Division of Licensing and Protection HC 2 South, 280 State Drive Waterbury, VT 05671-2060 <u>http://www.dail.vermont.gov</u> 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 13, 2022

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

Dear Mr. Pratt:

Enclosed is a copy of your acceptable plans of correction for the investigation conducted on **May 10, 2022.** 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,

Jamela Mcota RN

Pamela M. Cota, RN Licensing Chief

PRINTED: 05/26/2022 FORM APPROVED

| | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | (X3) DATE SURVEY COMPLETED | |
|--|---|---|--|--|--|
| | 475040 | | | с | |
| | 475019 | | | 05/10/2022 | |
| | | | | | |
| BURY HEALTH & REH | AB | | | | |
| (EACH DEFICIENC | CY MUST BE PRECEDED BY FULL | ID PREFIX TAG | PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP | OULD BE COMPLET | |
| INITIAL COMMENTS The Division of Licensing and Protection conducted an unannounced onsite complaint investigation on 5/10/22. The following regulatory violations were cited as a result: Personal Privacy/Confidentiality of Records CFR(s): 483.10(h)(1)-(3)(i)(ii) §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records. | | F 00 | The filing of this Plan of Corre does not constitute an admiss of the allegations set forth in t | he 6/7/20 | |
| | | F 58 | Health & Rehabilitation Cente prepared and executed a plan correction as evidence of the | er has n of facilities' | |
| | | | All residents are at risk for thi alleged deficient practice. | is potential | |
| accommodations, m telephone communio and meetings of fam this does not require | edical treatment, written and cations, personal care, visits, ily and resident groups, but the facility to provide a | | HIPPA policies which include their computer screens when actively accessing the reside | e closing not nt's chart | |
| residents right to per right to privacy in his written, and electron the right to send and | rsonal privacy, including the s or her oral (that is, spoken), nic communications, including d promptly receive unopened | | conduct random weekly audit monthly X2 of the med carts computers to ensure no resid | ts X4 and and lents | |
| materials delivered t including those deliv | to the facility for the resident, vered through a means other | | | • | |
| and confidential pers (i) The resident has of personal and med provided at §483.70 federal or state laws (ii) The facility must | sonal and medical records. the right to refuse the release dical records except as (i)(2) or other applicable s. allow representatives of the | | | | |
| | SUMMARY S (EACH DEFICIENT REGULATORY OR The Division of Lice conducted an unann investigation on 5/10 violations were cited Personal Privacy/Co CFR(s): 483.10(h)(1) §483.10(h) Privacy a The resident has a r confidentiality of his records. §483.10(h)(I) Persor accommodations, m telephone communic and meetings of fam this does not require private room for eac §483.10(h)(2) The fa residents right to per right to privacy in his written, and electror the right to send and mail and other letter materials delivered t including those deliv than a postal service §483.10(h)(3) The re and confidential per- (i) The resident has of personal and meet provided at §483.70 federal or state laws (ii) The facility must | CORRECTION IDENTIFICATION NUMBER: INITIAL COMMERTS INITIAL COMMENTS The Division of Licensing and Protection conducted an unannounced onsite complaint investigation on 5/10/22. The following regulatory violations were cited as a result: Personal Privacy/Confidentiality of Records CFR(s): 483.10(h)(1)-(3)(i)(ii) §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical | CORRECTION IDENTIFICATION NUMBER: A. BUILDING 475019 B. WING | CORRECTION IDENTIFICATION NUMBER: A. BUILDING 475019 B. WING ROVIDER OR SUPPLIER STREET ADDRESS. CITY, STATE, ZIP CODE SBURY HEALTH & REHAB STREET ADDRESS. CITY, STATE, ZIP CODE SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID INITIAL COMMENTS ID The Division of Licensing and Protection conducted an unannounced onsite complaint investigation on 5/10/22. The following regulatory violations were cited as a result: Personal Privacy/Confidentiality of Records CFR(s): 483.10(h)(1)-(3)(i)(ii) F 000 The filing of this Plan of Corre does not constitute an admiss of the allegations set forth in t statement of deficiencies. St. continued compliant investigation on 5/10/22. The following regulatory violations were cited as a result: Personal Privacy/Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records. F 583 Continued compliance with ap federal and state laws. §483.10(h)(1) Personal privacy includes and meetings of family and resident. synthen, and electronic communications, 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 mounciations, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to mail and medical records. (I) The resident has a right to secure and confidential persona | |

Nursing Home Administrator 6/3/2022

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.

| | | MEDICAID SERVICES | (X2) MULTIPLE CO | NSTRUCTION | OMB NO, 093 (X3) DATE SURVE | |
|--------------------------|---|---|---------------------|--|--------------------------------|-----------------------|
| | CORRECTION | IDENTIFICATION NUMBER: | A. BUILDING | | COMPLETED | |
| | | | | | с | |
| | | 475019 | B. WING | 05/10/202 | 22 | |
| NAME OF P | ROVIDER OR SUPPLIER | | STRE | EET ADDRESS, CITY, STATE, ZIP CODE | | |
| ST JOHNS | T JOHNSBURY HEALTH & REHAB | | 1248 HOSPITAL DRIVE | | | |
| | | | | NT JOHNSBURY, VT 05819 | | _ |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY) | D BE COMP | X5) PLETION ATE |
| F 583 | Continued From page | 9 1 | F 583 | | | |
| | to examine a resident | 's medical, social, and | | | | |
| | | s in accordance with State | | | | |
| | law. | is not met as evidenced | | | | |
| | by: | is not met as evidenced | | | | |
| | | n and interview, it was | | | 2 | |
| | | acility failed to maintain | | | | |
| | resident records in a | confidential manner. | | | | |
| | Observation on 5/10/ | 22 at approximately 12:50 | | | | |
| | PM, a medication cart on B Wing/Unit revealed a | | | | | |
| | | of the medication cart that | | | | |
| | | een with resident names | | | | |
| | | list of residents on a nursing | | | | |
| | | face up on the top of the nandwritten documentation | | | | |
| | | ents needs for the shift, and | | | | |
| | | d "BM [bowel movement] | | | | |
| | and a document title | | | | | |
| | medication cart was I | | | | | |
| | residents personal inf passers by for greate | ormation left accessible to r than 10 minutes. | | | | |
| | Interview on 5/10/22 | at approximately 12:51 PM | | | | |
| | with the Unit Manage | | | | | |
| | computer was left in t | | | | | |
| | | y all residents on the B | | | | |
| | Wing/Unit and the 2 s | eparate lists that were face | | | | |
| | up on the top of the n | | | | | |
| | contained resident na | | | | | |
| | treatments. | s upcoming or completed | | | | |
| | Interview on 5/10/22 | at approximately 1 PM with a | | | | |
| | | urse (LPN) that confirmed | | | | |
| | | for the medication cart | | | | |
| | | N confirmed the above | | | | |
| | observations and stat | ed that these lists and the | | | | |

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Facility ID: 475019

If continuation sheet Page 2 of 7

PRINTED: 05/26/2022 FORM APPROVED OMB NO 0938-0391

| | OF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | (X3) DATE SURVEY COMPLETED | |
|--------------------------|--|--|--|-----|---|--|--|
| | | | | | | с | |
| | | 475019 | B. WING | | | 05/10/2022 | |
| NAME OF P | ROVIDER OR SUPPLIER | R () | | | REET ADDRESS, CITY, STATE, ZIP CODE | | |
| ST JOHNS | BURY HEALTH & REHA | В | | | 48 HOSPITAL DRIVE AINT JOHNSBURY, VT 05819 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION) | ID PREFI TAG | × | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLET DATE | |
| F 583 | protected health infor residents in her/his ca s/he did leave this inf had left the medication resident who was have | e 2 mation belonging to the are. The LPN stated that ormation accessible as s/he n cart to provide care to a ving an issue with her/his | F | 583 | | | |
| F 880 SS=E | §483.80 Infection Co The facility must esta infection prevention a designed to provide a comfortable environm development and trai diseases and infection §483.80(a) Infection program. The facility must esta and control program a minimum, the follow §483.80(a)(1) A syster reporting, investigatin and communicable d staff, volunteers, visit providing services un arrangement based u conducted according accepted national sta §483.80(a)(2) Written procedures for the pr but are not limited to | (2)(4)(e)(f) htrol blish and maintain an ind control program a safe, sanitary and hent and to help prevent the hemission of communicable ns. prevention and control blish an infection prevention (IPCP) that must include, at ving elements: em for preventing, identifying, ng, and controlling infections iseases for all residents, ors, and other individuals ider a contractual upon the facility assessment to §483.70(e) and following andards; in standards, policies, and ogram, which must include, llance designed to identify pole diseases or | F | 380 | All residents who are on precautions are at risk for this alleged deficient practice. A house wide audit was conducted to ensure all rooms requiring precaution signs are in place or removed as necessary. The padded shower cushion was removed from use. The shower room was cleaned, and dirty gown and gloves were removed The nursing staff have been educate on the precaution procedures which include proper signage and removal timely cleaning the shower room afte each use and to remove tattered sho equipment from use when discovere The Administrator or designee will conduct random weekly X4 and mor X2 of precaution room signage, show equipment and cleanliness of shower rooms. The audit will be brought to QAPI for review and further interventions if needed. | o n the d er ower d. hthly wer er | |

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Event ID: 4SFD11

Facility ID: 475019

If continuation sheet Page 3 of 7

| CENTER | S FOR MEDICARE & | MEDICAID SERVICES | | | OWB NC | 0.0938-039 |
|--|---|--|---------------------------------------|---|--------------|---------------------------|
| INTEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X2) MULTIPLE (A. BUILDING | (X3) DATE SURVEY COMPLETED C | | | |
| | | 475019 | B. WING | | C 10/2022 | |
| NAME OF P | ROVIDER OR SUPPLIER | | STREET ADDRESS, CITY, STATE, ZIP CODE | | | |
| ST JOHNSBURY HEALTH & REHAB | | 1248 HOSPITAL DRIVE SAINT JOHNSBURY, VT 05819 | | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY) | BE | (X5) COMPLETIO DATE |
| F 880 | Continued From page | e 3 | F 880 | | | |
| | persons in the facility | | | | | |
| | | m possible incidents of se or infections should be | | TAG F 880 POC Accepte | d on | |
| | reported; | | | 6/13/22 by J. Kendall/P. | | |
| | (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 | at the inclusion should be the | | | | |
| | | at the isolation should be the ible for the resident under the | | | | |
| | (v) The circumstance | es under which the facility | | | | |
| | | ees with a communicable | | | | |
| | | kin lesions from direct s or their food, if direct | | | | |
| | contact will transmit t | | | | | |
| | | procedures to be followed | | | | |
| | by staff involved in di | rect resident contact. | | | | |
| | §483.80(a)(4) A syste | em for recording incidents | | | | |
| | identified under the fa | | | | | |
| | corrective actions tak | en by the facility. | | | | |
| | §483.80(e) Linens. | | | | | |
| | | lle, store, process, and | | | | |
| | transport linens so as infection. | s to prevent the spread of | | | | |
| | §483.80(f) Annual rev | view. uct an annual review of its | | | | |
| | | ir program, as necessary. | | | | |
| | | Γ is not met as evidenced | | | | |
| | Based on observation | on and interview, it was | | | | |
| | | acility failed to ensure the | | | | |
| | tacility was free of bro | eeches in infection control | | | | |

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Facility ID: 475019

If continuation sheet Page 4 of 7

PRINTED: 05/26/2022 FORM APPROVED

| CENTER | S FOR MEDICARE & | MEDICAID SERVICES | | | | OMB NO. | <u>. 0938-0391</u> |
|-----------------------------|--|--|-----------------------|-----------------------|---|-------------------------------|----------------------------|
| | DF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MUL A. BUILDI | TIPLE CONSTRUCTION | _ | (X3) DATE SURVEY COMPLETED | |
| | | 475019 | B. WING | | | C 05/1 | ; 0/2022 |
| NAME OF P | ROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, | STATE, ZIP CODE | | |
| | | | 1248 HOSPITAL DRIVE | | | | |
| ST JOHNSBURY HEALTH & REHAB | | | SAINT JOHNSBURY, | VT 05819 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFI TAG | X (EACH CORF | R'S PLAN OF CORRECTION RECTIVE ACTION SHOULD B RENCED TO THE APPROPRIA DEFICIENCY) | | (X5) COMPLETION DATE |
| F 880 | 12:45 PM revealed R Unit Manager, as a reprecautions. Resident on her/his room door visitors that Resident Personal Protective E required prior to ente Interview on 5/10/22 with the Unit Manager required when a resid Unit Manager confirm should have had a pr room do, however the 2.) Resident #2 was however, Resident #2 signage that alerted s was on precautions. the Unit Manager, as entering this resident Interview on 5/10/22 with the Unit Manager #2's room should not on her/his room door place on Resident #2 Manager stated that her/his PPE into Res [pronoun omitted] km Interview on 5/10/22 with the facility's Infer confirmed that reside | hits. /10/22 at approximately resident #1, identified by the esident who was on int #1 did not have signage that would alert staff or #1 was on precautions and Equipment (PPE) was ring Resident #1's room. at approximately 12:46 PM er, confirmed that signage is dent is on precautions. The ned that Resident #1's room recaution sign on her/his e sign was not in place. not on precautions; 2's room door did have staff and/or visitors that s/he A staff member, identified by an LNA was observed ts room with full PPE. at approximately 12:46 PM er, confirmed that Resident t have had a precaution sign c, however a sign was in 2's room door. The Unit the LNA probably wore ident #2's room "because ew you are a surveyor". at approximately 1:45 PM | F | 380 | DEFICIENCY) | | |
| | door and PPE must t | be worn when entering | | | | | |
| FORM CMS-256 | 67(02-99) Previous Versions Ob | solete Event ID:4SFD1 | 1 | Facility ID: 475019 | lf con | tinuation she | eet Page 5 of 7 |

FORM CMS-2567(02-99) Previous Versions Obsolete

If continuation sheet Page 5 of 7

| CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 475019 | | (X1) PROVIDER/SUPPLIER/CLIA (X | | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | |
|---|--|--|---------------------|---|------------------------------|----------------------------|
| | | 475019 | B. WING | | C 05/10/2022 | |
| | ROVIDER OR SUPPLIER | В | 12 | REET ADDRESS, CITY, STATE, ZIP COU 48 HOSPITAL DRIVE AINT JOHNSBURY, VT 05819 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY) | N SHOULD BE E APPROPRIATE | (X5) COMPLETION DATE |
| F 880 | have precaution signs should not be used for 3.) Observation on 5 1:15 PM with the Unit Wing/Unit shower and washcloths on the floor rolled up green johnny shower area, and a wigrab bar in the shower gloves were observed next to the shower observed next to the shower childings. The Unit Manager findings. The Unit Manager findings is was when previor approximately 1:35 Pl shower/whirlpool roor as it was when previor approximately 1:15 Pl confirmed that the shower date that the shower date with poor integrity, wit and the surface of the gel shower chair cush | to are on precautions. At on precautions should not a on their doors and PPE r these residents. (10/22 at approximately Manager, revealed the B d whirlpool room had 2 or of the shower area, a y on a shower chair in the et washcloth hanging on the ar area. A pair of nitrile d on the floor in the shower air. At approximately 1:17 PM r, confirmed the above anager and Surveyor the unit and returned to the whirlpool room at M and noted that the n was in the same condition usly observed at M. The Unit Manager ower/whirlpool room was not timely from the previous and that this was not (10/22 at approximately 1:15 ole gel shower chair cushion th tears/rips on the seams e cushion which prevents the ion from being properly ident uses in a way that ential spread of | F 880 | | | |

CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/26/2022 FORM APPROVED OMB NO. 0938-0391

| |) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | (X3) DATE SURVEY COMPLETED | |
|--|---|---|-----|--------------|-------------------------------|----------------------------|
| | 475019 | B. WING | | | C 05/10/2022 | |
| NAME OF PROVIDER OR SUPPLIER ST JOHNSBURY HEALTH & REHAB | | STREET ADDRESS, CITY, STATE, ZIP CODE 1248 HOSPITAL DRIVE SAINT JOHNSBURY, VT 05819 | | | 0 | |
| PREFIX (EACH DEFICIENCY MUS | MENT OF DEFICIENCIES JST BE PRECEDED BY FULL IDENTIFYING INFORMATION) | ID PREFI TAG | | ION SHOULD B | | (X5) COMPLETION DATE |
| F 880 Continued From page 6 with the Unit Manager, co findings and that the gel s not able to be properly sa would prevent potential sp infection/pathogens to oth Interview on 5/10/22 at ap with the acting Administra Control Practioner regard concern, who provided co findings. The Infection Co confirmed that the gel sho needed to be replaced as properly sanitize the gel s resident uses in a way the potential spread of infecti residents. | shower chair cushion is anitized in a way that spread of ther residents. ator and the Infection ding the above areas of confirmation of the above Control Practioner hower chair cushion s it was not possible to shower cushion between hat would prevent the | F | 880 | | | |

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Facility ID: 475019

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