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

April 25, 2024

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

Dear Ms. Hughes:

Enclosed is a copy of your acceptable plans of correction for the complaint investigation conducted on **March 22, 2024.** 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 03/22/2024

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

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F 000	INITIAL COMMENTS The Division of Licensing and Protection conducted an unannounced, onsight investigation of three facility reoported incidents (ACTS #22403,#22596,and #22492 on 3/19/2024, with off sight investigation continuing through 3/22/24 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	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 demostrate and maintain compliance.	
F 602 SS=D	Free from Misappropriation/Exploitation CFR(s): 483.12 §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to protect residents' rights to be free of misappropriation of property related to medication for one applicable resident (Resident # 1). Findings include: Per review of the facility-reported investigation documentation, on 12/30/23, the facility was running low on the Oxycodone prescription for Resident #1 and was attempting to reorder the medication. The pharmacy reported they could not fill the prescription. Their records indicated the facility had received a 30-day supply on 12/11/23, which consisted of 180 tablets.	F 602	F602 Specific Corrective Action 1. Resident #1 is free from misappropriation and is receiving his prescribed medication. The Identified nurse is no longer employed at any Genesis Center. 2. An audit was completed on all residents medications to validate that there was no issues related to misappropriation of medication. This included accuracy of narcotic counts. 3. Education was completed with licensed nursing staff to ensure they are following the process for validation of amount of narcotics received from the pharmacy. Logging of narcotics, narcotics counting and documentation and to ensure they are following medication administration as ordered. 4. The DON/designee will conduct weekly audits of the narcotic books to ensure the counts and the documention is correct. Weekly audits will also be completed on 20 residents to ensure their medication is being administered per the order. These audits will continue weekly x4, bi weekly x2 and monthly x3. Any concerns/trends identified will be addressed in real time and brought to QA Committee. Date of Compliance 5/6/2024 **Tag F 602 POC accepted on 4/25/24 by D. Hoffman/P. Cota**	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Betty Hughes LNFA | TITLE: Administrator | (X6) DATE: 4-22-24

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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F 602	Continued From page 1 Per record review of the Controlled Substance Logbook on B wing, it was revealed that an entry on 12/11/23, page 143, at 12:55 PM, Oxycodone, was signed by Licensed Practical Nurse #1 (LPN) and LPN #2. The number entered appears to be 90. However, this number is overwritten to indicate an amount of #120. The following four entries are overwritten to suggest that on 12/11 at 12:55 PM, #120 was entered instead of the original #90. Through an interview with LPN #1, the facility concluded that s/he had entered 90 into inventory rather than the #180 that was received from the pharmacy; when LPN #2 did not notice the discrepancy, s/he then overwrote the amount to reflect #120 and removed the remaining #60. Per record review, the facility completed a report with the Vermont Board of Nursing for suspicion of narcotic diversion. by LPN #1. Per interview with Corporate Staff on 3/19/24 at approximately 4:20 PM, they confirmed that the LPN was terminated under suspicion of diversion; they agreed the facility had not protected Resident #1 from misappropriation of his/her medications.	F 602		
F 607 SS=D	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(5)(ii)(iii) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures	F 607	F607 Specific Corrective Action 1. Current licensed staff have been reviewed to ensure they have not be terminated from other facilities for accusations of abuse or non-compliance. 2. Staff that have been terminated for alleged abuse will be added to a shared document. Each Genesis Center and the Regional HR Manager, will be responsible for comparing new hires to this list before offering a position in any of the Genesis Centers. NHA of the Genesis Vermont Centers and Regional HR director will be educated to this process.	

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F 607	Continued From page 2 to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, §483.12(b)(4) Establish coordination with the QAPI program required under §483.75. §483.12(b)(5) Ensure reporting of crimes occurring in federally-funded long-term care facilities in accordance with section 1150B of the Act. The policies and procedures must include but are not limited to the following elements. §483.12(b)(5)(ii) Posting a conspicuous notice of employee rights, as defined at section 1150B(d)(3) of the Act. §483.12(b)(5)(iii) Prohibiting and preventing retaliation, as defined at section 1150B(d)(1) and (2) of the Act. This REQUIREMENT is not met as evidenced by: Based on Record review and interviews, the facility failed to implement its policy and thoroughly investigate the work history of prospective staff. Findings include: Per a record review of a facility-reported incident (FRI), a Licensed Practical Nurse (LPN) was found to be involved in an incident on 12/30/23 in which 60 tablets of Oxycodone were unaccounted for. The FRI also reveals another incident in March 2024 in which the same LPN was named as a person of interest and investigated by a different facility for discrepancies in narcotic administrations. The LPN was terminated from employment as a result.	F 607	3. Education has been completed with center leaders and HR representatives, to include the schedulers and designees to ensure they are communicating non-compliance and disciplinary actions of staff on the shared document and to the persective agency to ensure they are not hired at other centers. In addition to adding non-compliant staff, these same staff were educated on varifying that new hires are not listed as non-compliance before hiring. 4. Audits to ensure new hires are not noted as non-compliant will be done weekly x4, monthly x3. Any concerns/trends identified will be addressed in real time and discussed in QA. Date of Complicance 5/6/2024 **Tag F 607 POC accepted on 4/25/24 by D. Hoffman/P. Cota**	

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F 607	Continued From page 3 A policy titled PS 300 Abuse Prohibition, page 4, #3 states, "The center will screen potential employees for a history of abuse, neglect or mistreating patients, including attempting to obtain information from previous employers and /or current employers and checking with appropriate licensing boards and registries." Per interview with the Clinical Marketing Advisor on 3/19/2024 at approximately 3:30 PM, s/he confirmed the facility did not know about the LPN's involvement with the prior facility regarding narcotics. The facility learned about it when the investigation into this incident was initiated. The facility did not contact previous employers to determine if there were performance issues. An interview with a Human Resources representative on 3/22/24 at approximately 9:40 AM revealed that the LPN was terminated from employment by another facility as a person of interest in misappropriation of narcotics in March 2024. The facility that employed her/him at the time is a sister facility. The LPN was then placed at two more sister facilities, where s/he was terminated for various reasons before employment with this facility. Per interview with the Market Operations Advisor on 3/22/24 at approximately 10:30 AM, s/he revealed that it is the responsibility of the agency placing the employee to check with prior employers for performance, and the facility did not follow their own policy by failing to obtain information about previous performance issues.	F 607		
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3)	F 755	F755 Specific Corrective Action	

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F 755	Continued From page 4 §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to implement a system to reconcile controlled medications consistently and accurately for one applicable resident (Resident #1). Findings include:	F 755	F755 Continued... 1. Resident #1's controlled medications are reconciled and accurate. Licensed staff are following the process in policy NSG 300: Controlled Substances. The narcotic books reflect the pharmacy logs. 2. An audit was completed to ensure implementation of reconciling controlled medications is followed consistendly and accurately . 3. Education was completed with licensed nursing regarding the following controlled drug policy: a) iControlled substances are received in sepa containers b) Licensed nursing staff must accept delivery take responsibility for receipt of controlled substances. c) Two licensed nurses and/or authorized nurs personnel, per state regulations, are require document placement of controlled substanc into inventory. d) A complete count of all Schedule II–IV contr substances is required at the change of shif state regulation or at any time in which narc keys are surrendered from one licensed nur staff to another. The count must be performe two licensed nurses and/or authorized nursi personnel, per state regulations. 4. DNS/Designee will complete audits to validate nurs are following the procedure for counting narcotics as outlined in the Controlled Drug Policy. These audits will weeklyx4, bi-weekly x2, then monthly x 4. Any concerns/trends identified will be addressed in real tim and discussed in the monthly QA Committee. Date of Compliance 5/6/2024 **Tag F 755 POC accepted on 4/25/24 by D. Hoffman/P. Cota**	

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F 755	Continued From page 5	F 755		

Per review of the facility-reported investigation documentation, on 12/30/23, the facility was running low on the Oxycodone prescription for Resident #1 and attempted to reorder the medication. The pharmacy reported they could not fill the prescription. Their records indicated the facility had received a 30-day supply of 180 tablets on 12/11/23.

Per record review of the Controlled Substance Log Book on B wing, it was revealed that an entry on 12/11/23, page 143, at 12:55 PM, Oxycodone, was signed by Licensed Practical Nurse #1 (LPN) and LPN #2. The number entered appears to be 90. However, this number is overwritten to indicate an amount of #120 and signed by LPN #3. The following four entries are overwritten to suggest that on 12/11 at 12:55 PM, #120 was entered instead of the original #90. Those following four entries were signed off with a quantity left of 119, 118, 117, 116 by LPN #2 and LPN #3. The following entry on 12/12/2023 shows the remaining amount of Oxycodone as 115 without overwriting.

Per a record review of the facility investigation report, the facility contacted the pharmacy on 12/31/23 and received written confirmation that the original amount of Oxycodone tablets delivered to the facility on 12/11 was 180.

The facility policy titled "NSG300Controlled Substances: Management of, last reviewed on 4/1/22 states:
"Storage: Two licensed nurses and/or authorized nursing personnel, per state regulations, are required to document the placement of controlled substances into inventory. Ongoing inventory: A

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F 755	Continued From page 6	F 755		

complete count of all Schedule ii-IV controlled substances is required at the change of shifts per state regulation or at any time when narcotic keys are surrendered from one licensed nursing staff to another. The count must be performed by two licensed nurses and/or authorized nursing personnel, per state regulations."
"Discrepancies noted at any step of the process will be reported to appropriate persons. If a discrepancy is noted, the nursing supervisor will be notified and immediately initiate an investigation using the: Controlled Substances Discrepancy Investigation Form". The Administrator and Director of Nursing are responsible for notifying appropriate enforcement agencies, according to state and federal regulations, of any controlled substance discrepancy that cannot be clarified satisfactorily."

Per interview with LPN#2 on 3/19/24 at approximately 2:20 PM, it was revealed that LPN #2 did not follow the procedure as outlined by the facility policy. LPN#2 did not count the inventory of Oxycodone as per the facility policy and did not make sure the narcotic count of Oxycodone was correct between shifts.
A record review of the facility investigation revealed that the facility had reported the incident to the local police and Adult Protective Services and filed a complaint with the Vermont Board of Nursing for suspicion of narcotic diversion.

Per interview with the Clinical Market Consultant on 3/19/24 at approximately 4:20 PM, it was confirmed that the facility concluded that LPN#1 received #180 of Oxcycodone from the pharmacy, s/he submitted #90 into inventory. When LPN #2 did not notice the error, s/he overwrote the amount of Oxycodone inventory to

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F 755	Continued From page 7 reflect the amount of #120. LPN #2 and LPN#3 continued to enter the incorrect remaining amount of Oxycodone without counting the entire inventory.	F 755		