

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 29, 2016

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

Dear Mr. Hallisey:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on May 31, 2016. 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
Licensing Chief

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

PRINTED: 06/07/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 475019	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED R-C 05/31/2016
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NAME OF PROVIDER OR SUPPLIER ST JOHNSBURY HEALTH & REHAB	STREET ADDRESS, CITY, STATE, ZIP CODE 1248 HOSPITAL DRIVE SAINT JOHNSBURY, VT 05819
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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}	INITIAL COMMENTS An unannounced onsite revisit was conducted by the Division of Licensing and Protection on 5/31/16. As the result, the following are regulatory findings. F 246 SS=E 483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. This REQUIREMENT is not met as evidenced by: Based on observation and confirmed by staff interview the facility failed provide accommodations of needs for 6 residents, who were left unattended in the activity room, with no mechanism in place to alert staff in an emergency situation. The findings include the following: Per observation at 11:45 AM, 6 residents were located in an activity room unattended. The activity room is located at the end of the hall adjacent to the dietary department. Per interview with the Licensed Nurse Aide (LNA) at 12 noon, confirmation was made that the residents are brought to the activity room for lunch by the unit staff. The LNA confirms that 2 of the 6 residents are able to make their needs known and the remaining 4 can not. The LNA also confirms that there is no system in place for	{F 000}	The filing of this plan of correction does not constitute an admission of the allegations set forth in the statement of deficiencies. The plan of correction is prepared and executed as evidence of the facility's continued compliance with the applicable law. F-246 The six residents in the activity room had no ill effects All Residents have the potential to be affected by the alleged deficient practice. Upon having an IDT meeting regarding the observation of above. The residents in this group have been relocated to a room on B wing. Staff have been re-educated on providing adequate group supervision and assistive devices to prevent accidents. The DNS or designee will conduct weekly audits X's 4 and monthly times 3 to ensure adequate group supervision and that assistive devices available to prevent accidents Results will be reported and reviewed at the QAPI Committee meeting for further recommendation. Compliance Date is 06/17 /2016. F 246 POC accepted 6/16/16 Simmons/AM	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER/REPRESANTATIVE'S SIGNATURE
Shawn T. Hallisey administrator TITLE (X5) DATE 6-16-16

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 250}	<p>Continued From page 2</p> <p>that [Resident #1] was still in pain and not strong enough yet to go home but "lots of things have to happen, like getting stronger, a handicapped van, caregivers...I guess I got to look into it". Per interview on 04/25/16 at 8:25 AM the staff member responsible for medically-related social services acknowledged that a meeting took place in March (2016) but "there hasn't been much movement on getting [Resident #1] home on a temporary basis... some delays in therapy...I am not sure why". The DNS on 04/25/16 at 3:19 PM confirmed there was no care plan written for possible discharge and/or provision of services to meet the needs of the resident, as would be expected from that meeting in March.]</p> <p>Per interview on 5/31/16, with the Social Service worker, Unit Manager and the Director of Nurses all confirm that the current Interdisciplinary Care Plan still does not address discharge planning, depression and pain as it relates to Resident #1's ability to manage his/her everyday physical, mental and psychosocial needs.</p> <p>Per record review social service notes dated as follows: 5/6/16, 5/9/16, and 5/20/16.</p> <p>There is no documented evidence in the medical record identifying that social services has followed up on any of initiatives discussed with family and or the resident. Per interview with the Social Worker confirmation was made that s/he did not follow up as documentation indicated nor is there documentation of any changes that were decided upon through care plan meetings. Per interview with the Occupational Therapist, confirmation is made that s/he was unaware that the resident had any desire to be discharged home nor has there been any discussion</p>	{F 250}		

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{F 250}	Continued From page 3 regarding a home evaluation to determine what adaptations would be necessary for a successful discharge.	{F 250}	
{F 280} SS=D	<p>483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP</p> <p>The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.</p> <p>A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.</p> <p>This REQUIREMENT is not met as evidenced by:</p>	{F 280}	<p>F-280</p> <p>Resident#1 and #2 careplan's have been updated to reflect their current needs.</p> <p>All Residents have the potential to be affected.</p> <p>Residents have had their careplans reviewed and updated as needed.</p> <p>The Interdisciplinary teams have been re-educated and are involved in the careplanning process.</p> <p>Careplans will be audited weekly x's 4, monthly x's 3 by the DNS or designee to ensure compliance. Any omissions researched and corrected. DNS or designee will conduct to ensure compliance. Results will be reported and reviewed at the QAPI meeting for further recommendation.</p> <p>Date of compliance is June 17, 2016</p>

F280 POC accepted 6/17/16 Simmons/Pmc

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{F 280}	<p>Continued From page 4</p> <p>Based on observation, staff interview and record review the facility failed to update the Care Plan for 2 of 4 applicable residents in the sample. (Residents #1 & #2) The findings include the following:</p> <ol style="list-style-type: none"> 1. During observation on 05/31/16 of morning care for Resident #2, a 'U'-shaped pillow was noted by the bedside, the resident was wearing gel-type slippers and a rolled wash cloth was used in the resident's contracted hand. During interview at that time, staff stated that there was a recent computer system change and explained that the current care plan is either a paper copy in a special binder or, if recently updated [within the last few weeks], would be in the computer. Resident #2 had both an old paper copy in the binder as well as a computer generated care plan. However, staff acknowledged the care plan identified as being the current care plan did not have the interventions that was observed during care. The DNS confirmed at 2:40 PM that the current care plan had missing interventions and was not correctly revised to reflect current care and services. 2. Per medical record review for Resident #1 who was admitted on 11/01/12 and readmitted after a hospitalization for aspiration pneumonia on 02/05/16 with diagnosis to include Cerebral Vascular Accident (CVA), Gastro-Esophageal Reflux Disease (GERD), Major Depressive Disorder, convulsions and left sided hand contracture. <p>Per review of the Interdisciplinary Care Plan (ICP), identifies that Resident #1 has a nutritional focus (problem) due to a CVA and needs a mechanically altered diet, depression, chronic</p>	{F 280}	

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{F 280}	<p>Continued From page 5</p> <p>pain issues and GERD. There is no evidence in the current ICP that depression is addressed (other than the nutritional focus), that initiatives that have been tried/have failed or succeeded or what the plan to manage the problem of depression is.</p> <p>Per review of the ICP, identifies that Resident #1 has a focus (problem) of chronic pain related to herniated lumbar discs. There is a notation that identifies that the resident has undergone Botox injections in the past. Per nurses notes dated 05/25/16 the resident left the facility for an appointment with the Medical Doctor (MD) at DHMC. Unit Manger (UM) confirms that the resident did receive a Botox injection, but there is no evidence in the medical record that the treatment was administered, nor is there any evidence that a follow up appointment is necessary. UM confirms that the notes do not reflect what transpired at the appointment nor has the care plan been updated to reflect the treatment provided or pain management with the current changes of treatment.</p> <p>Per interview on 05/31/16, with the Social Service worker, Unit Manager and the Director of Nurses all confirm that the current ICP does not address discharge planning, depression and pain for Resident #1.</p>	{F 280}		
{F 323}	<p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES</p> <p>SS=D</p> <p>The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.</p>	{F 323}		

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{F 323}	Continued From page 6	{F 323}			
	<p>This REQUIREMENT is not met as evidenced by: Based on observation and confirmed by staff interview the facility failed to ensure that for 6 residents, who were left unattended in the activity room, had adequate supervision or assistance in place to alert staff in an emergency situation. The findings include the following:</p> <p>Per observation at 11:45 AM, 6 residents were located in an activity room unattended. The activity room is located at the end of the hall adjacent to the dietary department.</p> <p>Per interview with the Licensed Nurse Aide (LNA) at 12 noon, confirmation was made that the residents are brought to the activity room for lunch by the unit staff. The LNA confirms that 2 of the 6 residents are able to make their needs known and the remaining 4 can not. The LNA also confirms that there is no system in place for the residents to notify staff if they have a need or an emergency situation developed. Residents were observed unattended for a period of time greater then 15 minutes, sitting in chairs around a table without supervision or a manner to alert staff in an emergency</p> <p>Also see F-246.</p> <p>F 441 483.65 INFECTION CONTROL, PREVENT SS=D SPREAD, LINENS</p> <p>The facility must establish and maintain an Infection Control Program designed to provide a</p>		<p>F-323</p> <p>The six residents in the activity room have not been negatively affected.</p> <p>All Residents have the potential to be affected by the alleged deficient practice. Upon having an IDT meeting regarding the observation, the residents in this group have been relocated to a room on B wing.</p> <p>Staff have been re-educated on providing adequate group supervision and assistive devices to prevent accidents.</p> <p>The DNS or designee will conduct weekly audits X's 4 and monthly times 3 to ensure adequate group supervision and that assistive devices available to prevent accidents</p> <p>Results will be reported and reviewed at the QAPI Committee meeting for further recommendation.</p> <p>Compliance Date is 06/17 /2016.</p> <p>F323 POC accepted 6/21/16 Semmens RN/PMC F 441</p>		

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F 441	<p>Continued From page 7</p> <p>safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and interview the facility failed to ensure that the Infection Control program</p>	F 441	<p>F-441</p> <p>Resident #3 had the sign immediately replaced on the door. The resident has been cleared and is no longer required to be on isolation.</p> <p>Resident #2's care of the urinary catheter bag has been corrected.</p> <p>All Residents have the potential to be affected by the alleged deficient practice.</p> <p>Nursing staff have been re-educated on infection control practices.</p> <p>The DNS or designee will conduct audits weekly X's 4 and monthly x's3 monitoring infection control practices.</p> <p>Results will be reported and reviewed at the QAPI Committee meeting for further recommendations.</p> <p>Compliance Date is 06/17/2016.</p> <p><i>F441 POC accepted 6/21/16 senmunsent/llr</i></p>	

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F 441	Continued From page 8 was maintained to prevent the spread and transmission of infection and consistently implement proper infection control measures. (Resident #2 and #3) Findings include: 1. Per observation during the initial tour at 9:22 AM on 05/31/16 Resident #3 was noted to have gloves and gowns stored on the room's door. During interview at that time, staff stated that the resident was "on precautions related to C-diff" (clostridium difficile, a bacterium of the intestine spread through direct or indirect contact). Nursing Staff acknowledged that a visitor may not know what the gown/gloves would signify and that a sign "is usually on the door". Review of the facility's Infection Control Policies and Procedures for contact precautions directs staff to place a "Stop, Please see nurse before entering room" sign on the door, as well as instruct staff and visitors regarding the precautions. During the Noon meal a friend of the family was observed walking into the room, sitting and talking with the patient, without a gown. The Staff Development Director confirmed at 12:26 PM there was no sign on the door to alert visitors of the potential risk of transmission of an microorganisms. A sign was then placed on the door. 2. Per observation on 05/31/16 at 9:30 AM, Resident #2's Foley drainage bag was uncovered and touching the floor. In addition, during provision of incontinence care, the Licensed Nursing Assistant (LNA) did not adhere to Infection Control practices for hand hygiene. Resident #2 was noted to be incontinent of feces. Two LNA's provided care at 10:00 AM. Two LNA's donned clean gloves, one LNA assisting keeping the resident in position for care. The other LNA removed the resident's soiled	F 441			

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F 441 Continued From page 9
brief, cleaned the resident's peri-area (pelvic and bottom area), and applied barrier cream. Without sanitizing and /or removing soiled gloves proceeded to place the soiled brief in a plastic bag, arrange clothing and the draw sheet and touch other personal items. The LNA then removed the soiled gloves, and without sanitizing or washing hands donned new gloves and continued with care. Per interview after the provision of care the LNA stated that the hands are washed after coming out of the resident's room. Additionally, the LNA acknowledged the Foley drainage bag was not covered until just prior to AM care. Per interview at 12:15 PM, the Unit Manager confirmed that staff members were to wash/sanitize hands each time gloves are soiled and removed and the Foley drainage bag should not be directly touching the floor.

F 441

F 514 483.75(l)(1) RES
SS=C RECORDS-COMPLETE/ACCURATE/ACCESSIBLE

F 514

The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.

The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.

This REQUIREMENT is not met as evidenced by:

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F 514 Continued From page 10

The facility failed to maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. This has the potential to effect all residents. Finding include:

Upon entry to the facility on 05/31/16 at 9:15 AM the Nurse Surveyor requested access to the electronic chart, which would include progress notes, assessment documentation, care plans and other pertinent information for provision of resident care. The clinical records were not complete; accurately documented nor readily accessible as follows:

a) The Administrator and DNS stated that they have a new operating system since the first week of June 2016. They acknowledged that not all information from the old electronic charts has been carried over to the new electronic chart.

b) The nurse surveyors made repeated attempts to gain access to the old electronic record for chart review. Nursing staff acknowledged that they are unable, as well, to gain access to the documentation from the previous months which has information, such as the resident's progress, response to treatment, change in condition and treatment, not readily available to the regular nursing staff. The Administrator confirmed "there is a problem with getting into the old electronic system".

c) Upon review for 2 of 4 residents (Residents #1 & #2), the care plans, as evident by documentation, were not complete or accurate. The was confirmed by the DNS at that time. (SEE

F 514

F-514

Resident #1 careplan has been updated to reflect the resident's current condition.

Resident #2 careplan has been updated to reflect the Resident's current condition and his MDS has been corrected to the proper coding for his wound.

All Residents have the potential to be affected.

Residents have had their careplan's reviewed and updated as needed.

The Center has been informed of the procedure for obtaining medical record information via computer from the past company.

The Interdisciplinary teams have been re-educated and are involved in the careplanning process.

The DNS or designee will conduct to ensure compliance weekly x's4, monthly x'3. Results will be reported and reviewed at the QAPI meeting for further recommendation.

Date of compliance is June 17, 2016

F514 POC accepted 6/21/16 Semmons RA/PMC

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F 514	Continued From page 11 F-280)	F 514		
	<p>d) Resident #2's description of a current pressure ulcer, as noted on the Skin Integrity Report as well as the quarterly MDS (minimum data set) dated 05/23/16 was inaccurate. This was confirmed by the MDS coordinator at 3:20 PM.</p> <p>Upon the exit conference the Administrator confirmed the clinical records were not complete, accurately documented nor readily accessible.</p>			