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

September 21, 2023

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

Dear Mr. Alaimo:

Enclosed is a copy of your acceptable plans of correction for the recertification survey conducted in conjunction with a complaint investigation on **August 30, 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,

PamelaMCotaRN
Pamela M. Cota, RN
Licensing Chief

Enclosure

| 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 08/30/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ST JOHNSBURY HEALTH & REHAB | 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 |
|---|---|---|---|---|
| E 000 | Initial Comments<br><br>The Division of Licensing and Protection conducted an emergency preparedness review during the annual recertification survey on 8/29/2023. There were no regulatory violations identified. | E 000 | This plan of correction was written to follow state and federal guidelines. It is not an admission of noncompliance. However, it is the facility commitment to demonstrate and maintain compliance. | |
| F 000 | INITIAL COMMENTS<br><br>The Division of Licensing and Protection conducted an unannounced, onsite recertification survey and complaint investigation, including report(s) # 222186 and #22217, from 8/28/23 through 8/30/23, to determine compliance with 42 CFR Part 483 requirements for Long Term Care Facilities. Deficiencies were cited as a result of this survey. | F 000 | | |
| F 584 SS=E | Safe/Clean/Comfortable/Homelike Environment<br>CFR(s): 483.10(i)(1)-(7)<br><br>§483.10(i) Safe Environment.<br>The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.<br><br>The facility must provide-<br>§483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible.<br>(i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk.<br>(ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. | F 584 | F587 Specific Corrective Action<br><br>1.Room A3, A6 and B22 were deep cleaned to include the floor.<br><br>2. A walk through of all resident rooms was completed to ensure the floors were clean.<br><br>3. The center has hired 2 more housekeepers that started on 9/11/23. The regional supervisor visits weekly to assist the team and is focused on recruitment. Maintenance has been assigned to assist where needed.<br><br>4. The Administrator/designee will round daily (M-F) to ensure resident floors are clean and free from debris. The administrator/ designee and housekeeping supervisor will meet daily (M-F) x3 and weekly x3 to discuss staffing needs.<br><br>Results of the audits will be discussed in QAPI.<br><br>Date of Compliance 10/3/23. | |

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
|---|---|---|
| [signature] | Administrator | 9/19/2023 |

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.

| 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 08/30/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ST JOHNSBURY HEALTH & REHAB | 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 584 | Continued From page 1<br>§483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior;<br><br>§483.10(i)(3) Clean bed and bath linens that are in good condition;<br><br>§483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv);<br><br>§483.10(i)(5) Adequate and comfortable lighting levels in all areas;<br><br>§483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and<br><br>§483.10(i)(7) For the maintenance of comfortable sound levels.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview, and record review, the facility failed to ensure residents were provided with a clean and comfortable environment as evidenced by debris-covered floors in resident rooms for days in a row. Findings include:<br><br>Per observation on 8/28/23 at approximately 12:30 PM, the floors in resident rooms A3 and A6 were visibly dirty with copious amounts of dust, dirt, and old food crumbs. The amount of debris on the floor was indicative of several days' worth of buildup. There was a dried, crusted, dark brown stain from spilled liquid in front of A6 Bed 1's nightstand.<br><br>Per observation on 8/28/23 at approximately 1:00 | F 584 | **Tag F 584 POC accepted on 9/21/23 by St. Stem/P. Cota** | |

| 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 08/30/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ST JOHNSBURY HEALTH & REHAB | 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 584 | Continued From page 2 | F 584 | | |

PM, the floors underneath the beds in room B22 had accumulated dust and debris under them. When the resident in Bed 1 was interviewed about the dirty floor at the time of the observation, the Resident stated, "I've asked them to clean under my bed many times, but they won't!"

Per observation on 8/28/23 at approximately 4:30 PM, the floors in rooms A3, A6, and B22 were in the same state as earlier in the day.

Per observation on 8/29/23 at approximately 8:00 AM, the floors in rooms A3, A6, and B22 had not been cleaned and additional accumulated dirt, dust, and crumbs were present.

Per interview on 8/29/23 at approximately 8:10 AM, the Housekeeping Supervisor confirmed the dirty state of the floors in rooms A3, A6, and B22. The housekeeping supervisor confirmed that A3 and A6 rooms had not been cleaned the previous day, or the day prior to that (8/27/23). They confirmed that B22 had been cleaned on 8/28/23 but that the floor under the beds had not been addressed. The Supervisor went on to say that there were no scheduled staff on 8/27/23 due to staffing challenges, and that they came in to clean a few rooms for which there had been complaints but did not clean the majority of the rooms.

Per record review of a grievance filed on 8/7/23 by a family member with complaints about dirty floors in resident rooms, the facility's written response stated that there is no housekeeping in the facility every other Sunday at this time due to staffing challenges.

| | | | |
|---|---|---|---|
| F 623 SS=B | Notice Requirements Before Transfer/Discharge | F 623 | |

| 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 08/30/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ST JOHNSBURY HEALTH & REHAB | 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 623 | Continued From page 3 CFR(s): 483.15(c)(3)-(6)(8) | F 623 | F623 Specific Corrective Action | |

§483.15(c)(3) Notice before transfer.
Before a facility transfers or discharges a resident, the facility must-
(i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman.
(ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and
(iii) Include in the notice the items described in paragraph (c)(5) of this section.

§483.15(c)(4) Timing of the notice.
(i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged.
(ii) Notice must be made as soon as practicable before transfer or discharge when-
(A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section;
(B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section;
(C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section;
(D) An immediate transfer or discharge is required by the resident's urgent medical needs,

1. Resident #17 discharged 9/9/23
Resident #42 discharged 8/30/23.
Both residents have completed transfer notices from their recent transfers.

2. An audit of all residents that transfered in the last 30 days was completed to validate transfer forms have been completed and copies have been sent to the appropriate parties.

3. Education has been completed with direct care staff responsible for transfers out of the center, social services and the business office to ensure the transfer notice was completed and uploaded.

4. The administrator/designee will complete weekly audits x3, monthly x4 to ensure the transfer paper work was completed, the correct notifications done and the documents uploaded to patient record.

Results of audits will be discussed in QAPI.

Date of Compliance 10/3/23

**Tag F 623 POC accepted on 9/21/23 by St. Stem/P. Cota**

| 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 08/30/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ST JOHNSBURY HEALTH & REHAB | 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 623 | Continued From page 4 | F 623 | | |

under paragraph (c)(1)(i)(A) of this section; or
(E) A resident has not resided in the facility for 30 days.

§483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following:
(i) The reason for transfer or discharge;
(ii) The effective date of transfer or discharge;
(iii) The location to which the resident is transferred or discharged;
(iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request;
(v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman;
(vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and
(vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act.

| 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 08/30/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ST JOHNSBURY HEALTH & REHAB | 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 623 | Continued From page 5 | F 623 | | |

§483.15(c)(6) Changes to the notice.
If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available.

§483.15(c)(8) Notice in advance of facility closure
In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l).
This REQUIREMENT is not met as evidenced by:
Based on staff interviews and record reviews the facility failed to notify the resident and/or resident representative in writing of a transfer/discharge and send a copy of the notice to the Ombudsman for 2 of 2 applicable residents (Residents #17 and #42).
Findings include:

1.Per record review the progress note revealed on 7/7/2023 Resident #17 experienced decreased oxygen saturation and malaise and was transferred to an acute care hospital where they were assessed and returned to the facility. There is no indication in the clinical record that staff notified the resident and/or representative or the Ombudsman regarding transfer or discharge in writing as required by regulation.

2.Per record review the progress note revealed on 8/12/23 Resident #42 experienced chest pain

| 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 08/30/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ST JOHNSBURY HEALTH & REHAB | 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 623 | Continued From page 6 | F 623 | | |

and was transferred to an acute care hospital where they were admitted for care. There is no indication in the clinical record that staff notified the resident and/or representative or the Ombudsman regarding transfer or discharge in writing as required by regulation.

On 8/29/2023 at approximately 2 PM the acting Administrator confirmed that written notice of transfer or discharge was not provided for either Resident #17 or Resident # 42 as required by regulation.

F 625 SS=B Notice of Bed Hold Policy Before/Upon Trnsfr
CFR(s): 483.15(d)(1)(2)

§483.15(d) Notice of bed-hold policy and return-

§483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies-
(i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility;
(ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any;
(iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and
(iv) The information specified in paragraph (e)(1) of this section.

§483.15(d)(2) Bed-hold notice upon transfer. At

F 625

F625 Specific Corrective Action

1. Resident #17 discharged 9/9/23 Resident #42 discharged 8/30/23. Both residents have a bed hold notice uploaded under documents in their medical record.

2. An audit of residents that transfered out of the center in the last 30 days has been completed to ensure they have all received the required Bed Hold Notice and that a copy has been uploaded to the medical record.

3. Education has been completed with social services and the business office to ensure the Bed Hold form is completed timely.

4. The Administrator/designee will conduct weekly audits x3, monthly x4 to ensure the bed hold policy is being followed. Type text here

Results of audits will be discussed in QAPI.

Compliance date 10/3/23

| 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 08/30/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ST JOHNSBURY HEALTH & REHAB | 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 625 | Continued From page 7 | F 625 | **Tag F 625 POC accepted on 9/21/23 by St. Stem/P. Cota** | |

the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section.
This REQUIREMENT is not met as evidenced by:
Based on staff interview and record reviews the facility failed to provide written information regarding the bed-hold policy for 2 of 2 applicable residents (Residents #17 and #42).
Findings include:

1. Per record review, on 7/7/2023 Resident #17 experienced decreased oxygen saturation and malaise and was transferred to an acute care hospital where they were assessed and returned to the facility. There is no indication in the clinical record that staff notified the resident and/or representative of the bed-hold policy in writing as required by regulation.

2. Per record review, on 8/12/23 Resident #42 experienced chest pain and was transferred to an acute care hospital where they were admitted for care There is no indication in the clinical record that staff notified the resident and/or representative of the bed hold policy in writing as required by regulation.

On 8/29/23 at approximately 2 PM the acting administrator confirmed that written information regarding the facility bed-hold policy had not been provided for either Resident #17 or Resident #42 as required by regulation.

| | | | |
|---|---|---|---|
| F 635 SS=D | Admission Physician Orders for Immediate Care CFR(s): 483.20(a) | F 635 | |

| 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 08/30/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ST JOHNSBURY HEALTH & REHAB | 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 635 | Continued From page 8 | F 635 | F635 Specific Corrective Action | |

§483.20(a) Admission orders
At the time each resident is admitted, the facility must have physician orders for the resident's immediate care.
This REQUIREMENT is not met as evidenced by:
Based on staff interview and record review, the facility failed to obtain accurate physician orders to provide necessary care and services on admission for 1 of 7 newly admitted (within 30 days) sampled residents (Resident #10). Findings include:

Facility policy OPS424 Medication Reconciliation, effective 9/1/2022, states,
"The patient's medication orders will be reconciled at each transition of care. Medication reconciliation is the process of comparing a patient's existing medication orders to all the previous medications the patient has been taking. The process involves obtaining and maintaining a complete and accurate list of current medication use across all healthcare settings. Medication reconciliation involves collaboration with the patient representative and multiple disciplines including admission liaisons, physicians/advanced practice providers (APP), licensed nurses, and pharmacy. ...
For patients admitted from the hospital: obtain and review copies of Medication Administration Records (MARs), Treatment Administration (TARs), transfer forms, and Physician's Order Sheets (POS). A medication history will be obtained for all patients and documented in the patient's medical record as soon as possible after admission. A medication history: . . . May include review of ordered and/or over the counter medications taken prior to hospitalization."

1. Resident #10 discharged 8/28/23.

2. An audit of all new admissions for the last 30 days was completed to validate that physician orders were accurate, and a medication history was obtained and documented in the patient's medical record, any issues identified have been corrected.

3. Education is being completed with the appropriate licensed staff and providers regarding Policy OPS424 Medication Reconciliation.

4. The DON/Designee will complete weekly audits x3, monthly x3 to ensure this process is being followed.

Results of the audits will be reviewed in QAPI.

Date of Compliance 10/3/23

**Tag F 635 POC accepted on 9/21/23 by St. Stem/P. Cota**

| 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 08/30/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ST JOHNSBURY HEALTH & REHAB | 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 635 | Continued From page 9 | F 635 | | |

Per record review, Resident #10 was admitted to the facility on 8/3/23 for rehabilitation, wound management, and pain management, following a surgery.

Per interview on 8/28/23 at 10:45 AM, Resident #10 stated that s/he did not receive a blood thinner or a diuretic (medication used to treat fluid retention) that s/he was taking at home for weeks after she was admitted to the facility and revealed that his/her stitches were removed almost a week later than they should have been. S/He stated that no one had asked him/her about what meds s/he was taking at home and his/her home medications were not reviewed until s/he informed nursing staff that s/he noticed significant fluid buildup in his/her stomach and legs. At that time, s/he was put back on a diuretic and blood thinner.

Review of Resident #10's hospital discharge summary reveals that his/her stitches were scheduled to be removed on 8/11/23. Review of a Physician's Assistant admission note dated 8/4/23 states that Resident #10 "is due to have [his/her] staples removed on 8/11/23," and has a history of pulmonary embolisms [PE; blood clot in lungs] and long-term use of anticoagulants [blood thinners]. This admission note does not reflect that home medications were reviewed with Resident #10. A progress note dated 8/20/23 states, "Resident c/o [complains of] to this nurse about right lower quadrants swelling ... Resident's legs also +2 pitting edema, resident told this nurse while [s/he] was home [s/he] was taking diuretics."

Review of Resident #10's Physician Orders and

| 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 08/30/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ST JOHNSBURY HEALTH & REHAB | 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 635 SS=E | Continued From page 10<br>medication and treatment administration records reveals the following orders, "Staple removal on 8/16/23 from three incisions," with a start date of 8/16/23, five days after recommended in Resident #10's discharge summary; Furosemide [diuretic] "for CHF [congestive heart failure; when the heart doesn't pump blood as efficiently as it should and can cause fluid buildup], fluid retention," with a start date of 8/21/23, 18 days after admission; and Apixaban [anticoagulant] for "history of PE," with a start date 8/22/23, 19 days after admission. | F 635 | | |
| F 656 SS=E | Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3)<br><br>§483.21(b) Comprehensive Care Plans<br>§483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following -<br>(i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and<br>(ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6).<br>(iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the | F 656 | F656 Specific Corrective Action<br><br>1.Resident #36's comprehensive care plan has been updated to include his medical diagnosis, weight monitoring and medications.<br><br>2. An audit of new admissions has been completed to ensure their comprehensive careplans include their medical diagnosis, weight monitoring and medications.<br><br>3. Education is being completed with staff that are responsible with completing comprehensive careplans for new admissions<br><br>4. The DON/Designee will completed weekly audits x3, monthly x3 to validate new admission's comprehensive care plans include diagnosis, weight maintenance and medications<br><br>Results of these audits will be reviewed in QAPI.<br><br>Compliance Date 10/3/23 | |

| 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 08/30/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ST JOHNSBURY HEALTH & REHAB | 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 656 | Continued From page 11 | F 656 | **Tag F 656 POC accepted on 9/21/23 by St. Stem/P. Cota** | |

findings of the PASARR, it must indicate its rationale in the resident's medical record.
(iv)In consultation with the resident and the resident's representative(s)-
(A) The resident's goals for admission and desired outcomes.
(B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.
(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.
§483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must-
(iii) Be culturally-competent and trauma-informed.
This REQUIREMENT is not met as evidenced by:
Based upon interview and record review, the facility failed to implement Care Plan interventions related to diagnoses, weight monitoring, and medications for 1 resident [Res.#36] of 27 sampled residents.
Findings include:

Res.# 36 was admitted to the facility on 1/25/23 with diagnoses that include Chronic Kidney Disease, Morbid (Severe) Obesity, Retention of Urine, and Congestive Heart Failure [Congestive Heart Failure (CHF) occurs when the heart muscle doesn't pump blood as well as it should. When this happens, blood often backs up and fluid can build up in the lungs]. (https://www.mayoclinic.org/diseases-conditions/heart-failure/symptoms-causes/syc-20373142),.

| 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 08/30/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ST JOHNSBURY HEALTH & REHAB | 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 656 | Continued From page 12 | F 656 | | |

Review of Physician Orders for Res.#36 includes an order for "Furosemide Oral Tablet 80 milligrams-
Give 1 tablet by mouth two times a day for CHF".
[Furosemide belongs to a group of medicines called loop diuretics (also known as water pills). Furosemide is given to help treat fluid retention (edema) and swelling that is caused by congestive heart failure, kidney disease, or other medical conditions. It works by acting on the kidneys to increase the flow of urine. In addition to using this medicine, treatment of your high blood pressure may include weight control.] (https://www.mayoclinic.org/drugs-supplements/furosemide-oral-route/description/drg-20071281)
Further review of Physician Orders reveals an order dated 3/16/23 for "Weight daily: one time a day for CHF on Furosemide. Notify MD if 5 lb. or more gain in 24 hours".

Per review of the facility's Weights and Heights policy [effective 6/1/01, revised 6/15/22], regarding "Obtaining and Documenting Weight: If the body weight is not as expected, re-weigh the patient".
Under "Significant Weight Change Management", the policy states:
- Significant weight changes will be reviewed by the licensed nurse for assessment.
- Significant weight change is defined as:
- 5% in one month, 10% in six months.
- The licensed nurse will:
- Notify the physician/APP and Dietitian of significant weight changes.
- Document notification of physician/APP and Dietitian in the PCC Weight Change Progress Note.
- The licensed nurse will notify the:
- Physician/APP of the Dietitian

| 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 08/30/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ST JOHNSBURY HEALTH & REHAB | 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 656 | Continued From page 13 | F 656 | | |

recommendations;
- Patient representative of the weight change and Dietitian recommendations. Notification will be documented."

Review of Res.#36's medical record reveals no documentation of weights completed as ordered on 31 days between 3/16/23 and 6/26/23, when the order was discontinued and changed to weekly weights. Additionally, review of recorded weights reveals weight changes over 24 hours of minus 45 lbs. [3/23: 323 lbs., 3/24: 278 lbs.], a gain of 12.1 lbs. [3/31: 267.4 lbs., 4/1: 279.5 lbs.], a gain of 7.5 lbs. [4/3: 281.5, 4/4: 289 lbs.], and a gain of 30.8 lbs. [4/12: 283.2, 4/13: 314 lbs.] with no reweight to ensure accuracy of the weights or notification of the physician regarding a weight gain of 5 lb. or more in 24 hours per the physician's order.
On 6/26/23, the weight order was changed from daily to weekly weights. Review of weekly weights records a weight loss of 9.6 lbs. over 1 week [7/10: 333.4 lbs., 7/17: 323.8 lbs.] and a weight gain of 14 lbs. in 1 week [7/31: 324 lbs., 8/7: 338 lbs.]. Review of Res.#36's medical record reveals no physician notification of the resident's significant weight loss and gain.

Nurses Notes dated 8/15/23 record "chronic edema [swelling caused by too much fluid trapped in the body's tissues] bilateral lower extremities [legs]. Left lower extremity having large amount of drainage ...Notified Physician's Assistant". On 8/20/23, the Physician was notified Res.#36 was reporting pain to h/her legs. Physician assessment notes record "Left leg: with venous stasis changes [a condition of slow blood flow in the veins, usually of the legs] to lower leg noted. Generalized edema, erythema [abnormal

| 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 08/30/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ST JOHNSBURY HEALTH & REHAB | 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 656 Continued From page 14

redness] extending from foot up leg ...". The Physician ordered the resident sent to the hospital for a "higher level of care".

Review of Res.#36's Care Plan reveals the resident identified as "at nutritional risk: morbid obesity, at risk for significant weight gains/losses as on Lasix [Furosemide]", with interventions that include "Weigh per order and alert dietitian and physician to any significant loss or gain" and "Monitor for changes in nutritional status such as ... unplanned weight loss or gain and notify dietician/physician".

An interview was conducted with Res.#36's Unit Manager [UM] and the facility's Clinical Lead on 8/29/23 at 11:40 AM. The UM and Clinical Lead confirmed that Physician Orders for Res.#36 included Daily Weights from 3/16/23 to 6/26/23, and the order was not completed on 31 days. Additionally, the UM and Clinical Lead confirmed that Res.#36's medical record included weights with significant losses and gains, with no Physician notification per order, per the resident's Care Plan, and per the facility's Weights and Heights policy.

F 657 Care Plan Timing and Revision
SS=D CFR(s): 483.21(b)(2)(i)-(iii)

§483.21(b) Comprehensive Care Plans
§483.21(b)(2) A comprehensive care plan must be-
(i) Developed within 7 days after completion of the comprehensive assessment.
(ii) Prepared by an interdisciplinary team, that includes but is not limited to--
(A) The attending physician.
(B) A registered nurse with responsibility for the

F 656

F 657 F657 Specific Corrective Action

1. Resident #10 discharged 8/28/23. Resident #43's comprehensive careplan was updated to include interventions and achievable goals to reach and maintain the highest practicable well-being.

2. An audit of resident comprehensive careplans has been completed to ensure they include interventions and achievable goals to reach and maintain the highest practicable well-being.

| 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 08/30/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ST JOHNSBURY HEALTH & REHAB | 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 657 | Continued From page 15 | F 657 | F657 cont... | |

resident.
(C) A nurse aide with responsibility for the resident.
(D) A member of food and nutrition services staff.
(E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan.
(F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident.
(iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.
This REQUIREMENT is not met as evidenced by:
Based on interview and record review the facility failed to revise a comprehensive care plan to include interventions and achievable goals to reach or maintain the highest practicable well-being for 2 of 27 sampled (Residents #43 & #10). Findings include:

1. The care plan for Resident #43 was not updated to include a resident-centered goal based on individual strengths, weaknesses, and personal goals regarding mental health.

Resident #43 was admitted to the facility in August 2022 with diagnoses including bipolar disorder, Aspergers Syndrome, and anxiety disorder.

Per record review, Resident #43 has expressed "feeling tired or having little energy" as well as

3. Education is being completed with staff that are responsible for completing comprehensive careplans.

4. The DON/Designee will complete weekly audits x3, monthly x3 on all new admissions to ensure their comprehensive care plans include interventions and achievable goals to reach and maintain the highest practicable well-being.

Results of audits will be discussed in QAPI.

Date of Compliance 10/3/23

**Tag F 657 POC accepted on 9/21/23 by St. Stem/P. Cota**

| 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 08/30/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ST JOHNSBURY HEALTH & REHAB | 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 657 | Continued From page 16 | F 657 | | |

"feeling down, depressed, or hopeless" during MDS (Minimum Data Set, a Federal system collecting periodic comprehensive resident data) assessments done on November 16, 2022, February 6, 2023, March 12, 2023, and May 26, 2023. During an interview with Resident #43 on August 28, 2023, when asked if they attend activities they responded "no" and clarified when asked why "I just don't like to."

The care plan initiated on August 16, 2022, contains the nursing diagnosis of "exhibits or is at risk for distressed/fluctuating mood symptoms related to bipolar disorder, Asperger's syndrome, and anxiety" with a goal of "will demonstrate improved mood by next review as evidenced by verbalizing he is satisfied with his care and attending 2 planned activities a week through the next review."

During an interview with the Activities Director on August 30, 2023, at 2:50 PM they stated Resident #43 had briefly attended one planned activity during the past year and acknowledged Resident #43 stays in their room most of the time. The Activities Director confirmed there were no interventions in place to support the goal nor was the goal updated to reflect resident preference.

2. Per multiple observations on 8/28/23 and 8/29/23, Resident #30 was wearing the same clothing on each day, with it becoming increasingly soiled by the second day of observation. Per interview on 8/28/23 at 1:37 PM with Resident #30's Representative, s/he revealed that s/he had visited Resident #30 the previous day, on 8/27/23, and she is in the same clothes today as she was the day before. S/he continued to explain that s/he visits Resident #30

| 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 08/30/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ST JOHNSBURY HEALTH & REHAB | 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 657 Continued From page 17

about 3 times a week and s/he is frequently in the same clothing.

Review of Licensed Nursing Assistant documentation for the day shift (7:00 AM through 3:00 PM) for 8/1/23 through 8/23/23 reveals that Resident #30 refused to be dressed 5 of the 28 days. Per interview on 8/29/23 at 11:57 AM, a Licensed Nursing Assistant confirmed that Resident #30 refuses care "all the time."

Review of Resident #30's care plan reveals that Resdeint #30, "requires assist for ADL [activities of daily living] care and eating due to cognitive impairment," created on 2/1/23, and interventions for dressing include, "I like to layer my clothes," created on 6/16/23. There are no interventions describing what type of support Resident #30 needs for dressing and does not include interventions to address refusal of dressing.

On 8/29/23 at approximately 12:30 PM, the Market Clinical Lead confirmed that Resident #30's care plan did not include interventions regarding refusal of ADL care.

F 657

F 684 Quality of Care
SS=D CFR(s): 483.25

§ 483.25 Quality of care
Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices.

F 684 F684 Specific Corrective Action

1. Resident #30 is free from s/s of Covid.

2. A review of resident progress notes were audited to ensure anyone with symptoms was receiving care related to their symptoms, including assessment, monitoring and testing.

| 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 08/30/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ST JOHNSBURY HEALTH & REHAB | 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 684 | Continued From page 18 | F 684 | F684 cont... | |

This REQUIREMENT is not met as evidenced by:
Based on interview and record review, the facility failed to ensure that residents received care related to symptoms, including assessment, monitoring, and testing, for 1 of 27 sampled residents (Resident #30). Findings include:
Per interview on 8/28/23 at 1:40 PM, Resdeint #30's Representative revealed that a few weeks earlier, Resident #30 had a bad cough and had lost his/her sense of taste and smell. S/He stated that when s/he inquired with staff about testing Resident #30 for COVID 19, staff told him/her that Resident #30 did not get tested because everyone in the building has a cold right now.

Review of Resdeint #30's physician orders reveals an order for Guaifenesin (cough medicine) extended release every 12 hours for 7 days for chest congestion starting on 8/10/23. There are no nursing assessments, provider assessments, or change of condition assessments documented regarding Resident #30's symptoms requiring cough medicine. There are no vital signs for monitoring Resdeint #30's condition, including temperature, respiratory rate, heart rate, and oxygen saturation, in progress notes, medication and treatment administration records, or vital sign documentation records after 7/24/23. There are no orders to administer a COVID-19 test or any test results indicating that Resident #30 was tested for COVID-19 around the time the cough medicine was being administered.

Per interview on 8/30/23 at 9:40 AM, the Market Clinical Lead revealed that the COVID-19 policies and procedures include health department guidance. This guidance includes testing for

3. Education is being done with licensed staff to ensure that residents are receiving care related to their symptoms, including assessments, monitoring and testing (if needed).

4. The DON/Designee will conduct daily audits (M-F) for 2 weeks of nursing notes to ensure residents are being assessed, monitored and tested if required. These audits will continue weekly x3, then monthly x 3

Results of audits will be discussed in QAPI.

Date of Compliance 10/3/23

**Tag F 684 POC accepted on 9/21/23 by St. Stem/P. Cota**

| 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 08/30/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ST JOHNSBURY HEALTH & REHAB | 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 684 | Continued From page 19 | F 684 | | |

COVID-19 when symptoms include cough and loss of taste or smell (https://www.healthvermont.gov/disease-control/covid-19). S/He confirmed that there was no evidence in Resident #30's medical record that Resident #30 was assessed, was being monitored for new or worsening symptoms, or had been tested for COVID-19 during the time when Resident #30 was taking cough medicine.

F 692 Nutrition/Hydration Status Maintenance
SS=E CFR(s): 483.25(g)(1)-(3)

§483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident-

§483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise;

§483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health;

§483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet.
This REQUIREMENT is not met as evidenced by:
Based upon interview and record review, the facility failed to assure that weights were monitored per physician orders regarding a

F 692 F692 Specific Corrective Action

1. Resident #10 discharged 8/28/23. Resident #36 has an order for daily weights

2. An audit of weights has been completed to validate the Weight and Height policy is being followed.

3. Education is being completed to licensed staff inregards to Weight and Height policy's requirements.

4. The DON/Designee will complete resident weight audits x3, monthly x4 to validate weight orders are being followed, significant weight changes are being documented and the provider is being notified, per the policy.

Results of the audits will be discussed in QAPI.

Compliance Date 10/3/23

| 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 08/30/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ST JOHNSBURY HEALTH & REHAB | 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 692 | Continued From page 20 | F 692 | **Tag F 692 POC accepted on 9/21/23 by St. Stem/P. Cota** | |

resident identified as at risk related to diagnoses and medications for 2 residents [Res.#36 and #10] of 27 sampled residents.
Findings include:

1.) Res.# 36 was admitted to the facility on 1/25/23 with diagnoses that include Chronic Kidney Disease, Morbid (Severe) Obesity, Retention of Urine, and Congestive Heart Failure [Congestive Heart Failure (CHF) occurs when the heart muscle doesn't pump blood as well as it should. When this happens, blood often backs up and fluid can build up in the lungs]. (https://www.mayoclinic.org/diseases-conditions/heart-failure/symptoms-causes/syc-20373142),.
Review of Physician Orders for Res.#36 includes an order for "Furosemide Oral Tablet 80 milligrams-
Give 1 tablet by mouth two times a day for CHF". [Furosemide belongs to a group of medicines called loop diuretics (also known as water pills). Furosemide is given to help treat fluid retention (edema) and swelling that is caused by congestive heart failure, kidney disease, or other medical conditions. It works by acting on the kidneys to increase the flow of urine. In addition to using this medicine, treatment of high blood pressure may include weight control.] (https://www.mayoclinic.org/drugs-supplements/furosemide-oral-route/description/drg-20071281)
Further review of Physician Orders reveals an order dated 3/16/23 for "Weight daily: one time a day for CHF on Furosemide. Notify MD if 5 lb. or more gain in 24 hours".

Per review of the facility's Weights and Heights policy [effective 6/1/01, revised 6/15/22], regarding "Obtaining and Documenting Weight: If the body weight is not as expected, re-weigh the

| 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 08/30/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ST JOHNSBURY HEALTH & REHAB | 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 692 | Continued From page 21 | F 692 | | |

patient".
Under "Significant Weight Change Management", the policy states:
- Significant weight changes will be reviewed by the licensed nurse for assessment.
- Significant weight change is defined as:
- 5% in one month, 10% in six months.
- The licensed nurse will:
- Notify the physician/APP and Dietitian of significant weight changes.
- Document notification of physician/APP and Dietitian in the PCC Weight Change Progress Note.
- The licensed nurse will notify the:
- Physician/APP of the Dietitian recommendations;
- Patient representative of the weight change and Dietitian recommendations.
Notification will be documented."

Review of Res.#36's medical record reveals no documentation of weights completed as ordered on 31 days between 3/16/23 and 6/26/23, when the order was discontinued and changed to weekly weights. Additionally, review of recorded weights reveals weight changes over 24 hours of minus 45 lbs. [3/23: 323 lbs., 3/24: 278 lbs.], a gain of 12.1 lbs. [3/31: 267.4 lbs., 4/1: 279.5 lbs.], a gain of 7.5 lbs. [4/3: 281.5, 4/4: 289 lbs.], and a gain of 30.8 lbs. [4/12: 283.2, 4/13: 314 lbs.] with no reweight to ensure accuracy of the weights or notification of the physician regarding a weight gain of 5 lb. or more in 24 hours per the physician's order.
On 6/26/23, the weight order was changed from daily to weekly weights. Review of weekly weights records a weight loss of 9.6 lbs. over 1 week [7/10: 333.4 lbs., 7/17: 323.8 lbs.] and a weight gain of 14 lbs. in 1 week [7/31: 324 lbs., 8/7: 338

| 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 08/30/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ST JOHNSBURY HEALTH & REHAB | 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 692 | Continued From page 22 | F 692 | | |

lbs.]. Review of Res.#36's medical record reveals no physician notification of the resident's significant weight loss and gain.

Nurses Notes dated 8/15/23 record "chronic edema [swelling caused by too much fluid trapped in the body's tissues] bilateral lower extremities [legs]. Left lower extremity having large amount of drainage ...Notified Physician's Assistant". On 8/20/23, the Physician was notified Res.#36 was reporting pain to h/her legs. Physician assessment notes record "Left leg: with venous stasis changes [a condition of slow blood flow in the veins, usually of the legs] to lower leg noted. Generalized edema, erythema [abnormal redness] extending from foot up leg ...". The Physician ordered the resident sent to the hospital for a "higher level of care".

An interview was conducted with Res.#36's Unit Manager [UM] and the facility's Clinical Lead on 8/29/23 at 11:40 AM. The UM and Clinical Lead confirmed that Physician Orders for Res.#36 included Daily Weights from 3/16/23 to 6/26/23, and the order was not completed on 31 days. Additionally, the UM and Clinical Lead confirmed that Res.#36's medical record included weights with significant losses and gains, with no Physician notification per order and per the facility's Weights and Heights policy.

2.Review of Physician Orders for Resident #10 include an order for Furosemide to treat CHF and fluid retention, starting on 8/21/23 for 14 days, and an order to "Obtain daily weights one time a day for on Furosemide for 14 days," starting on 8/22/23.

Review of Resident #10's medical record reveals

| 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 08/30/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ST JOHNSBURY HEALTH & REHAB | 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 692 Continued From page 23

no documentation of weights completed as ordered on 8/27/23 or 8/28/23.

Per interview on 8/30/23 at 10:30 AM, the Market Clinical Lead confirmed that weights were obtained for Resident #10 as ordered.

F 740 Behavioral Health Services
SS=D CFR(s): 483.40

§483.40 Behavioral health services.
Each resident must receive and the facility must provide the necessary behavioral health care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Behavioral health encompasses a resident's whole emotional and mental well-being, which includes, but is not limited to, the prevention and treatment of mental and substance use disorders.
This REQUIREMENT is not met as evidenced by:
Based on observations, interviews, and record review the facility failed to provide the necessary behavioral health care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being for 1 of 27 residents sampled (Resident #43).

Resident #43 was not provided with behavioral health care services despite their displayed depressed behavior and assessments indicating depression.

Resident #43 was admitted in August 2022 with diagnoses including bipolar disorder, Aspergers syndrome, and anxiety disorder. Resident #43 was observed on 8/28/23 at 9:30 AM, 11:30 AM,

F 692

F740 Specific Corrective Action

F 740

1. A referral for behavioral health services has been initiated for Resident #43.

2. A review of residents has been completed to ensure all residents that require behavioral health services have services in place, referral was placed or refusal has been documented and discussed.

3. Education with licensed staff and social services has been completed in regards to resident needs for behavioral health services and the referral process.

4. The IDT will continue review resident's needs for maintaining the hightest practicable physical, mental and physchosocial well-being.

Any concerns identified will be addressed immediatelyand discussed in QAPI.

Date of Compliance 10/3/23

**Tag F 740 POC accepted on 9/21/23 by St. Stem/P. Cota**

| 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 08/30/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ST JOHNSBURY HEALTH & REHAB | 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 740 | Continued From page 24 | F 740 | | |

and 2 PM sitting in a wheelchair at the bedside in their room with their head down on folded arms resting on the over-bed table. On 8/29/23 Resident #43 was observed in the same place with their head down on folded arms at 9 AM and 3 PM. At 3:15 on 8/28/23 two Licensed Nursing Assistants who were familiar with Resident #43 stated "[s/he] always sits like that". On 8/30/23 Resident #43 was again observed in the same place in the same position at 9:45 AM. During an interview with Resident #43 on 8/28/23 at 9:30 AM they denied attending activities and when asked if they had visitors they stated, "Not really".

A record review of the MDS (Minimum Data Set, a Federal system collecting periodic comprehensive resident data) section D "Mood" revealed on assessments done February 6, 2023, March 12, 2023, and May 26, 2023, Resident #43 admitted "feeling tired or having little energy" and "feeling down, depressed or hopeless". During an interview with the Director of Social Services on 8/29/23 at 2:30 PM they stated awareness of these assessments and confirmed there were no behavioral health care services made available to Resident #43.

F 756 SS=E Drug Regimen Review, Report Irregular, Act On
CFR(s): 483.45(c)(1)(2)(4)(5)

§483.45(c) Drug Regimen Review.
§483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist.

§483.45(c)(2) This review must include a review of the resident's medical chart.

§483.45(c)(4) The pharmacist must report any

F 756 F756 Specific Corrective Action

1. Pharmacy recommendations have been reviewed for Resident #6 and Resident #13, the physician was notified and changes were made and documented.

2. A review of pharmacy recommentations was reviewed and compared to resident records for accuracy, any changes needed were made at the time of the audit.

| 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 08/30/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ST JOHNSBURY HEALTH & REHAB | 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 756 Continued From page 25

irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon.
(i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug.
(ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified.
(iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record.

§483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident.
This REQUIREMENT is not met as evidenced by:
Based on staff interview and record review, the facility failed to ensure that the physician reviewed the pharmacist's medication regimen review recommendations, took action to address the recommendations, and documented the rationale in the resident's medical record for two of five sampled residents (Residents #6 and #13).
Findings include:

F 756 F756 cont...

3. Education was completed with licensed staff in regards to following pharmacy recommendations.

4. The DON/designee will continue to audit that pharmacy recommendations are being reviewed and implemented at the physician's request. Audits to be done weekly x3, biweekly x3 and monthly x3.

Results of audits will be discussed in QAPI.

Compliance Date 10/3/23

**Tag F 756 POC accepted on 9/21/23 by St. Stem/P. Cota**

| 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 08/30/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ST JOHNSBURY HEALTH & REHAB | 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 756 | Continued From page 26 | F 756 | | |

1. Per review of Resident #6's record, the pharmacist identified irregularities and made physician recommendations during the months of October 2022, January 2023, April 2023, July 2023, and August 2023. There is no documentation or evidence of physician acknowledgement of the recommendations, actions taken, or a rationale for the recommendations made for the months of October 2022, January 2023, or April 2023.

Per interview on 8/30/23 at approximately 10:30 AM, the Market Clinical Lead confirmed that no documentation or evidence of physician response could be found for the 3 months in question.

2. Per review of Resident #13's record, the pharmacist identified irregularities and made physician recommendations during the months of August 2022, October 2022, January 2023, February 2023, July 2023, and August 2023. There is no documentation or evidence of physician acknowledgement of the recommendations, actions taken, or a rationale for the recommendations made for the months of August 2022, October 2022, January 2023, or February 2023.

Per interview on 8/30/23 at approximately 10:30 AM, the Market Clinical Lead confirmed that no documentation or evidence of physician response could be found for the 3 months in question.