>CNE or designee will audit to ensure two nurses are signing off medication list upon discharge. This will be reviewed weekly x4 and monthly x3.</p> <p>Findings will be reviewed at QAPI and recommendations will be made as needed.</p> <p>Completion date 5/11/2021</p>	

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

Ross Farnsworth

TITLE

Center Executive Director

(X6) DATE

5/14/2021

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: 05/05/2021
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 C 04/28/2021
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 583	<p>Continued From page 1</p> <p>to examine a resident's medical, social, and administrative records in accordance with State law.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based upon interview and record review, the facility failed to ensure the personal privacy and confidentiality of personal and medical information of 2 residents [Res. #1 and Res. #2] of 3 sampled residents.</p> <p>Findings include:</p> <p>Per review of the medical records for Res. #3 the resident was discharged home with his/her family on the evening of 4/13/21. Per review of Nursing Notes dated 4/15/2021 "This writer received phone call from [Res.#3's son] regarding a concern on medication given when discharged. He stated when they went through the bag he noticed there was another resident's medication that was in [Res. #3's] bag."</p> <p>Per review of photographic information provided by Res. #3's family, Res. #3 received medications clearly labeled for Res. #1 and Res. #2. Review of the photographic information of Res. #1's medications sent to Res. #3 include the medication label which reveals the name of Res. #1, the name of the resident's medication, the medication's National Drug Code, the name of the prescribing Physician, and the medical diagnosis for which the medication was ordered for Res. #1. Additionally, the label includes the notation "Caution: Federal law prohibits transfer of this drug to any person other than patient for whom prescribed."</p> <p>Review of the photographic information of Res. #2's medications sent to Res. #3 include the</p>	F 583			

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

PRINTED: 05/05/2021
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 C 04/28/2021
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 583	Continued From page 2 medication labels which reveals the name of Res. #1, the name of the resident's medication, the medication's National Drug Code, and the name of the prescribing Physician. Additionally, the labels include the notation "Caution: Federal law prohibits transfer of this drug to any person other than patient for whom prescribed." An interview was conducted with the facility's Director of Nursing [DON] on 4/27/21 at 3:17 PM. The DON confirmed that Res. #3's family had contacted the facility about receiving the personal medications for Res. #1 and Res. #2. The DON reported that Res. #3's family had returned to the facility to obtain Res. #3's medications the day after he was discharged. The DON was unable to explain or determine how or why Res. #1's and Res. #2's medications were included and given to Res. #3's family. The DON confirmed the medications and the information on the medication packet included personal and medical information, and that privacy and confidentiality of Res.#1 and Res. #2 was compromised when the medication was released to Res. #3 and his/her family.	F 583	F 583 POC accepted 5/25/21 – T. Dougherty RN/PMC		
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 upon interview and record review, the facility failed to ensure services provided by the facility met professional standards of quality	F 658			

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 C 04/28/2021
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 658	<p>Continued From page 3 regarding administration of medications per Physician's Orders for 1 resident [Res. #3] of 3 sampled residents.</p> <p>Findings include:</p> <p>Review of the medical records for Res. #3 reveal the resident was transferred to the facility on 4/12/21 and admitted to the facility at approximately 5:00 PM. Review of Res. #3's Discharge Summary from the Hospital records Res. #3's 'PRINCIPAL DIAGNOSIS: Diabetic foot ulcer of the left foot with severe pain'.</p> <p>Admission information to the facility lists Res. #3's diagnoses as including: Diabetes with a Left foot ulcer, pain in left foot, pain in right hip, Chronic Obstructive Pulmonary Disease [a chronic inflammatory lung disease that causes obstructed airflow from the lungs], Conjunctivitis [an inflammation or infection of the transparent membrane that lines your eyelid and covers the white part of your eyeball], and Gout [a common and complex form of arthritis that is characterized by sudden, severe attacks of pain, swelling, redness and tenderness in the joints].</p> <p>Included in Res. #3's transfer information were orders for medications to be continued at the facility.</p> <p>Review of Physician Orders for Medications for Res. #3 include:</p> <p>-Oxycontin [an opioid medication is used to help relieve moderate to severe pain] 20 milligrams [mg] - give one tablet by mouth two times a day for pain management - start date 4/12/21 -8:00 PM;</p> <p>-Lidocaine patch 5% apply to affected area topically one time a day for pain apply 3 patches and remove per schedule. Start date 4/13/21</p>	F 658	<p>F 658</p> <p>Medications that are unavailable on admission will be discussed with provider to determine further instructions. Residents in question are no longer in the facility. All new admissions will be audited weekly x4 and monthly x2.</p> <p>Education provided to staff regarding medication administration policy on new admissions.</p> <p>CNE or designee will audit new admissions medication record to ensure policy was followed. This will be completed weekly x4 and monthly x2.</p> <p>Findings will be reviewed at QAPI and recommendations will be made as needed.</p> <p>Completion date 5/11/2021</p>		

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 C 04/28/2021
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 658	<p>Continued From page 4</p> <p>-8:00 AM; -Lantus SoloStar Solution Pen-injector 100 unit/ml [milliliter] (Insulin Glargine)- Inject 20 unit subcutaneously at bedtime for Diabetes -Active: 4/12/2021 -8:00 PM; -Budesonide formoterol fumarate aerosol- 1 puff inhale orally one time a day for breathing -Start date 4/13/21 -8:00 AM; -Tiotropium bromide monohydrate aerosol solution- 2 puff orally one time a day for breathing - start date 4/13/21 8:00 AM; -Ketotifen fumarate solution - instill 1 drop in both eyes two times a day for allergic conjunctivitis- start date 4/12/21 -8:00 PM; -Febuxostat tablet 80 mg -give one tablet by mouth one time a day for gout- start 4/13/21 8:00 AM.</p> <p>Per review of the Nursing Admission Evaluation for Res. #3, dated 4/12/21 at 4:38 PM, under 'Verbal Pain Evaluation', the report lists the resident's pain is in the 'foot and lower back' and that the pain is 'chronic'. The evaluation notes that the pain is 'continuous' and under the question 'What relieves your pain?' is the answer 'Routine medication'.</p> <p>A review of Res. #3's Medication Administration Record [MAR] was conducted for the time Res. #3 was admitted to the facility on 4/12/21 at approximately 5:00 PM through the time Res. #3 was discharged from the facility on 4/13/21 at approximately 8:00 PM.</p> <p>The MAR reveals Res. #3 was due to receive the pain medication Oxycontin 2 times during his stay and did not receive it once. Res. #3 was due to receive 3 Lidocaine 5% patches for pain one time and did not receive them.</p>	F 658			

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

PRINTED: 05/05/2021
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 C 04/28/2021
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 658	<p>Continued From page 5</p> <p>Res. #3 was due to receive Lantus Insulin at bedtime to control his diabetes/blood sugar and did not receive it. According to the Centers for Disease Control and Prevention target blood sugar levels before meals is 80 to 130. (https://www.cdc.gov/diabetes/managing/manage-blood-sugar.html) On the morning of 4/13/21 Res. #3's blood sugar was 199.</p> <p>Res. #3 was due to receive Budesonide formoterol fumarate aerosol- for shortness of breath one time a day and did not receive it. Res. #3 was due to receive Tiotropium bromide monohydrate aerosol solution- for shortness of breath one time a day and did not receive it. Res. #3 was due to receive Ketotifen fumarate solution -1 drop in both eyes two times a day for allergic conjunctivitis- and did not receive it once. Res. #3 was due to receive -Febuxostat tablet 80 mg - one tablet by mouth one time a day for gout- and did not receive it.</p> <p>Further review of the Medication Administration Record [MAR] for Res. #3 reveals the MAR was either left blank for the times the medications were ordered to be administered or a code was noted on the MAR. The code directs the person to "see nurses notes". Review of the MAR reveals the code was used 7 times. Review of Nurses Notes reveal a single note reads "on order from pharmacy. resident denies pain or discomfort at present". Further review of Nurses Notes contains no documentation that the Pharmacy was notified that the medications were not available, or that Res. #3's Physician was notified that the resident had not received the medications as ordered.</p> <p>Per review of the facility's policy NSG305</p>	F 658			

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

PRINTED: 05/05/2021
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 C 04/28/2021
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 658	Continued From page 6 "Medication Administration: General", under the heading "PRACTICE STANDARDS", the policy includes "If medication[s] is not available, the nurse will: -Coordinate with pharmacy to procure the medication[s] as soon as possible and discuss possible substitution options with pharmacist, if applicable; -Notify the physician/advanced practice provider of the unavailability of the medication[s]; -Discuss substitution options for ordered medication[s] with physician/ advanced practice provider if applicable; -If unable to provide the medication[s] or substitution[s] within one hour of prescribed time, refer to Medication Errors policy An interview was conducted with the facility's Director of Nursing [DON] on 4/27/21 at 3:17 PM. The DON confirmed that Res. #3's MAR contained blanks and codes for multiple medications indicating that the medications were not given as ordered. The DON also reported that each time the code on the MAR was used, a separate Nurses Note detailing why the medication was not given should have been written but was not. Additionally, the DON confirmed that there was no documentation that the Pharmacy or Res. #3's physician was notified of the missed doses of medication, per the "PRACTICE STANDARDS" listed in the facility's Medication Administration policy.	F 658	F 658 POC accepted 5/25/21 – T. Dougherty RN/PMC		
F 755 SS=D	Pharmacy Srvc/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain	F 755			

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 C 04/28/2021
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 755	<p>Continued From page 7</p> <p>them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.</p> <p>§483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.</p> <p>§483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who-</p> <p>§483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility.</p> <p>§483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and</p> <p>§483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based upon interview and record review, the facility failed to provide routine drugs and biologicals to meet the needs of 1 resident [Res. #3] of 3 sampled residents. Findings include:</p> <p>Review of the medical records for Res. #3 reveal the resident was transferred to the facility on 4/12/21 and admitted to the facility at</p>	F 755	<p>F 755</p> <p>New admission's medications will be given as provider ordered. Residents in question are no longer in the facility. All new admissions will be audited weekly x4 and monthly x2.</p> <p>Education provided to staff regarding medication administration policy on new admissions.</p> <p>CNE or designee will audit new admissions medication record to ensure policy was followed. This will be completed weekly x4 and monthly x2.</p> <p>Findings will be reviewed at QAPI and recommendations will be made as needed.</p> <p>Completion date 5/11/2021</p>		

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

PRINTED: 05/05/2021
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 C 04/28/2021
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 755	<p>Continued From page 8</p> <p>approximately 5:00 PM. Review of Res. #3's Discharge Summary from the Hospital records Res. #3's 'PRINCIPAL DIAGNOSIS: Diabetic foot ulcer of the left foot with severe pain'.</p> <p>Admission information to the facility lists Res. #3's diagnoses as including: Diabetes with a Left foot ulcer, pain in left foot, pain in right hip, Chronic Obstructive Pulmonary Disease [a chronic inflammatory lung disease that causes obstructed airflow from the lungs], Conjunctivitis [an inflammation or infection of the transparent membrane that lines your eyelid and covers the white part of your eyeball], and Gout [a common and complex form of arthritis that is characterized by sudden, severe attacks of pain, swelling, redness and tenderness in the joints].</p> <p>Included in Res. #3's transfer information were orders for medications to be continued at the facility.</p> <p>Review of Physician Orders for Medications for Res. #3 include:</p> <ul style="list-style-type: none"> -Oxycontin [an opioid medication is used to help relieve moderate to severe pain] 20 milligrams [mg] - give one tablet by mouth two times a day for pain management - start date 4/12/21 -8:00 PM; -Lidocaine patch 5% apply to affected area topically one time a day for pain apply 3 patches and remove per schedule. Start date 4/13/21 -8:00 AM; -Lantus SoloStar Solution Pen-injector 100 unit/ml [milliliter] (Insulin Glargine)- Inject 20 unit subcutaneously at bedtime for Diabetes -Active: 4/12/2021 -8:00 PM; -Budesonide formoterol fumarate aerosol- 1 puff inhale orally one time a day for breathing -Start date 4/13/21 -8:00 AM; 	F 755			

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

PRINTED: 05/05/2021
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 C 04/28/2021
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 755	<p>Continued From page 9</p> <p>-Tiotropium bromide monohydrate aerosol solution- 2 puff orally one time a day for breathing - start date 4/13/21 8:00 AM;</p> <p>-Ketotifen fumarate solution - instill 1 drop in both eyes two times a day for allergic conjunctivitis- start date 4/12/21 -8:00 PM;</p> <p>-Febuxostat tablet 80 mg -give one tablet by mouth one time a day for gout- start 4/13/21 8:00 AM.</p> <p>Per review of the Nursing Admission Evaluation for Res. #3, dated 4/12/21 at 4:38 PM, under 'Verbal Pain Evaluation', the report lists the resident's pain is in the 'foot and lower back' and that the pain is 'chronic'. The evaluation notes that the pain is 'continuous' and under the question 'What relieves your pain?' is the answer 'Routine medication'.</p> <p>A review of Res. #3's Medication Administration Record [MAR] was conducted for the time Res. #3 was admitted to the facility on 4/12/21 at approximately 5:00 PM through the time Res. #3 was discharged from the facility on 4/13/21 at approximately 8:00 PM.</p> <p>The MAR reveals Res. #3 was due to receive the pain medication Oxycontin 2 times during his stay and did not receive it once. Res. #3 was due to receive 3 Lidocaine 5% patches for pain one time and did not receive them.</p> <p>Res. #3 was due to receive Lantus Insulin at bedtime to control his diabetes/blood sugar and did not receive it. According to the Centers for Disease Control and Prevention target blood sugar levels before meals is 80 to 130. (https://www.cdc.gov/diabetes/managing/manage-blood-sugar.html) On the morning of 4/13/21 Res. #3's blood sugar was 199.</p>	F 755			

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 C 04/28/2021
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 755	<p>Continued From page 10</p> <p>Res. #3 was due to receive Budesonide formoterol fumarate aerosol- for shortness of breath one time a day and did not receive it. Res. #3 was due to receive Tiotropium bromide monohydrate aerosol solution- for shortness of breath one time a day and did not receive it. Res. #3 was due to receive Ketotifen fumarate solution -1 drop in both eyes two times a day for allergic conjunctivitis- and did not receive it once. Res. #3 was due to receive -Febuxostat tablet 80 mg - one tablet by mouth one time a day for gout- and did not receive it.</p> <p>Further review of the Medication Administration Record [MAR] for Res. #3 reveals the MAR was either left blank for the times the medications were ordered to be administered or a code was noted on the MAR. The code directs the person to "see nurses notes". Review of the MAR reveals the code was used 7 times. Review of Nurses Notes reveal a single note reads "on order from pharmacy. resident denies pain or discomfort at present". Further review of Nurses Notes contains no documentation that the Pharmacy was notified that the medications were not available, or that Res. #3's Physician was notified that the resident had not received the medications as ordered.</p> <p>Per review of the facility's policy NSG305 "Medication Administration: General", under the heading "PRACTICE STANDARDS", the policy includes "If medication[s] is not available, the nurse will: -Coordinate with pharmacy to procure the medication[s] as soon as possible and discuss possible substitution options with pharmacist, if applicable;</p>	F 755			

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 C 04/28/2021
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 755	<p>Continued From page 11</p> <ul style="list-style-type: none"> -Notify the physician/advanced practice provider of the unavailability of the medication[s]; -Discuss substitution options for ordered medication[s] with physician/ advanced practice provider if applicable; -If unable to provide the medication[s] or substitution[s] within one hour of prescribed time, refer to Medication Errors policy. <p>An interview was conducted with the facility's Director of Nursing [DON] on 4/27/21 at 3:17 PM. The DON confirmed that Res. #3's MAR contained blanks and codes for multiple medications indicating that the medications were not given as ordered. The DON also reported that each time the code on the MAR was used, a separate Nurses Note detailing why the medication was not given should have been written but was not. Additionally, the DON confirmed that there was no documentation that the Pharmacy or Res. #3's physician was notified of the missed doses of medication, per the "PRACTICE STANDARDS" listed in the facility's Medication Administration policy.</p>	F 755	<p>F 755 POC accepted 5/25/21 – T. Dougherty RN/PMC</p> <p>Type text here</p>		