

## 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

May 5, 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 investigation survey conducted on **April 7, 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

Lamela MCotaRN

Licensing Chief

PRINTED: 04/24/2023 FORM APPROVED

DEPARTMENT OF HEALTH AND	J HUMAN SERVICES	CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0					
TATEMENT OF DEFICIENCIES	(Y1) PROVIDER/SUPPLIER/CLIA	(Y2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY				

	F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	COMPLE	ETED
		475019	B. WING	3		04	C <b>07/2023</b>
						04/	0112023
	PROVIDER OR SUPPLIER	AB		1:	TREET ADDRESS, CITY, STATE, ZIP CODE 248 HOSPITAL DRIVE AINT JOHNSBURY, VT 05819		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	E	(X5) COMPLETION DATE
F 000	INITIAL COMMENT	S	F0	00			5/10/2023
	conducted an onsite						
F 655 SS=E	Baseline Care Plan CFR(s): 483.21(a)(1	)-(3)	F 6	55	Specific Corrective Action		
SS=E	§483.21 Comprehent Planning §483.21(a) Baseline §483.21(a)(1) The fairmplement a baseline that includes the insteffective and personath that meet profession. The baseline care place (i) Be developed with admission.  (ii) Include the minimal necessary to properly including, but not lim  (A) Initial goals based orders.  (B) Physician (C) Dietary orders.  (D) Therapy services.  (E) Social services.	Care Plans cility must develop and e care plan for each resident ructions needed to provide -centered care of the resident al standards of quality care. an must- nin 48 hours of a resident's  num healthcare information y care for a resident ited to- d on admission orders.		IIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIII	Resident #2 expired at the facility on 04/14, Resident #3 was discharged on 04/16/2023. Resident #4 was discharged on 04/05/23. Resident #5 currently has a Care Plan in placement his needs.  Method to Assess for Others  An audit of resident's baseline care plans we completed to validate care plans are in placement his meets are in placement of the minimum healthcare information necessary to properly care for a resident incount not limited to Initial goals based on admorders, Physician orders, Dietary orders, The services, Social services, PASRR recommend of applicable.	ere e that n luding, ission erapy	
	comprehensive care care plan if the comp (i) Is developed within admission.  (ii) Meets the required	plan in place of the baseline		4 r F li F S	The facility developed baseline care plans well hours of a resident's admission and including minimum healthcare information necessary properly care for a resident including, but not imited to Initial goals based on admission of Physician orders, Dietary orders, Therapy se social services, PASRR recommendation, if applicable. Licensed staff/IDT will be re-edulo this process.	de the to ot rders, rvices,	

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

5123

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

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CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING \_ С 475019 B. WING 04/07/2023 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1248 HOSPITAL DRIVE ST JOHNSBURY HEALTH & REHAB **SAINT JOHNSBURY, VT 05819** (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION COMPLETION PREFIX PRFFIX (FACH DEFICIENCY MUST BE PRECEDED BY FULL (FACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 655 Continued From page 1 F 655 §483.21(a)(3) The facility must provide the resident and their representative with a summary **Quality Assurance** of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. DON/Designee will complete random (iii) Any services and treatments to be weekly audits of resident's CP to validate administered by the facility and personnel acting on behalf of the facility. that they are in place within 48hrs of (iv) Any updated information based on the details admission. Results of these audits will be of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced brought to the monthly QAPI Committee for further review and Based on interview and record review, the facility failed to develop a baseline care plan within 48 recommendations. hours of admission that included the minimum healthcare information necessary to properly care for the resident for 4 applicable residents Tag F 655 POC accepted on 5/5/23 by (Residents #2, #3, #4, and #5). Findings include: S. Stem/P. Cota 1. Resident #2 was admitted to the facility on 1/30/2023 and has diagnoses that include: heart failure, hypertension, history of stroke, type 2 diabetes, and neurogenic bladder. Resident #2's care plan for risk for skin break down was created on 3/22/2023, 51 days after admission, and his/her care plan for risk for falls was created on 3/30/2023, 59 days after admission. 2. Resident #3 was admitted to the facility on 2/3/2023 and has diagnoses that include: heart failure, Alzheimer's disease, chronic embolism and thrombosis, osteoarthritis, hypertension, and anemia. Resident #2's care plan for risk for skin break down was created on 2/10/2023, 7 days after admission.

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F 655	1/25/2023 and has didementia, bipolar discabnormalities of gait a depressive disorder, a #4's care plan for risk created on 3/24/2023 and his/her care plan on 3/23/2023, 57 days.  4. Resident #5 was ac 1/31/2023 and has didentered in the second abnormalities of gait a care plans for risk for for falls were created admission.  Facility policy titled "C Care Plan", last revise that "a baseline care pwithin 48 hours and in healthcare information for a patient"  On 3/23/2023 at 12:45 Nursing confirmed that areas have not been and stated that the un received education on plans.  On 3/23/2023 at 2:52 stated that s/he was mather care areas that are care plans.	dmitted to the facility on agnoses that include: order, repeated falls, and mobility, COPD, major and hypertension. Resident for skin break down was , 58 days after admission, for risk for falls was created is after admission.  dmitted to the facility on agnoses that include: ad falls, osteoarthritis, type 2 sis, depression, and and mobility. Resident #5's skin break down and risk on 2/8/2023, 8 days after  PS416 Person-Centered and on 10/24/2023, states olan must be developed clude the minimum on necessary to properly care  of PM, the Director of the some baseline care plan completed for all residents it manager had just creating and revising care	F 655				

PRINTED: 04/24/2023 FORM APPROVED DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING С 475019 B. WING 04/07/2023 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1248 HOSPITAL DRIVE ST JOHNSBURY HEALTH & REHAB **SAINT JOHNSBURY, VT 05819** (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) COMPLETION PROVIDER'S PLAN OF CORRECTION PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 655 Continued From page 3 F 655 Lead confirmed that the above residents did not have baseline care plans for the above areas within 48 hours of admission. Quality of Care F 684 F 684 Specific Corrective Action F 684 CFR(s): 483.25 SS=G § 483.25 Quality of care Resident # 1 orders for wound care to Quality of care is a fundamental principle that LLE were reviewed and are affirmed in applies to all treatment and care provided to facility residents. Based on the comprehensive place per order. The resident's care plan assessment of a resident, the facility must ensure has been updated. that residents receive treatment and care in accordance with professional standards of Resident was evaluated, preventative practice, the comprehensive person-centered skin care is in place as per his updated care plan, and the residents' choices. care plan. This REQUIREMENT is not met as evidenced by: Licensed nursing staff was educated on Based on observation, record review, and interview, the facility failed to provide safe and change in condition, skin integrity and effective skin and wound care consistent with wound management, wound care facility policy and professional standards of practice for 1 applicable resident (Resident #1) dressing guidelines, and documentation with existing non-pressure ulcer wounds by failing of skin care provided. LNA staff was to: accurately perform and document skin educated on pressure relieving devices, inspections (skin checks), accurately and regularly perform non-pressure ulcer wound nutrition/hydration, repositioning, evaluations per facility schedule, perform and change in condition, shower schedule, document daily monitoring of non-pressure ulcer wounds or dressings, follow physician's orders for diabetic and foot care, and preventive treatment and implement care plan interventions skin care. related to wound treatment. Findings include: Resident #1 was initially admitted to the facility on 8/31/2021 and readmitted to the facility from the hospital on 3/20/2023 with diagnoses that include: type 2 diabetes, dementia, peripheral vascular disease, absence of two left toes, heart disease. major depressive disorder, and abnormalities of

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days post fall. A change in condition note dated 3/10/2023 reveals the following nursing observations: "LLE [left lower extremity] presents swollen bruised on 3/8 with open area to the planter area of the left foot, now red hot to touch, initial xray negative for fx [fracture]. Resident with marked decreased in physical abilities and requires max assist with adls [activities of daily living], WBC [white blood cells] elevated. Refusing meals. Significant decline from usual baseline." A nursing note dated 3/11/2023 states that Resident #1 was sent to the hospital on 3/10/2023 for further evaluation.  An emergency department provider note dated 3/11/2023 states that Resident #1s' "diagnosis of septic shock likely secondary to cellulitis and potential pneumonia." A Podiatry note dated 3/13/2023 reveals that Resident #1 had "L [left] foot with full thickness ulceration plantar [bottom of the foot] L 2nd metatarsal [foot bones that connect to the toes] head "present for months" with probe to bone, exposed bone, and purulence," and recommendations were made for "daily dressing changes, avoidance of anything but paper tape, and use of a prevalon or comparable heal offloading boot." A hospital provider progress note dated 3/14/23 states that the source Resident #1's septic shock was from a "diabettic foot wound with osteomyelitis/cellulitis LLE." A hospital discharge summary dated 3/20/2023 reveals that Resident #s 1 wound on		had falls on 3/6/2023 note dated 3/9/2023 r complaints of pain to right rib cage; and left days post fall. A chan 3/10/2023 reveals the observations: "LLE [le swollen bruised on 3/6 planter area of the left initial xray negative for marked decreased in requires max assist w living], WBC [white block Refusing meals. Signit baseline." A nursing in that Resident #1 was 3/10/2023 for further example of the foot with full thickness of the foot] L 2nd meta connect to the toes] he with probe to bone, expurulence," and recom "daily dressing change but paper tape, and us comparable heel offlow provider progress note the source Resident # "diabetic foot wound w LLE." A hospital disches	and 3/10/2023. A provider eveals that Resident #1 had his/her left ankle/heel and foot bruising and swelling 3 ge in condition note dated following nursing left lower extremity] presents with open area to the foot, now red hot to touch, r fx [fracture], Resident with physical abilities and lith adls [activities of daily lood cells] elevated. If cant decline from usual lote dated 3/11/2023 states sent to the hospital on evaluation.  In the provider note dated Resident #1's "diagnosis of condary to cellulitis and A Podiatry note dated Resident #1 had "L [left] ulceration plantar [bottom lateral foot bones that lead "present for months" posed bone, and lateral foot long and lateral foot latera		A facility wide skin sweep was performed to evaluate each resident's skin status to determine follow-up care and services were indicated. This is continued bi weel individualized resident head to toe observations.  A resident record audit was also performed to evaluate compliance preventative skin care, head to toe assessment, shower schedule, treatment, notification of change.  Systematic Process  An ad hoc QAA was performed to complete a systematic review with revisions as determined/ indicated. New LNAs will be oriented and annueducated on pressure relieving devinutrition/hydration, repositioning, change in condition, shower schedule Diabetic and foot care, and prevent	if any kly skin with skin ually ces,	

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CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391

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F 684	there for months, profinad purulent drainage did not want surgical but agreed to wound changes, pain medicaneeded. The note refeinstructions regarding changes to left foot ar nurse to evaluate and wounds.  A nurse note dated 3/2 Resident #1 was readhad "Dressing to left fosero/sang drainage [Swatery fluid] to dressir this time, awaiting wounds were bare, and his/heimultiple bandages and of the bed. The outer calong with the fitted be on 3/23/2023 at 1:19 (LNA) stated that Resisupervision with some the hospital. Since Resident #1 has not lewas readmitted.  On 3/23/2023 at 1:55 Nurse (LPN) and the Ewere observed inspect dressings. A gauze wr	his/her left foot had been bed down to the bone, and be. It stated that Resident #1 management of his/her foot treatment, dressing stion, and antibiotics as ers to the podiatrist's wound care/dressing and to consult a wound care treat patient's foot  20/2023 states that limited from the hospital and boot, moderate amount erosanguineous; pinking. Dressing not removed at und care instructions."  20/2026 states that limited from the hospital and boot, moderate amount erosanguineous; pinking. Dressing not removed at und care instructions."  20/2027 states that limited from the hospital and boot, moderate amount erosanguineous; pinking. Dressing not removed at und care instructions."  20/2028 states that limited from the hospital and boot, moderate amount erosanguineous; pinking. Dressing not removed at und care instructions."  20/2029 states that limited from the hospital and boot, moderate amount erosanguineous; pinking. Dressing not removed at und care instructions."  20/2023 states that limited from the hospital and boot, moderate amount erosanguineous; pinking. Dressing not removed at und care instructions."  20/2023 states that limited from the hospital and boot, moderate amount erosanguineous; pinking. Dressing not removed at und care instructions."  20/2023 states that limited from the hospital and boot, moderate amount erosanguineous; pinking. Dressing not removed at und care instructions."	F 684	Licensed nurses will be oriented a annually educated on change in condition, skin integrity and woun management, wound care dressing guidelines, and documentation of care provided. A risk evaluation is completed on admission, re-admis weekly for the first month of stay, quarterly and with any possible significant change. Each facility renow has a formalized schedule heatoe skin checks weekly, bi-weekly bathing, foot observations during and during specific individualized ato toe foot care as noted on order and documented on the treatment administrative records, LNA documentation and resident individualized care plan for individualized care.  In the event of change of condition status and or non-pressure related observations, the resident's practification will be alerted for guidance and or resident and or responsible party wonotified with the care plan individual updated. The Unit Manager/desig will do	d g skin s now sion, esident ad to care inkle sets t ualized in or ioner ders, will be ially	

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AT DEAL ENGINEERING A PRINTED: 04/24/2023 FORM APPROVED DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING C 475019 B. WING 04/07/2023 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1248 HOSPITAL DRIVE ST JOHNSBURY HEALTH & REHAB **SAINT JOHNSBURY, VT 05819** (X5) COMPLETION DATE SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION **PREFIX** (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 684 Continued From page 7 F 684 Any concerns identified will be 6.4 Perform and document skin inspection on all addressed at the time of recognition. newly admitted/readmitted patients weekly thereafter and with any significant change of Results of the DON audit and process condition; will be included in the facility 6.5 Complete wound evaluation upon admission/readmission, new in-house acquired. monthly risk management/quality weekly, and with unanticipated decline in improvement meeting for additional wounds; 6.6 Perform daily monitoring of wounds consideration as determined dressings for presence of complications or appropriate. declines, 6.6.1 Document daily monitoring of ulcer/wound site with or without dressing.' Tag F 684 POC accepted on 5/5/23 by Further review of Resident #1's medical record S. Stem/P. Cota reveals the flowing: Resident #1's care plan includes the following focus: "[Resident] has Diabetic Ulcer r/t Diabetes, Lack of sensation to affected area," created on 5/31/2022. Interventions include: "Ensure appropriate protective devices are applied to affected areas," created on 5/31/2022, "Monitor/document wound: Size, Depth, Margins: periwound skin, sinuses, undermining, exudates, edema, granulation, infection, necrosis, eschar, gangrene, Document progress in wound healing on an ongoing basis. Notify MD as indicated," created on 5/31/2022, and "Treat wound as per facility protocol," created on 5/31/2022. Skin checks on 2/7/2023, 2/10/2023, 2/17/2023, 2/25/2023, and 3/4/2023 do not include documentation of Resident #1's diabetic foot ulcer. There are no physician's orders for wound care in February or the beginning of March 2023. The

following physician's orders started on 3/9/2023: "Ball of left foot. Cleanse with wound cleanser, pat dry, apply double layer xeroform to wound bed. Cover with DPD. every 1 hours as needed

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CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

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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 686 SS=G	Continued From page 8 for wound care," and 3/10/2023: "Ball of left foot. Cleanse with wound cleanser, pat dry, apply double layer xeroform to wound bed. Cover with DPD. every day shift for wound." There is no documentation in the treatment administration record (TAR) or medication administration record (MAR) that the wound was treated when Resident #1 returned from the hospital on 3/20/2023 through 2:00 PM on 3/23/2023.  There are no weekly wound assessments or documentation of daily wound monitoring, of Resident #1's diabetic foot ulcer in February or March prior to 3/24/2023.  On 4/7/2023 at 11:12 AM, the Market Clinical Lead confirmed that skin assessments should include all wounds, even if they are not new, until they are resolved. S/He confirmed that Resident #1 did not have: accurate skin assessments prior to transferring to the hospital on 3/10/2023, physician orders for his/her diabetic ulcer until 3/9/2023, and that wound assessments and monitoring did not occur until 3/24/2023. Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii)  §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 unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent	F 686	Specific Corrective Action	

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING \_ C 475019 B. WING 04/07/2023 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1248 HOSPITAL DRIVE ST JOHNSBURY HEALTH & REHAB SAINT JOHNSBURY, VT 05819 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION DATE (X4) ID **PREFIX PRFFIX** (FACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL CROSS-REFERENCED TO THE APPROPRIATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) F 686 Continued From page 10 F 686 **Systematic Process** hypertension, history of stroke, type 2 diabetes, and neurogenic bladder. Resident #2's Minimum An ad hoc QAA was performed to Data Set (MDS; a comprehensive assessment complete a systematic review with used as a care-planning tool) dated 2/6/2023 reveals that s/he is at risk for developing pressure revisions as indicated. New LNAs will ulcers. These clinical conditions and be oriented and annually educated comorbidities are risk factors for developing pressure ulcers. on pressure relieving devices, nutrition/hydration, repositioning, On admission Resident #2 had the following physician orders: left heel protector to left heel at change in condition, shower all times every shift," and "calazimine to redness schedule, diabetic and foot care, and on coccyx [the lowest part of the back, directly below the sacrum], penis and scrotum two times preventive skin care. a day for redness." Licensed nurses will be oriented and On 2/7/2023, A skin assessment notes "Pressure Area(s): Location(s): Redness/excoriation on annually educated on change in sacrum and under both butt cheeks. Calazime condition, skin integrity and wound cream applied." management, wound care dressing A progress note dated 2/12/23 reveals that a guidelines, and documentation of "CNA [Certified Nurse Aide] alerted RN skin care provided. A risk evaluation [Registered Nurse] of blister on left heel. No pain on assessment. Sponge dressing applied for is now completed on admission, reprotection. MD and DON [Director of Nursing] aware. Left voicemail for family. Foam foot admission, weekly for the first month protector in place." of stay, quarterly and with any possible significant change. Each A 2/14/2023, a skin check notes that no skin injuries/wounds are identified. facility resident now has a formalized schedule head to toe skin checks Resident #2 was transferred to the hospital on 2/19/2023 due to an altered mental state. A weekly, bi-weekly bathing, foot wound consult note from the hospital reveals that observations during care and during Resident #2 has right and left heel deep tissue injuries, a reddened area to the sacrum, and a specific individualized ankle to toe pink area to the right medial thigh. The following recommendations were made for treatment to the foot care as noted on order sets and documented on the treatment

administrative records,

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ensuring that this system is in place to support adherence to the pressure

injury program.

representative in the ac-PRINTED: 04/24/2023 FORM APPROVED DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING \_ С 475019 B. WING 04/07/2023 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1248 HOSPITAL DRIVE ST JOHNSBURY HEALTH & REHAB SAINT JOHNSBURY, VT 05819 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION COMPLETION DATE PREFIX PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) F 686 Continued From page 12 F 686 The DON/ designee will complete a record (TAR) shows the first physician order for weekly audit of eight residents per wound treatment to Resident #2's left heel. month to evaluate their skin status, On 3/11/2023, the TAR shows the first physician confirmation that anything present order for wound treatment to Resident #2's right has been appropriately identified by the system and that the system was A 3/11/2023 skin check reveals a scratch on followed through detection, Resident #2's nose. There is no documentation of the injuries/wounds to Resident #2's heels or notification of change, care and sacrum. documentation. Any concerns On 3/15/2023, the first wound evaluation was identified will be addressed at the completed for Resident #2, revealing an time of recognition. Results of the unstageable left heel ulcer. No evaluations were done for Resident #2's sacrum or right heel. DON/ designee audit and process will be included in the facility monthly On 3/22/2023, wound evaluations reveal an unstageable left heel ulcer and a stage 3 risk management/quality pressure ulcer [full thickness skin loss] to the improvement meeting for additional соссух. consideration as determined On 3/22/2023, the TAR shows the first physician appropriate. order for wound treatment to Resident #2's соссух. On 3/22/2023, 51 days after admission, a care Tag F 686 POC accepted on 5/5/23 by plan was created for Resident #2 with the S. Stem/P. Cota following focus: "Resident at risk for skin breakdown related to advanced age (great than 75 years), frail fragile skin, impaired cognition, incontinence and has actual skin breakdown." On 3/24/2023, wound evaluations reveal an unstageable left heel ulcer, a stage 2 pressure ulcer [partial-thickness skin loss with exposed dermis] to the right heel, a stage 3 pressure ulcer to the coccyx, and a deep tissue injury to the left

hand.

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	PROVIDER OR SUPPLIER	В		1:	TREET ADDRESS, CITY, STATE, ZIP CODE 248 HOSPITAL DRIVE 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	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 686	paper tape, and use of heel offloading boot." assessment dated 3// Resident #1 had a statis/her left ankle. A hid dated 3/20/2023 refer instructions regarding changes to left foot an nurse to evaluate and wounds.  A nurse note dated 3/ Resident #1 was read 3/20/2023 and had "D moderate amount ser [Serosanguineous; pin Dressing not removed wound care instruction."  On 3/23/2023 at approximate part approximate the bed. The outer of along with the fitted be bed. The outer of along with the fitted be bed. The outer of hursing (DON) inspective may be a padded bandage: Two padded bandages the back of Resident #1 bandages were dated.  On 3/23/2023 at 2:10 s/he thinks that the nuget dressing orders be assessment and a drenursing note on 3/20/20	oidance of anything but of a prevalon or comparable A hospital wound 16/2023 reveals that age 2 pressure ulcer on ospital discharge summary is to the podiatrist's wound care/dressing and to consult a wound care treat patient's foot  20/2023 states that mitted from the hospital on ressing to left foot, o/sang drainage nk watery fluid] to dressing. I at this time, awaiting ns."  oximately 1:00 PM, erved in bed. His/her legs r left foot was dressed with d pressed into the footboard dressing was visibly bloody, ed sheet. At 1:55 PM, a rse (LPN) and the Director lected the dressings. A ved from the lower section soiled with blood and fluid. Is were revealed wrapping the left ankle area. These 3/19/23.  PM, the DON stated that rsing staff were waiting to effore doing a wound	F 6	86				

PRINTED: 04/24/2023 FORM APPROVED DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING С 475019 B. WING 04/07/2023 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1248 HOSPITAL DRIVE ST JOHNSBURY HEALTH & REHAB **SAINT JOHNSBURY, VT 05819** (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) COMPLETION ID PROVIDER'S PLAN OF CORRECTION PREFIX PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) F 686 Continued From page 15 F 686 wound on Resident #1's ankle and that there were no physician orders for treatment of the wound on his/her ankle. Further review of Resident #1's medical record reveals the flowing: Upon return to the facility, the 3/20/2023 nursing skin assessment does not document the pressure ulcer located on Resident #1's ankle. There are no physician's orders for wound care for Resident #1's pressure ulcer upon returning to the facility on 3/20/2023 through 3/32/2023. There is no wound assessments or documentation of daily wound monitoring of Resident #1's pressure ulcer from 3/20/2023 through 3/24/2023. Resident #1's care plan was not revised to include actual skin breakdown related to his/her left ankle pressure ulcer until 3/23/2023. On 3/23/2023 at 2:10 PM, the DON confirmed that no one in the facility has assessed Resident #1's wound, treated his/her wound, or updated his/her care plan to reflect the actual wound. 3. Record review and interview reveal that Resident #3 was at risk for developing pressure ulcers and developed three pressure ulcers after admission. The facility failed to provide timely and accurate skin and wound assessments, revise his/her care plan to reflect his/her clinical skin condition and needs, and provide daily monitoring of existing pressure ulcers placing Resident #3 at increased risk for wound complications and developing additional pressure ulcers.

MANUFACTURES IN COURTS A PROGRAM WINDOW

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CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY IDENTIFICATION NUMBER: COMPLETED AND PLAN OF CORRECTION A. BUILDING \_ B. WING 475019 04/07/2023 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1248 HOSPITAL DRIVE ST JOHNSBURY HEALTH & REHAB **SAINT JOHNSBURY, VT 05819** (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) F 686 F 686 Continued From page 16 Record review reveals that Resident #3 was admitted to the facility on 2/3/2023 and has diagnoses that include: heart failure, Alzheimer's disease, chronic embolism and thrombosis, osteoarthritis, hypertension, and anemia. Resident #3's MDS dated 2/10/2023 reveals that s/he is at risk for developing pressure ulcers. These clinical conditions and comorbidities are risk factors for developing pressure ulcers. Resident #3's care plan for risk for skin break down was created on 2/10/2023, 7 days after admission. On 3/7/2023, a skin check reveals that resident #3 has "3 blood filled blisters to left outer foot and heel and rt [right] heel." On 3/10/2023, wound evaluations reveal a deep tissue pressure injury of the right heel, a deep tissue pressure injury of the left lateral foot, and a deep tissue pressure injury of the left heel. Skin checks on 3/21/2023 and 3/22/2023 do not reveal any skin injuries/wounds for Resident #3. On 3/23/2023, a skin check reveals that resident #3 has deep tissue pressure injuries to the left and right heel and an unstageable pressure ulcer to the left malleolus [ankle area]. Resident #3's care plan was not updated to reflect actual wounds until 3/23/2023. Facility policy titled NSG236 Skin Integrity and Wound Management, last revised on 2/1/2023. states: "A comprehensive initial and ongoing nursing assessment of intrinsic and extrinsic factors that influences skin health, skin/wound

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY COMPLETED

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION  IG	(X3) DA COMPI	TE SURVEY LETED
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	PROVIDER OR SUPPLIER	В		STREET ADDRESS, CITY, STATE, ZIP CODE 1248 HOSPITAL DRIVE SAINT JOHNSBURY, VT 05819	3,1,	
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F 686	be performed. The place reflective of asses comprehensive patier evaluation. Staff will of monitor patients for clarevisions to the plan of Standards include:  "6. A licensed nurse with a licensed n	ability of a wound to heal will an of care for the patient will sment findings from the at assessment and wound continually observe and manges and implement of care as needed."Practice will:  Interest or suspected skin ment skin inspection on all stitled patients weekly y significant change of evaluation upon now, new in-house acquired, sticipated decline in daily monitoring of wounds are of complications or ment daily monitoring of or without dressing."  Por to obtain orders."  and revise as indicated."  PM, the Director of Nursing is should document all skin even if they have been there  AM, the Market Clinical kin assessments should en if they are not new, until e confirmed that Residents have consistently accurate are daily monitoring of care plans were not	F 686			

F 686 Continued From page 18 Resident #1, #2 wound treatment orders. Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d) (1/2) \$483.25(d) (1/2) \$493.25(d) (1/2) \$493		F OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION (X3) DAT COMPLE				
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FREFIX REGULATORY OR LSC DEMIPRING INFORMATION)  F 686  Continued From page 18 Resident #1, #2 wound treatment orders. F 689 SS=E  Resident #1, #2 wound treatment orders. The facility must ensure that - \$483.25(d)(1)(2) \$483.25(d)(1)(2) \$483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and  \$483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and  \$483.25(d)(2) Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure 3 of 3 sampled residents (Residents #1, #4, and #5) remained free of accident hazards as possible regarding implementing interventions for effectiveness. Findings include:  1. Resident #1 was initially admitted to the facility on 8/31/2021 and readmitted to the facility on 8/31/2021 and readmitted to the facility on 8/31/2021 and readmitted to the facility from the hospital on 3/20/2023 with diagnoses that include: type 2 diabetes, dementia, peripheral vascular disease, absence of two left toes, heart disease, major depressive disorder, and abnormalities of gait and mobility. Resident #1*8 Minimum Data Set (MDS; a comprehensive assessment used as a care-planning tool) dated 3/11/2023 reveals that she needs staff supervision for transferring and tolleting, had a fall since the last MDS assessment, and was receiving antidepressant medications. These clinical conditions and comorbidities are risk factors for falls.			В			1248 HOSPITAL DRIVE		
Resident #1, #2 wound treatment orders. Free of Accident Free of Accident Septimized to include new post-fall interventions to prevent future falls. Resident #1 and #5 care plans were updated to include new post-fall interventions to prevent future falls. Resident #1 and #5 care plans were updated to include new post-fall interventions to prevent future falls. Resident #4 was discharged on 04/05/23.  Method to Assess for Others  Wethod to Assess for Others  The DON/Designee will complete a review of residents with falls within the last 30 days to validate new post-fall interventions to prevent future falls. Resident #4 was discharged on 04/05/23.  Method to Assess for Others  The DON/Designee will complete a review of residents with falls within the last 30 days to validate new post-fall interventions to prevent future falls were added to the satisfaction of residents and fisks and assessing interventions for effectiveness. Findings include:  1. Resident #1 was initially admitted to the facility on 8/31/2021 and readmitted to the facility for 8/31/3021 and readmitted to the facility for 8/31/3021 and readmitted to the facility for 8/31/3021 and readmitted to the facility f	PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFI	×	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	Ē	COMPLETION
Feed Accident Free of Accidents. The facility must ensure that- §483.25(d) (2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility falled to ensure 3 of 3 sampled residents (Resident #1 and #3 days to validate new post-fall interventions to prevent future falls.  Resident #4 was discharged on 04/05/23.  Method to Assess for Others  Method to Assess for Others  The DON/Designee will complete a review of residents with falls within the last 30 days to validate new post-fall interventions to prevent future falls were adde to the resident spanning implementing interventions to reduces hazards and risks and assessing interventions for effectiveness. Findings include:  1. Resident #1 was initially admitted to the facility on 8/31/2021 and readmitted to the facility from the hospital on 3/20/2023 with diagnoses that include: type 2 diabetes, dementia, peripheral vascular disease, absence of two left toes, heart disease, major depressive disorder, and abnormalities of gait and mobility. Resident #1's Minimum Data Set (MDS; a comprehensive assessment used as a care-planning tool) dated 3/11/2023 reveals that she needs staff supervision for transferring and tolleting, had a fall since the last MDS assessment, and was receiving antidepressant medications. These clinical conditions and comorbidities are risk factors for falls.	F 686			F 6	86	Specific Corrective Action		181X
DON/Designee will report findings to the QAPI committee for review.  Tag F 689 POC accepted on 5/5/23 by S. Stem/P. Cota		Free of Accident Hazards/Supervision/ 483.25(d)(1)(2)  §483.25(d) Accidents The facility must ensu §483.25(d)(1) The res as free of accident ha  §483.25(d)(2)Each res supervision and assist accidents. This REQUIREMENT by: Based on interview and failed to ensure 3 of 3 (Residents #1, #4, and of accident hazards a implementing interven and risks and assessi effectiveness. Finding  1. Resident #1 was in on 8/31/2021 and react the hospital on 3/20/20 include: type 2 diabeted vascular disease, absorbitations of gait a Minimum Data Set (Minimum Data Set (Minimum Data Set) (Minimum D	Devices CFR(s):  Inter that - sident environment remains zards as is possible; and  sident receives adequate tance devices to prevent  is not met as evidenced  and record review, the facility sampled residents d #5) remained free as possible regarding ations to reduces hazards ang interventions for s include:  itially admitted to the facility dmitted to the facility from 23 with diagnoses that es, dementia, peripheral ence of two left toes, heart sive disorder, and and mobility. Resident #1's DS; a comprehensive a care-planning tool) dated a s/he needs staff arring and toileting, had a assessment, and was ant medications. These	F6		Resident #1 and #5 care plans were updated to include new post-fall intervito prevent future falls. Resident #4 was discharged on 04/05/2 Method to Assess for Others  The DON/Designee will complete a review of residents with falls within the last 30 days to validate new post-fainterventions to prevent future falls we to the resident's plan of care.  Systematic Process  The facility implements interventions to reduces hazards and risks including assinterventions for effectiveness. DON/Designee will educate nursing sta on the Fall Management Program.  Quality Assurance  The DON/Designee will audit 5 resident falls per week for 4 weeks then monthly months to validate falls management prollowed including identifying falls, documenting circumstances, and new printerventions to prevent future falls. The DON/Designee will report findings to the committee for review.  Tag F 689 POC accepted on 5/5/23	II Pre adde  contact of the second of the se	

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	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED
		475019	B. WING		C 04/07/2023
	PROVIDER OR SUPPLIER	В		STREET ADDRESS, CITY, STATE, ZIP CODE  1248 HOSPITAL DRIVE  SAINT JOHNSBURY, VT 05819	
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(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	(X5) COMPLETION DATE
F 689	had falls on 3/6/2023 note dated 3/9/2023 r complaints of pain to right rib cage; and left days post fall. A chang 3/10/2023 reveals the observations: "Residerib cage, with pain upocough, xrays on the 6 or infiltrates, LLE [left swollen bruised on 3/8 planter area of the left initial xray negative for marked decreased in requires max assist w living], WBC [white block Refusing meals. Signit baseline." A nursing nothat Resident #1 was 3/10/2023 for further example of the system of the sys	and 3/10/2023. A provider eveals that Resident #1 had his/her left ankle/heel and foot bruising and swelling 3 ge in condition note dated following nursing int with bruised right sided on deep breathing and or th negative for FX [fracture] lower extremity] presents with open area to the foot, now red hot to touch, if x [fracture], Resident with physical abilities and ith adls [activities of daily bod cells] elevated. Gicant decline from usual ote dated 3/11/2023 states sent to the hospital on evaluation.  In includes the following is at risk for falls," created esident #1] has an ADL Self ficit r/t [related to] Unsteady ess/giddiness," created on the reveal that Resident #1 inbulation, bed mobility, and ons were created or revised the fall or ADL care plan.	F 689		

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	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE ( A. BUILDING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		475019	B. WING		04/07/2023
	PROVIDER OR SUPPLIER	ъВ	12	REET ADDRESS, CITY, STATE, ZIP CODE 48 HOSPITAL DRIVE AINT JOHNSBURY, VT 05819	
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F 689	1/25/2023 and has didementia, bipolar discaphormalities of gait a depressive disorder, a #4's MDS dated 2/1/2 staff assistance for trailocomotion, had falls in admission, wanders of antianxiety and antiderisk factors for falls.  A facility incident report had falls on 1/29/2023 and 3/12/20 for risk for falls was or days after admission.  3. Resident #5 was act 1/31/2023 and has dially hypertension, repeated diabetes, spinal steno abnormalities of gait a MDS dated 2/7/2023 rassistance for transfer in the month prior to a receiving antidepressable clinical conditions and factors for falls.  A facility incident report had falls on 2/15/2023 Resident #5's care pla	dmitted to the facility on agnoses that include: order, repeated falls, and mobility, COPD, major and hypertension. Resident 2023 reveals that s/he needs ansferring, toileting, and in the month prior to daily, and was receiving apressant medications. Ons and comorbidities are ort reveals that Resident #4 8, 3/6/2023, 3/8/2023, 223. Resident #4's care plan reated on 3/23/2023, 57 dmitted to the facility on agnoses that include: and falls, osteoarthritis, type 2 sis, depression, and and mobility. Resident #5's reveals that s/he needs staff rring and toileting, had falls dmission, and was ant medications. These comorbidities are risk of risk for falls was 8 days after admission, and	F 689		

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