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 Reporting Line (888) 700-5330
To Report Adult Abuse: (800) 564-1612

October 15, 2024

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

RE: Complaint Survey Findings - Past Non-Compliance

Dear Ms. Hughes:

On **September 24, 2024**, the Division of Licensing and Protection, completed a complaint investigation at St Johnsbury Health & Rehab. As a result of that survey, the Division determined that at a point in time prior to the date of our visit you were not in substantial compliance with the federal regulations applicable to long-term care facilities.

Statement of Deficiencies Form CMS 2567

Enclosed is a statement of deficiency generated as a result of the survey. All references to regulatory requirements in the enclosure and in this letter are found in Title 42, Code of Federal Regulations. As the cited deficiencies were corrected at the time of our visit, no plan of correction is required. Please **sign page 1 and return a signed copy of the 2567 to this office.**

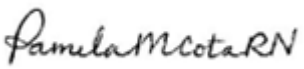
Informal Dispute Resolution (IDR) Opportunity

In accordance with 42 CFR §488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. To be given such an opportunity, you are required to send your written request, along with the specific deficiencies being disputed, including an explanation of why you are disputing those deficiencies, to Pamela Cota, RN, at the Division of Licensing and Protection. Contact information is listed below. Please include if you would prefer a virtual meeting or prefer to submit information in writing for review. This request must be sent during the same ten days you have for submitting your plan of correction. You must still submit a plan of correction for all deficiencies, including those you are disputing, by the due date. An incomplete informal dispute resolution process will not delay the effective date of any

enforcement action. Please note that the following are not allowable disputes in the IDR process: scope and severity of deficiencies, unless they are immediate jeopardy level or constitute substandard quality of care; remedies imposed by CMS; survey process or inconsistency issues; or concerns about the IDR process.

Email (preferred): Pamela.Cota@vermont.gov
Mailing address: Division of Licensing and Protection, attn Pamela Cota
HC 2 South, 280 State Drive
Waterbury, VT 05671-2060
Phone: (802) 241-0480

Sincerely,



Pamela M. Cota, RN, BS
Assistant Division Director
State Survey Agency Director

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 09/24/2024

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 complaint intake # 23294, #22863, #23285, #23273, and a facility reported incident #23160 on 9/24/2024 to determine compliance with 42 CFR Part 483 requirements for Long Term Care Facilities. Regulatory violations were identified during the investigations.	F 000		
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 interviews, the facility failed to assure that residents are free from misappropriation of resident property related to personal funds for one resident (Resident #1) out of three residents sampled. Findings include: Per record review on Resident #1 has diagnoses of Atrial Fibrillation (a condition that causes the heart to beat irregularly), Cellulitis (a serious bacterial infection of the skin), Hypothyroidism (a disease that causes your thyroid to release too little thyroid hormone), and Metabolic Encephalopathy (a disease that causes brain impairment). Per report from APS (Adult Protective Services) received on 7/12/24, Resident #1 gave $400 to LNA #1 (Licensed	F 602	Past noncompliance: no plan of correction required.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Betty Hughes | TITLE: Administrator | (X6) DATE: 10-15-24

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	F 602		

Nursing Assistant) to fix his/her vehicle that had a broken back window. An internal investigation was supplied to the surveyor. Per the investigation and witness statements, LNA #1 was approached by Resident #1 once and declined the $400. Resident #1 approached LNA #1 a second time with $400 in an envelope. LNA#1 accepted the $400 from Resident #1. A police report was made by the Adminsitrator on 7/12/24. On 7/19/24 LNA #1 repaid Resident #1 the $400 she had accepted in an envelope. LNA #1 was terminated on 7/19/24 following the completion of the internal investigation.

Per interview with the facility administrator at 1:46 PM s/he confirmed LNA #1 took the money from Resident #1. . The NE, Administrator, and Clinical Marketing Advisor agreed that the facility did not protect Resident #1 from misappropriation of personal funds.

It was determined that the facility had implemented actions to correct the noncompliance prior to the start of the re-certification survey, which included termination of LPN #1 on 7/19/24. The facility self-reported the concern on 7/12/24 to the state agency and the local police department. The facility also completed an internal investigation that was completed on 7/16/24. In the internal investigation, the facility discussed conducting random interviews with residents and staff asking if they "have or know of any residents offering gifts/money and/or staff accepting gifts/money from residents. The facility will continue to monitor these results weekly x4 and monthly x3." The facility implemented an individualized performance improvement plan for LNA#2 and LNA#3 to re-educate on reporting suspected

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F 602	Continued From page 2 abuse, neglect, or misappropriation of property. LNA#2, LNA #3, and the facility's employees received additional education on the facility's abuse, neglect and misappropriation of property policy, the facility's policy on accepting gifts and gratuities from residents, and the Code of Conduct policy for the facility. The facility was able to demonstrate monitoring of the corrective action and sustained compliance. Works Cited "Atrial Fibrillation." Mayo Clinic. Atrial fibrillation - Symptoms and causes - Mayo Clinic. Accessed September 30, 2024. "Cellulitis." Mayo Clinic. Cellulitis - Symptoms & causes - Mayo Clinic. Accessed September 30, 2024. "Hypothyroidism." Mayo Clinic. Hypothyroidism (underactive thyroid) - Symptoms and causes - Mayo Clinic Accessed September 30, 2024. "Metabolic Encephalopathies." American Academy of Physical Rehabilitation (AAPR). Metabolic Encephalopathies (aapmr.org) Accessed September 30, 2024.	F 602		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in	F 609		

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F 609	Continued From page 3 serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on record review and interviews, the facility failed to develop and/or implement policies and procedures for ensuring the reporting of a reasonable suspicion of a crime in accordance with section 1150B of the Act for 1 resident (Resident #1) of three sampled residents. Findings include: Per report from APS (Adult Protective Services) received on 7/12/24, Resident #1 gave $400 to LNA #1 (Licensed Nursing Assistant) to fix his/her vehicle that had a broken back window. An internal investigation was supplied to the surveyor. Per the investigation and witness statements, LNA #1 was approached by Resident #1 once and declined the $400. Resident #1 approached LNA #1 a second time with $400 in an envelope. LNA#1 accepted the $400 from Resident #1. The alleged misappropriation was overheard by a Unit Manager and was reported to	F 609	Past noncompliance: no plan of correction required.	

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F 609	Continued From page 4	F 609		

APS and the state agency on 7/12/24. On 7/19/24 LNA #1 repaid Resident #1 the $400 she had accepted in an envelope. LNA #1 was terminated on 7/19/24 following the completion of the internal investigation. A police report was filed on 7/12/24.

Per witness statement from LNA #2 dated 7/13/24 states, "About a week ago [LNA #1] came to me and said a Resident offered to help her fix window by giving her money ...I told another [LNA] about it on 7/11/24..." Per witness statement from LNA #3, "On Thursday 7/11/24 [LNA #2] stated "[Resident #1] gave [LNA#1] $400 to fix [LNA #1]'s back window. Please don't tell anybody."

Facility policy titled "OPS300 Abuse Prohibition" states:
"6.1 Anyone that witnesses an incident of suspected abuse, neglect, involuntary seclusion, injuries of unknown origin, or misappropriation of patient property is to tell the abuser to stop immediately and report the incident to his/her supervisor immediately, regardless of shift worked.
6.1.1 The notified supervisor will report the suspected abuse immediately to the Administrator or designee and other officials in accordance with state law."
"7. Immediately upon receiving information concerning a report of suspected or alleged abuse, mistreatment, or neglect, the Administrator or designee will perform the following ..."
"7.2 Report allegations involving abuse (physical, verbal, sexual, mental) not later than 2 hours after the allegation is made."
"7.4 Report allegations to the appropriate state and local authority(s) involving neglect,

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F 609	Continued From page 5	F 609		

exploitation or mistreatment (including injuries of unknown source), suspected criminal activity, and misappropriation of patient property within 24 hours if the event does not result in serious bodily injury."
"7.5 Notify local law enforcement, Licensing Boards and Registries, and other agencies as required."
"7.7 Initiate an investigation within 2 hours of an allegation of abuse that focuses on:
7.7.1 whether abuse or neglect occurred and to what extent."

Per interview with the facility administrator at 1:46 PM s/he confirmed LNA #1 took the money from Resident #1. S/he confirmed that LNA#1 and LNA #2 did not report the misappropriation of money to staff or state agency at the time of notice of this concern. Per interview with the NE, Administrator and Market Clinical Advisor 4:00 PM it was confirmed that LNA #2 and LNA #3 did not report the misappropriation of property immediately and within 24 hours.

It was determined that the facility had implemented actions to correct the noncompliance prior to the start of the re-certification survey, which included termination of LPN #1 on 7/19/24. The facility self-reported the concern on 7/12/24 to the state agency and the local police department. The facility also completed an internal investigation that was completed on 7/16/24. In the internal investigation, the facility discussed conducting random interviews with residents and staff asking if they "have or know of any residents offering gifts/money and/or staff accepting gifts/money from residents. The facility will continue to monitor these results weekly x4 and monthly x3."

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F 609	Continued From page 6 The facility implemented an individualized performance improvement plan for LNA#2 and LNA#3 to re-educate on reporting suspected abuse, neglect, or misappropriation of property. LNA#2, LNA #3, and the facility's employees received additional education on the facility's abuse, neglect and misappropriation of property policy, the facility's policy on accepting gifts and gratuities from residents, and the Code of Conduct policy for the facility. The facility was able to demonstrate monitoring of the corrective action and sustained compliance.	F 609		