

## DEPARTMENT OF DISABILITIES, AGING AND INDEPENDENT LIVING

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

June 26, 2014

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

Provider ID #: 475019

Dear Mr. Hallisey:

The Department of Public Safety completed a Life Safety Code Survey at your facility on June 20, 2014. This survey found your facility to be in Substantial Compliance with all Fire Safety and ANSI standards.

Enclosed is the Deficiency Summary Sheet, Form CMS-2567, which requires your signature in accordance with instructions noted on the form. Please return the form to this office no later than **July 6, 2014**.

If you have any questions regarding this report, please do not hesitate to contact me.

Sincerely,



Pamela M. Cota, RN  
Licensing Chief

PC:jl

Enclosure

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

PRINTED: 06/25/2014  
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>01 - 01 BUILDING</b>  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>06/20/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>ST JOHNSBURY HEALTH &amp; REHAB</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1248 HOSPITAL DRIVE SAINT JOHNSBURY, VT 05819</b>		
(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	
K 000	INITIAL COMMENTS  An unannounced onsite Life Safety Code inspection was completed on 6/20/14 by the Division of Fire Safety. The facility was found to be in substantial compliance with applicable Life Safety Code requirements.	K 000			

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.