

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

August 15, 2012

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

Provider #: 475019

Dear Mr. Hallisey:

Enclosed is a copy of your acceptable plans of correction for the survey and complaint investigation conducted on **July 5, 2012**. 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:ne

Enclosure



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

RECEIVED
Division of
AUG 12
PRINTED: 07/17/2012
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 _____	Licensing and Protection	(X3) DATE SURVEY COMPLETED C 07/05/2012
NAME OF PROVIDER OR SUPPLIER ST JOHNSBURY HEALTH & REHAB			STREET ADDRESS, CITY, STATE, ZIP CODE 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	F 000			
F 281 SS=D	<p>483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS</p> <p>The services provided or arranged by the facility must meet professional standards of quality.</p> <p>This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility failed to assure that services being provided met professional standards of quality for 1 resident (Resident #1) of the sample group by failing to follow physician's orders regarding blood tests, and failing to notify the physician of the test results. Findings include:</p> <p>1. Per record review on 7/5/12 Resident #1, whose diagnoses include Diabetes, has physician orders dated 6/13/12 for fasting blood sugar levels to be checked every morning for 10 days, and to call the physician if the level is above 200. Per record review of Resident #1's Diabetic Record (DR) and the Medication Administration Record (MAR) the fasting blood sugar tests were started on 6/14/12, and were to be conducted every morning through 6/23/12. Additionally, both the DR and MAR note the physician's order that if the fasting blood sugar level was above 200 during the 10 days, the physician was to be called.</p> <p>Per interview with the facility's Director of Nursing</p>	F 281	<p>Resident #1 had expired prior to the complaint survey.</p> <p>All residents have the potential to be affected. The medical records of all residents with MD orders regarding blood tests and the notification of the physician of the results of those blood tests have been audited for completeness.</p> <p>The staff nurses have been re educated on the following of MD orders for blood tests and the notification of the MD of test results.</p> <p>The DNS or designee will conduct random audits of MD orders for laboratory tests and the notifying the MD of the results. Daily times 14. Weekly X's 4. Every two weeks times 4. Then Monthly times two. The results of the audit will be brought to the monthly QA meeting and reviewed.</p> <p>F281 POC accepted 8/14/12 TDougherty RN / Pmc</p>	August 1, 2012	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Shawn T. Hallisey

TITLE

Administrator

(X6) DATE

7-31-12

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 281	Continued From page 1 Services (DNS) on 7/5/12 at 1:30 P.M. the DNS confirmed Resident #1's fasting blood sugar levels were recorded on both the DR and the MAR as being greater than 200 for 3 consecutive days in June 2012, and that Resident #1's physician should have been contacted on the first day and again on each day afterward when the levels were that high. The DNS also confirmed there was no documentation anywhere on Resident #1's chart that the physician was contacted, per physician order, until the 3rd time when Resident #1's fasting blood sugar level was tested and registered greater than 200. Additionally, the DNS confirmed that there was no documentation on the DR, MAR, or the resident's medical chart that Resident #1's fasting blood sugar levels were checked on 6/18/12, one of the 10 days covered by the physician's order.	F 281		
F 505 SS=0	483.75(j)(2)(ii) PROMPTLY NOTIFY PHYSICIAN OF LAB RESULTS The facility must promptly notify the attending physician of the findings. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review the facility failed to promptly notify the physician of lab results per physician orders for 1 resident (Resident #1) of the sample group. Findings include: 1. Per record review on 7/5/12 Resident #1, whose diagnoses include Diabetes, has physician orders on 6/13/12 for fasting blood sugar levels to be checked every morning for 10 days, and to call the physician if the level is above 200. Per record	F 505	Resident #1 had expired prior to the complaint survey. All residents have the potential to be affected. The medical records of all residents with MD orders regarding blood tests and the notification of the physician of the results of those blood tests have been audited for completeness. The staff nurses have been re educated on the following of MD orders for blood tests and the notification of the MD of test results. The DNS or designee will conduct random audits of MD orders for laboratory tests and the notifying the MD of the results. Daily times 14. Weekly X's 4. Every two weeks times 4. Then Monthly times two. The results of the audit will be brought to the monthly QA meeting and reviewed. F505 PDC accepted 8/14/12 TDougherty RN/ Pmc	August 1, 2012

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F 505	<p>Continued From page 2</p> <p>review the Physician's History and Physical notes for Resident #1's admission on 6/13/12 report "[blood sugar level] 85 this morning. Discontinue Glyburide [a medication used to control blood sugar levels]. Check fasting blood sugar levels every A.M. for 10 days".</p> <p>Per record review of Resident #1's Diabetic Record, fasting blood sugar level on 6/21/12 is recorded as 239 and on 6/22/12 as 232. On 6/23/12 Resident #1's blood sugar level is recorded as 298. Per record review, Resident #1's physician was sent a fax from h/her nurse listing all the fasting blood sugar levels beginning on 6/14/12 and reporting the resident was refusing h/her nutritional supplement shakes because h/her blood sugar levels "have been high". Per interview with the facility's Director of Nursing Services (DNS) on 7/5/12 at 1:30 P.M. the DNS confirmed Resident #1's blood sugar levels were recorded on both the Diabetic Record and the Medication Administration Record as being greater than 200 for 3 consecutive days in June 2012, and that Resident #1's physician should have been contacted on the first day and again on each day afterward when the levels were that high. The DNS also confirmed there was no documentation anywhere on Resident #1's chart that the physician was contacted, per physician order, until the 3rd time when Resident #1's fasting blood sugar level was tested and registered greater than 200.</p> <p>According to The American Diabetes Association, fasting blood sugar levels should be between 70 and 100. (1) (1) <http://diabetesinformationexchange.com/uncate</p>	F 505		
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