

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
To Report Adult Abuse: (800) 564-1612
Survey Fax: (802) 241-0343

February 12, 2016

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

Provider ID #: 475019

Dear Mr. Hallisey:

The Division of Licensing and Protection completed a survey at your facility on **January 20, 2016**. The purpose of the survey was to determine if your facility was in compliance with Federal participation requirements for nursing homes participating in the Medicare and Medicaid programs. This survey found that your facility was in substantial compliance with the participation requirements. However, there is one deficiency that does not require a plan of correction but does require a commitment to correct. All references to regulatory requirements contained in this letter are found in Title 42, Code of Federal Regulations. Please **sign the enclosed CMS-2567 and return** the original to this office by **February 22, 2016**.

Informal Dispute Resolution

In accordance with §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, and an explanation of why you are disputing those deficiencies, to Suzanne Leavitt, RN, MS, Assistant Division Director, Division of Licensing and Protection. This request must be sent during the same ten days you have for returning the enclosed CMS-2567 statement of deficiencies. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

Sincerely,



Pamela M. Cota, RN
Licensing Chief

Enclosure

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

PRINTED: 01/28/2016
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 C 01/20/2016
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 An unannounced onsite investigation of 1 facility self-reported incident and 1 complaint concerning care and services was completed by the Division of Licensing and Protection on 1/20/16. While the facility was found to be in substantial compliance, the following issues were identified that require correction.	F 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.

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER # 475019	MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	DATE SURVEY COMPLETE: 1/20/2016
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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
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ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
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F 208

483.12(d)(1)-(4) PROHIBITING CERTAIN ADMISSION POLICIES

The facility must not require residents or potential residents to waive their rights to Medicare or Medicaid; and not require oral or written assurance that residents or potential residents are not eligible for, or will not apply for, Medicare or Medicaid benefits.

The facility must not require a third party guarantee of payment to the facility as a condition of admission or expedited admission, or continued stay in the facility. However, the facility may require an individual who has legal access to a resident's income or resources available to pay for facility care to sign a contract, without incurring personal financial liability, to provide facility payment from the resident's income or resources.

In the case of a person eligible for Medicaid, a nursing facility must not charge, solicit, accept, or receive, in addition to any amount otherwise required to be paid under the State plan, any gift, money, donation, or other consideration as a precondition of admission, expedited admission or continued stay in the facility.

However, a nursing facility may charge a resident who is eligible for Medicaid for items and services the resident has requested and received, and that are not specified in the State plan as included in the term "nursing facility services" so long as the facility gives proper notice of the availability and cost of these services to residents and does not condition the resident's admission or continued stay on the request for and receipt of such additional services; and a nursing facility may solicit, accept, or receive a charitable, religious, or philanthropic contribution from an organization or from a person unrelated to a Medicaid eligible resident or potential resident, but only to the extent that the contribution is not a condition of admission, expedited admission, or continued stay in the facility for a Medicaid eligible resident.

States or political subdivisions may apply stricter admissions standards under State or local laws than are specified in this section, to prohibit discrimination against individuals entitled to Medicaid.

This REQUIREMENT is not met as evidenced by:

Based on staff interview and record review, the facility failed to ensure that an individual, who did not have legal access to a former residents' income or resources and had no personal financial liability, was not held liable to provide the facility payment from his/her own personal finances for the resident's stay for 1 of 3 residents in the sample (Resident #4). Findings include:

Per 1/20/16 medical record review, Resident #4 was listed as his/her own responsible party for medical and financial decisions. During an interview on 1/20/16 at approximately 1:45 PM, the facility billing office manager (BOM) confirmed that Resident #4 was his/her own responsible party. Per the BOM, the resident continued to have an outstanding bill following his/her discharge from the facility in June 2015 and the facility enlisted a lawyer to assist with payment collection.

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

The above isolated deficiencies pose no actual harm to the residents

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On November 9, 2015, the facility's attorney sent a letter addressed to Resident #4 and his/her family member requesting payment for the balance owed to the facility that was not covered by insurance. The letter goes on to state that Resident #4's family member may also be "...responsible to pay the debt ... because ...the [family member] signed a certain Admission Agreement as [resident's] "Responsible Party"... and that [the family member] could be held liable for damages ...late fees, interest, and the facility's attorney's fees and other costs of collection.. [and] this letter is the Facility's final demand that you pay or make arrangements to pay the outstanding balance...within thirty (30) days of your receipt of this letter."

Per interview, the BOM reported that although Resident #4's family signed an admission agreement so that care could be provided to the resident, the signature on the admission agreement did not confer financial responsibility to the family member for the resident's stay in the facility. S/he confirmed that the family member should not have been billed and has dropped pursuing payment from him/her.

*This is an "A" level finding.

F 387

483.40(c)(1)-(2) FREQUENCY & TIMELINESS OF PHYSICIAN VISIT

The resident must be seen by a physician at least once every 30 days for the first 90 days after admission, and at least once every 60 days thereafter.

A physician visit is considered timely if it occurs not later than 10 days after the date the visit was required.

This REQUIREMENT is not met as evidenced by:
Based on staff interview and medical record review, the facility failed to assure that the physician visited each resident at least once every 30 days for the first 90 days after admission, and at least once every 60 days thereafter for 1 of 3 residents in the survey sample (Resident #1) Findings Include:

Per 1/13/16 Medical Record review, Resident #1 who was a long term resident in the facility (admitted in 2012) with diagnosis of hypertension, depression, hypothyroidism, dementia, and other chronic medical conditions was not seen by the attending physician every 60 days after the first 90 days of his admission as required by regulations. The resident was seen by his/her physician on 4/14/15 and 6/18/15. On 1/13/16 at 3:00 PM the Director of Nursing (DNS) confirmed that there was no evidence that the resident was seen by his/her physician after the 6/18/15 visit thru the resident's discharge from the facility and admission to the hospital on 10/12/15 (an approximate 4 month interval). The DNS reported that the residents' private physicians keep track of their own schedules of when residents are due for visits and the facility medical record staff keep a check off sheet that visit notes are received prior to filing them in resident's medical records.

*This is an "A" level finding.

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