

DEPARTMENT OF DISABILITIES, AGING AND INDEPENDENT LIVING

<u>Division of Licensing and Protection</u> 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

July 6, 2023

Ms. Opal Dacosta, Administrator St Johnsbury Health & Rehab 1248 Hospital Drive Saint Johnsbury, VT 05819-9248

Dear Ms. Dacosta:

Enclosed is a copy of your acceptable plans of correction for the complaint investigation conducted on **June 21, 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

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

PRINTED: 06/30/2023 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED			
			7 50		С			
475019			B. WING		06/21/2023			
NAME OF P	ROVIDER OR SUPPLIER	^		STREET ADDRESS, CITY, STATE, ZIP CODE				
STJOHNS	BURY HEALTH & REHA	В		1248 HOSPITAL DRIVE				
OF COMMODORY HEALTH & REIND				SAINT JOHNSBURY, VT 05819				
(X4) ID	(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD				
			PREFIX TAG	CROSS-REFERENCED TO THE APPROPR				
				DEFICIENCY)				
F 000	00 INITIAL COMMENTS		F 00	00				
		e investigation of four						
		ucted by the Division of						
		ion on June 21, 2023. The olation was cited as a						
result:		illon was cited as a		The facility staff have received education of inclusive of activities that constitute misap				
F 943	Abuse, Neglect, and I	Exploitation Training	F 94	of regident property	n oprilation			
SS=B CFR(s): 483.95(c)(1)				All others have the potential to be affected	by the			
				deficient practice.				
	• , ,	glect, and exploitation.						
	In addition to the freedom from abuse, neglect,			The facility trains employees, both new em and ongoing training for all employees on a	buse			
	and exploitation requi			inclusive of Misappropriation of patient prop	perty,			
	that at a minimum edu	ovide training to their staff		which is defined as the deliberate misplace exploitation, or wrongful, temporary or perm	ment, nanent			
	triat at a minimum eut	icales stall on-		use of a patient's belongings or money with patient's consent. Facility staff will be re-ed	out the			
	§483.95(c)(1) Activitie	s that constitute abuse,		this process.	ucated to			
		and misappropriation of						
	resident property as s	et forth at § 483.12.		The facility NHA/Designee will conduct ran interviews with staff and residents to valida				
				process is followed weekly x 4, bi-weekly x and monthly x 2. Results of these audits wi	2.			
	§483.95(c)(2) Procedures for reporting incident of abuse, neglect, exploitation, or the			brought to the QAPI Committee for further	eviewand r			
	misappropriation of re			ecommendations.				
	misappropriation of re	sident property		D-460				
§483.95(c)(3) De		ia management and		Date of Compliance 7/11/2023				
	resident abuse prever	ntion.						
		is not met as evidenced		Tag F 943 POC accepted on 7/6/2	3 by			
	by:	and also an estimated familia.		H. Fox/P. Cota	, ,			
		and observations the facility						
		ng to their staff that at a eir staff on activities that						
		iation of resident property.						
	Resident #1 on two separate occasions provided							
	his/her debit card to staff after which							
	unauthorized charges or withdrawals were alleged to have been made resulting in an							
		being conducted by local						
	law enforcement.	boning contracted by local						
ABORATORY D	IRECTOR'S OR PROVIDER/SI	UPPLIER REPRESENTATIVE'S SIGNATURI	E	TITLE	(X6) DATE			

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.

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		475040	B. WING			С	
NAME OF PROVIDER OR SUPPLIER		475019	B. WING	STREET ADDRESS, CITY, STATE,	ZIR CODE	06/	21/2023
				1248 HOSPITAL DRIVE	ZII CODE		
ST JOHNSBURY HEALTH & REHAB				SAINT JOHNSBURY, VT 05	819		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG				(X5) COMPLETION DATE
	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		FS	43			