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

May 13, 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 **April 26, 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,

Pamela M Cota RN
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 04/26/2024

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 000	INITIAL COMMENTS The Division of Licensing and Protection conducted an unannounced, onsite investigation of one facility-reported incident and one complaint, including reports #22950 and #22952, on 4/26/24 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's commitment to demonstrate and maintain compliance.	
F 645 SS=D	PASARR Screening for MD & ID CFR(s): 483.20(k)(1)-(3) §483.20(k) Preadmission Screening for individuals with a mental disorder and individuals with intellectual disability. §483.20(k)(1) A nursing facility must not admit, on or after January 1, 1989, any new residents with: (i) Mental disorder as defined in paragraph (k)(3)(i) of this section, unless the State mental health authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission, (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services; or (ii) Intellectual disability, as defined in paragraph (k)(3)(ii) of this section, unless the State intellectual disability or developmental disability authority has determined prior to admission- (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility;	F 645	F645 Specific Corrective Action 1. Resident #1 discharged 4/17/2024. 2. An audit of resident records was completed to validate a full PASARR was completed for those residents, meeting criteria including those that exceeded a 30 day stay at the facility. 3. The facility requires that all admissions have a Preadmission Screening prior to entry into the facility. The facility requires a full PASARR for those individuals with a mental disorder and individuals with intellectual disability if the stay is expected to be >30 days. NHA, Social Services, and DON will be re-educated to this process. 4. NHA/Designee will complete audits to validate residents with a mental disorder and individuals with intellectual disability have a full PASARR completed for stays >30 days. These audits will be weekly x 4 weeks, bi-weekly x 4 weeks, and then monthly x 3 months. Results of these audits will be brought to the monthly QAPI Committee for further review and recommendations. Date of Compliance 5/28/2024	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Beth Hill — TITLE: Administrator — (X6) DATE: 5.13.24

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 645	Continued From page 1 and (B) If the individual requires such level of services, whether the individual requires specialized services for intellectual disability. §483.20(k)(2) Exceptions. For purposes of this section- (i)The preadmission screening program under paragraph(k)(1) of this section need not provide for determinations in the case of the readmission to a nursing facility of an individual who, after being admitted to the nursing facility, was transferred for care in a hospital. (ii) The State may choose not to apply the preadmission screening program under paragraph (k)(1) of this section to the admission to a nursing facility of an individual- (A) Who is admitted to the facility directly from a hospital after receiving acute inpatient care at the hospital, (B) Who requires nursing facility services for the condition for which the individual received care in the hospital, and (C) Whose attending physician has certified, before admission to the facility that the individual is likely to require less than 30 days of nursing facility services. §483.20(k)(3) Definition. For purposes of this section- (i) An individual is considered to have a mental disorder if the individual has a serious mental disorder defined in 483.102(b)(1). (ii) An individual is considered to have an intellectual disability if the individual has an intellectual disability as defined in §483.102(b)(3) or is a person with a related condition as described in 435.1010 of this chapter.	F 645	**Tag F 645 POC accepted on 5/13/24 by K. Ruffe/P. Cota**	

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F 645	Continued From page 2	F 645		

This REQUIREMENT is not met as evidenced by:

Based on staff interview and record review, the facility failed to ensure that residents admitted with mental disorders are screened prior to admission to a nursing facility to determine the appropriateness of admission and the need for specialized services for one of four sampled residents (Resident #1). Findings include:

Per record review, Resident #1 was admitted to the facility on 2/22/24 with diagnoses of major depressive disorder and unspecified mental disorder. Resident #1 was also prescribed an antipsychotic medication (Lurasidone) prior to admission and continued receiving it while admitted to the facility. A pre-assessment screening and resident review (PASRR) Level 1 assessment was not filled out by the discharging hospital. The exemption reason was documented as Resident #1 would be unlikely to need admission greater than 30 days.

Per progress note review, Resident #1 expressed suicidal ideation to facility staff on 4/11/24 and 4/17/24. Resident #1 also eloped from the facility on 4/17/24. Resident #1 did not return to the facility for care after they eloped on 4/17/24 and was formally discharged on 4/22/24. Per review of a local mental health crisis screening note performed on 4/17/24, Resident #1 has had a serious suicide attempt in the past and has been hospitalized within the last 6 months for treatment of their mental illness. Per a social services note from 4/11/24, "This writer and resident discussed [their] past attempts of killing [themselves] via overdosing." There is no evidence in the record that a Level 1 assessment was ever completed on Resident #1 despite Resident #1 being

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F 645	Continued From page 3 admitted well over 30 days. The level 1 PASRR includes questions about a residents' mental health history. The three questions under the mental health section are as follows: - Does this individual have one of the following diagnosis? Schizophrenia, mood disorder, delusional disorder, personality disorder, somatoform disorder, psychotic disorder, anxiety disorder, substance use disorder, none, other mental disorder that may lead to chronic disability - Has this individual had a disability or significant impairment in major life functions in the past six months due to a psychiatric disorder or substance use disorder? - Has this individual had a hospitalization for associated condition or substance use disorder within the past three years? Had the level 1 PASRR been completed, Resident #1 would have been a candidate to have all questions answered as "yes". Per interview on 4/26/24 at approximately 2:30 PM, the Market Operations Lead confirmed that a level 1 PASRR was not completed as required for Resident #1.	F 645		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §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	F 656		

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F 656	Continued From page 4 needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (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 (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). (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 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 on staff interview and record review, the	F 656	Past noncompliance: no plan of	

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F 656	Continued From page 5 facility failed to ensure that each resident had a comprehensive, person-centered care plan that meets their psychosocial needs for one of 4 sampled residents (Resident #1). Findings include: Per record review, Resident #1 was admitted to the facility on 2/22/24 with diagnoses of major depressive disorder and unspecified mental disorder. Resident #1 was also prescribed an antipsychotic medication (Lurasidone) prior to admission and continued receiving it while admitted to the facility. Per progress note review, Resident #1 expressed suicidal ideation to facility staff on 4/11/24. A social services note from this day states, "This writer spoke with resident ... [they] told this writer that [they] wanted to 'kill [themselves]. I can't do this anymore ...' ...This writer and resident discussed [their] past attempts of killing [themselves] via overdosing. Resident stated again [they] wanted to die and requested to go to the hospital." Resident #1 expressed suicidal ideation again on 4/17/24. A nursing note from this day states, "Resident stated to this nurse that [they] wanted to kill [themselves]. Social services and crisis prevention called." Per progress notes, Resident #1 ended up eloping from the facility on 4/17/24 and was ultimately brought to the emergency department for psychiatric evaluation. Per review of Resident #1's care plan, there was no care plan focus or interventions developed for Resident #1's suicidal ideations until 4/17/24. Per interview on 4/26/24 at approximately 3:00 PM, the Director of Nursing confirmed that Resident #1's care plan had not been developed for suicidal ideations in a timely manner to	F 656	correction required.	

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F 656	Continued From page 6 address their psychosocial needs. The facility was able to provide the following evidence of appropriate corrective actions taken place to address this regulatory violation prior to the State Survey Agency's entrance: - Facility-wide education regarding suicidal ideations and suicide care implementation. - Education of the social services director in charge of overseeing care plans. - House-wide audits to assess current state of compliance and ongoing compliance. - Quality improvement projects related to care of residents with suicidal ideations and care planning. As a result, this finding is considered past noncompliance.	F 656		