

Division of Licensing and Protection
103 South Main Street, Ladd Hall
Waterbury, VT 05671-2306
<http://www.dail.vermont.gov>
Voice/TTY (802) 871-3317
To Report Adult Abuse: (800) 564-1612
Fax (802) 871-3318

March 28, 2013

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

Dear Mr. Hallisey:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **March 4, 2013**. 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

PC:jl



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

PRINTED: 03/12/2013
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 C 03/04/2013
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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 investigation of an entity self report was completed by the Division of Licensing and Protection on 3/4/13. Based on information gathered, the following regulatory violations were cited.	F 000		
F 155 SS=D	483.10(b)(4) RIGHT TO REFUSE; FORMULATE ADVANCE DIRECTIVES The resident has the right to refuse treatment, to refuse to participate in experimental research, and to formulate an advance directive as specified in paragraph (8) of this section. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to honor the right to refuse treatment for 1 of 3 residents in the applicable sample (Resident #1) when the nurse provided cardiopulmonary resuscitation (CPR) despite knowledge of a Do Not Resuscitate (DNR) designation in the medical record. Findings include: 1. During record review on 3/4/13, the medical record of Resident #1 was found to contain a Living Will document which was signed by Resident #1 and two witnesses on 1/9/2004. The Living Will specified the wishes of Resident #1 as not to receive artificial respiration or cardiopulmonary resuscitation. The physician's orders, signed on 2/14/13, indicated a code status of "Do Not Resuscitate/Do Not Intubate" [which can be abbreviated DNR/DNI]. The Alert Conditions page in the medical record was	F 155		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Shawn I. Hallasey</i>	TITLE <i>Administrator</i>	(X6) DATE <i>3/25/13</i>
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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 155 Continued From page 1
flagged "DNR/DNI". The Kardex card for Resident #1, a reference for staff in providing care according to the written plan of care, contained a DNR/DNI notation. Resident #1 was designated on the face sheet of the medical record as his/her own guarantor. There was no evidence in the medical record of a legally designated guardian or durable power of attorney for healthcare for Resident #1. The facility's written policy statement for Do Not Resuscitate Order states, "Our facility will not use cardiopulmonary resuscitation and related emergency measures to maintain life functions on a resident when there is a Do Not Resuscitate Order in effect".

The nurse notes dated 2/21/13 specified that Resident #1 was found unresponsive at 7:25 AM. The nurse was unable to auscultate (hear with a stethoscope) a heartbeat or blood pressure. The spouse was informed of the DNR designation, yet requested "everything done". The written nurse notes further state that 911 was called, and that the nurse started cardiopulmonary resuscitation at 7:30 AM. During an interview on 3/4/13 at 12:17 PM, the nurse stated that s/he had sent another nurse to check the medical record and s/he was aware of the DNR status for Resident #1 prior to performing CPR on 2/21/13.

F 281 483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS
SS=D

The services provided or arranged by the facility must meet professional standards of quality.

This REQUIREMENT is not met as evidenced by:
Based on record review and staff interview, the

F 155 F155
How will the corrective action be accomplished for those residents found to have been affected by the deficient practice?
~~Resident #1 was discharged from this facility to an acute care facility on February 21, 2013.~~
Resident #1 had been discharged from this facility to an acute care facility on February 21, 2013.

How will the facility identify other residents having the potential to be affected by the same deficient practice?
All residents with a DNR order and/or Advance Directive have the potential to be effected by this alleged deficient practice. All residents medical records have been reviewed for DPOA, Advance Directives and DNR status.

What measures will be put in place to ensure that the deficient practice will not occur?
Nurses, Social Worker, Admissions Coordinator have been reeducated on the adherence to DNR Policy, Advance Directives and DPOA.

How will the facility monitor its corrective actions to ensure that the deficient practice will not reoccur?
An random audit will be conducted for adherence to the DNR policy, Advance Directives and DPOA. There will be random audits 3 times a week for 2 weeks. Weekly random audits for 4 weeks then monthly audits x's 2weeks
Results will be reported through the QA process with interventions as appropriate.

F 281 The Administrator or designee is responsible for this process

accepted by [Signature] for [Signature]

03/25/13

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F 281	<p>Continued From page 2</p> <p>facility failed to assure that nurses met professional standards of nursing practice regarding following physician orders for resuscitation status for 1 of 3 residents in the applicable sample (Resident #1). Findings include:</p> <p>1. During record review on 3/4/13, the medical record of Resident #1 was found to contain a physician's order, signed on 2/14/13, which indicated "Do Not Resuscitate/Do Not Intubate" [which can be abbreviated DNR/DNI]. The nurse notes dated 2/21/13 specified that Resident #1 was found unresponsive at 7:25 AM. The nurse was unable to auscultate (hear with a stethoscope) a heartbeat or measure a blood pressure. The spouse was informed of the DNR designation, yet requested "everything done", per the nurse notes. The written nurse notes further state that 911 was called, and that the nurse started cardiopulmonary resuscitation at 7:30 AM. During an interview on 3/4/13 at 12:17 PM, the nurse stated that s/he had sent another nurse to check the medical record and s/he was aware of the DNR order for Resident #1 prior to performing CPR on 2/21/13.</p> <p>Reference: Lippincott Manual of Nursing Practice (9th ed.). Wolters Kluwer Health/Lippincott Williams & Wilkins.</p>	F 281	<p><u>F281</u></p> <p><u>How will the corrective action be accomplished for those residents found to have been affected by the deficient practice.</u></p> <p>Resident #1 was found unresponsive at 7:25 AM. Resident #1 had been discharged from this facility to an acute care facility on February 21, 2013.</p> <p><u>How will the facility identify other residents having the potential to be affected by the same deficient practice</u></p> <p>All residents with a DNR order and/or Advance Directive have the potential to be effected by this alleged deficient practice. All residents medical records have been reviewed for DPOA, Advance Directives and DNR status.</p> <p><u>What measures will be put in place to ensure that the deficient practice will not occur</u></p> <p>Nurses, Social Worker, Admissions Coordinator have been receducated on the adherence to DNR Policy, Advance Directives and DPOA.</p> <p><u>How will the facility monitor its corrective actions to ensure that the deficient practice will not reoccur</u></p> <p>An random audit will be conducted for adherence to the DNR policy, Advance Directives and DPOA. There will be random audits 3 times a week for 2 weeks. Weekly random audits for 4 weeks then monthly audits x's 2weeks</p> <p>Results will be reported through the QA process with interventions as appropriate.</p> <p>The Administrator or designee is responsible for this process</p>	03/25/13