



**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

June 13, 2024

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

Provider ID #: 475019

Dear Ms. Hughes:

On **June 12, 2024**, we conducted a revisit to the surveys of **March 22, 2024**, and **April 26, 2024**, to verify that your facility had achieved substantial compliance. Based on our revisit, we found that your facility is in substantial compliance with participation requirements found in Title 42, Code of Federal Regulations as of **May 28, 2024**.

If you have any questions concerning this letter, please contact me at (802) 241-0480.

Sincerely,

A handwritten signature in cursive script that reads "Pamela Cota RN".

Pamela Cota, RN  
Licensing Chief

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

PRINTED: 06/13/2024  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>475019</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>R-C</b> <b>06/12/2024</b>
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NAME OF PROVIDER OR SUPPLIER  <b>ST JOHNSBURY HEALTH &amp; REHAB</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>1248 HOSPITAL DRIVE</b> <b>SAINT JOHNSBURY, VT 05819</b>
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(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
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{F 000}	<p>INITIAL COMMENTS</p> <p>The Division of Licensing and Protection conducted an unannounced, onsite revisit survey at the facility on the date indicated in the upper right hand corner of this form. The violation(s) previously identified have been corrected.</p>	{F 000}		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE \_\_\_\_\_ TITLE \_\_\_\_\_ (X6) DATE \_\_\_\_\_

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.