VERMONT

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

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

February 22, 2023

Ms. Alyssa Maker-Lawal, Administrator
St Johnsbury Health & Rehab
1248 Hospital Drive
Saint Johnsbury, VT 05819-9248

Dear Ms. Maker-Lawal:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **January 31, 2023.** Please post this document in a prominent place in your facility.

We may follow-up to verify that substantial compliance has been achieved and maintained. If we find that your facility has failed to achieve or maintain substantial compliance, remedies may be imposed.

Sincerely,

Pamela M Cota RN

Pamela M. Cota, RN
Licensing Chief

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 475019 | A. BUILDING _____ B. WING _____ | C 01/31/2023 |

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

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| F 000 | INITIAL COMMENTS<br><br>The Division of Licensing and Protection conducted an onsite, unannounced investigation of two complaints and two facility reported events. The following regulatory violations were cited as a result:<br>Reporting of Alleged Violations<br>CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) | F 000 | This Plan of Correction is submitted as required under Federal and State regulation and statutes applicable to long term care providers. This Plan of Correction does not constitute an admission of liability on the part of the facility, and such liability is hereby specifically denied. The submission of the plan does not constitute an agreement by the facility that the surveyors' findings or conclusions are accurate, that the findings constitute a deficiency, or that the scope or severity regarding any of the deficiencies cited are correctly applied | 2/28/2023 |
| F 609 SS=D | §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must:<br><br>§483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures.<br><br>§483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced | F 609 | 1. Corrective action for the residents affected by the alleged deficient practice:<br><br>LPN 2 was educated on the process for reporting allegations of abuse immediately but no later than 2 hours after the allegation was made.<br><br>LPN 1 is no longer employed.<br><br>2. Corrective action taken for those residents having the potential to be affected by the alleged deficient practice:<br><br>All residents have the possibility of being affected by the alleged deficient practice. | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE 2/17/2023

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| F 609 | Continued From page 1<br>by:<br>Based on staff interview and record review, the facility failed to ensure that allegations of abuse are reported immediately, but not later than 2 hours, after the allegation is made. Findings include:<br><br>1. Per review of facility reported event investigation documentation, LPN (licensed practical nurse) 2 reported that LPN 1 told LPN 2 during a conversation that "we should just kill [Resident #2] and just help [them] die. We can just give [them] extra morphine from another bottle and no one would even know."<br><br>Per interview on 1/31/23 at approximately 12:30 PM, the Administrator stated that the conversation between the two LPNs took place on either 1/10/23 or 1/11/23. LPN 2 did not report this conversation to anyone else until 1/12/23 during a conversation with the facility's Scheduler. The Scheduler then reported the incident<br>immediately to the Administrator and DON (Director of Nursing). The Administrator confirmed that LPN 2 should have reported this conversation immediately to a member of the leadership team. The Administrator also<br>confirmed that the Scheduler is not considered an appropriate person for staff to report allegations of abuse to.<br><br>Per review of the facility's emails, the facility did not report the incident to the appropriate agencies until 1/13/23 at 7:55 PM.<br><br>Per interview on 1/31/23 at approximately 3:45 PM, the Administrator confirmed that they<br>reported the allegation of abuse the day after they were informed of the abuse allegation and not | F 609 | Facility staff were in-serviced on the Abuse Prohibition Policy. Reeducation will be provided by the Director of Nursing /designee to facility staff, including agency staff, on or before 2/28/2023 regarding alleged violations involving abuse, neglect, exploitation or mistreatment including misappropriation of resident property are reported immediately, but not later than 2 hours after the allegation is made.<br><br>3. Measures/Systemic changes put in place to assure the alleged deficient practice does not re occur:<br><br>Facility staff were in-serviced on the Abuse Prohibition Policy. Reeducation will be provided by the Director of Nursing /designee to facility staff, including agency staff, on or before 2/28/2023 regarding alleged violations involving abuse, neglect, exploitation or mistreatment including misappropriation of resident property are reported immediately, but not later than 2 hours after the allegation is made.<br><br>4. Corrective actions will be monitored to ensure the alleged deficient practice will not re occur:<br><br>NHA/Designee will complete 5 staff interviews regarding abuse reporting conducted weekly x 4 then monthly x 3 months and findings will be discussed at Quality Assurance meeting and modifications will be made if applicable to ensure substantial compliance<br><br>**Tag F 609 POC accepted on 2/22/23 by K. Ruffe/P. Cota** | 2/28/2023 |

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| F 609<br><br>F 755 SS=D | Continued From page 2<br>within the timeframe specified in the regulation. Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3)<br><br>§483.45 Pharmacy Services<br>The facility must provide routine and emergency drugs and biologicals to its residents, or obtain 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.<br><br>§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.<br><br>§483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who-<br><br>§483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility.<br><br>§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<br><br>§483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review and staff interviews, the | F 609<br><br>F 755 | 1. Corrective action for the residents affected by the alleged deficient practice:<br><br>Identified LPN is no longer employed by the center. We completed a controlled substance discrepancy investigation for resident #1 and #2. No identified narcotic diversion was identified.<br><br>2. Corrective action taken for those residents having the potential to be affected by the alleged deficient practice:<br><br>Nursing Management completed an audit of controlled medication logs on 2/3/23 to validate no identified medication discrepancies.<br><br>All current residents receiving controlled medications have the potential to be affected by the alleged deficient practice.<br><br>3. Measures/Systemic changes put in place to assure the alleged deficient practice does not re occur:<br><br>Licensed Nurses including agency nurses will be re-educated by the Director of Nursing/Designee on policy and procedure regarding accurate documentation of controlled medications and the process to notify the immediate supervisor upon discovery of an identified discrepancy.<br><br>4. Corrective actions will be monitored to ensure the alleged deficient practice will not re occur:<br><br>Medication Administration and Controlled Medication Log will be reviewed weekly x 4 | 2/28/2023 |

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| F 755 | Continued From page 3<br>facility failed to implement a system to consistently and accurately reconcile controlled medications for 2 of 5 sampled residents needing pain medication [Resident #1 and #2]. Findings include:<br><br>1. Per record review, Resident #1 was admitted to the facility on 8/29/22 with diagnoses that include mouth cancer, failure to throve and pain. Resident #1 has a physician's order for "oxyCODONE HCl Solution 5 MG/5ML Give 5 ml via G-Tube four times a day for pain management." Per his/her medication administration record for December, oxycodone was administered as ordered from 12/1/22 through 12/10/22.<br><br>Review of the controlled substance log for Unit B1 reveals on page 34 an entry on 12/10/22 that reads "count corrected" and indicates a remaining quantity of 80 ml. This is a reduction of 5 ml from the previous count. This line is initialed by two Licensed Practical Nurses (LPNs).<br><br>Facility policy titled "NSG300 Controlled Substances: Management of," last reviewed on 4/1/22, states: "Discrepancies noted at any step of the process will be reported to appropriate persons. If a discrepancy is notes, the nursing supervisor will be notified and immediately initiate an investigation using the "Controlled Substances Discrepancy Investigation Form". The Administrator and Director of Nursing are responsible for the notification of appropriate enforcement agencies, according to state and federal regulations, of any controlled substance discrepancy which cannot be clarified satisfactorily." | F 755 | and then monthly x 3 months and findings will be discussed at Quality Assurance meetings and modifications will be made if applicable to ensure substantial compliance.<br><br>DON/Designee will observe shift count 5 times a week times 4, biweekly times 2, and monthly and findings will be discussed at Quality Assurance meeting and modifications will be made if applicable to ensure substantial compliance<br><br>DON/Designee will complete a controlled medication administration med pass observation audit on 2 nurse's weekly times 4, biweekly times 2, and monthly and findings will be discussed at Quality Assurance meetings and modifications will be made if applicable to ensure substantial compliance.<br><br>**Tag F 755 POC accepted on 2/22/23 by K. Ruffe/P. Cota** | 2/28/2023 |

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| F 755 | Continued From page 4<br>On 1/31/23 at 3:42 PM, interview with Director of Nursing (DON) and Administrator revealed that leadership was not aware of this count correction. The DON stated that a count cannot be corrected with only two LPNs because a registered nurse is required for count corrections. The DON confirmed that the staff were not using the system in place for reporting discrepancies in controlled substances per facility policy.<br><br>On 1/31/23 at approximately 4:20 PM, the Administrator confirmed that there is no system in place to safeguard accounting for controlled medications per facility policy.<br><br>2. Per review of Resident #2's controlled substance log, an LPN signed that 0.25 ml of morphine liquid was removed from the controlled substance drawer for Resident #2 on 1/11/2023 at 9:45 AM. Per review of Resident #2's MAR (medication administration record), no administration of morphine was recorded as given to Resident #2 on 1/11/2023.<br><br>Per review of the facility's investigation documentation, an interview with the LPN who signed out the morphine on 1/11/2023 stated that they sometimes forget to mark medications as administered in a resident's MAR when they are busy.<br><br>Per interview on 1/31/23 at 3:42 PM, the DON confirmed that the facility's procedure for documenting administration of controlled medications was not followed. | F 755 | | 2/28/2023 |