

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

May 24, 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 **May 8, 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

FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES NO PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 475019	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/08/2013
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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
F 000 F 282 SS=D	<p>INITIAL COMMENTS</p> <p>An unannounced recertification survey and complaint investigation was conducted by the Division of Licensing and Protection from 5/6/13 to 5/8/13. The following are regulatory findings.</p> <p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</p> <p>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>This REQUIREMENT is not met as evidenced by: Based on medical record review, family, staff and administrative staff interviews, and observation, the facility failed to implement the care plan for 1 of 26 residents in the Stage 2 sample (Resident #37). Findings include: Per medical record review on 5/7/13, Resident #37 has a left cervical dystonia/torticollis (defined by the Mayo Clinic as a painful condition in which the neck muscles contract involuntarily, causing the head to twist or turn to one side). Per review of the MDS (minimum data set) quarterly review dated 3/13/13, Resident #37 is nonverbal and requires total assistance for all ADLs (activities of daily living) including transfers and positioning. His/her plan of treatment developed by Occupational Therapy, dated 10/14/11, and confirmed by a staff occupational therapist on 5/7/13 at 2:47 PM as his/her most current plan of care, specified that Resident #37 be positioned safely in a Broda wheelchair with neck/head support when seated. Per observation on 5/6/13,</p>	F 000 F 282	<p><u>F 282</u></p> <p><u>How will the corrective action be accomplished for those residents found to have been affected by the deficient practice.</u> Resident#37 Plan of Care has been reviewed and re-implemented. The facility has had OT re-evaluate the resident for positioning and has implemented recommendations. <u>How will the facility identify other residents having the potential to be affected by the same deficient practice</u> All immobile residents have been re-evaluated for positioning devices and changes have been implemented if needed. And any changes in their Plans of Care have been reviewed with nursing staff <u>What measures will be put on place to ensure that the deficient practice will not occur</u> Licensed nursing staff have been reeducated on following the Plan of Care and keeping it updated to reflect the current needs of the residents.</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Shawn T. Hallisey</i>	TITLE 5-22-13	(X6) DATE
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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 282 Continued From page 1
Resident #37 was seated in his/her wheelchair with his/her neck/head flexed forward and to the left side with no support to the left neck/head. Per interview on 5/6/13 at 3:52 PM with Resident #37's family, who visits one to two times per day, he/she reported that Resident #37's head is not supported when he/she is sitting in his/her wheelchair. Per interview on 5/7/13 at 3:15 PM, an LNA who provides direct care for the resident reported that he/she places a pillow behind the back of Resident #37's head for support; however, he/she does not position another pillow to provide support to his/her left neck/head.

F 282 How will the facility monitor its corrective actions to ensure that the deficient practice will not reoccur
An audit will be conducted for adherence Plans of Care for immobile residents. There will be random weekly audits for 2 weeks. Then monthly audits x's 2.

Results will be reported through the QA process with interventions as appropriate.

The DNS or designee is responsible for this process

F282a POC accepted 5/23/13 K Campos RN/pmc

05/22/13

Per interview on 5/8/13 at 9:45 AM, the B wing unit manager reported that Resident #37's family brought a foam neck support for him/her,, but when it became soiled, it was discarded. He/she confirmed that no neck/head support device was obtained to replace it and no left neck/head support is currently being provided.

F 309 SS=D 483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING

Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.

F 309 F 309
How will the corrective action be accomplished for those residents found to have been affected by the deficient practice.
Resident#37 Plan of Care has been reviewed and re-implemented. The facility has had OT re-evaluate the resident for positioning and has implemented recommendations.
How will the facility identify other residents having the potential to be affected by the same deficient practice
All residents who are immobile and require postioning devices had their Care Plans reviewed and changes have been implemented if needed. And any changes in their Plans of Care have been reviewed with nursing staff

This REQUIREMENT is not met as evidenced by:
Based on medical record review, family, staff and administrative interviews and observation, the facility failed to assure that services were

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F 309

Continued From page 2
provided to meet the highest practicable level of well-being for 1 of 26 residents in the stage 2 sample (Resident #37) regarding proper neck/head support and positioning when seated. Findings include:

Per medical record review on 5/7/13, Resident #37 has a left cervical dystonia/torticollis (defined by the Mayo Clinic as a painful condition in which the neck muscles contract involuntarily, causing the head to twist or turn to one side). Per review of the MDS (minimum data set) quarterly review dated 3/13/13, Resident #37 is nonverbal and requires total assistance for all ADLs (activities of daily living) including transfers and positioning. His/her plan of treatment developed by Occupational Therapy, dated 10/14/11, and confirmed by a staff occupational therapist on 5/7/13 at 2:47PM as his/her most current plan of care, specified that Resident #37 be positioned safely in a Broda wheelchair with neck/head support when seated. Per observation on 5/6/13, Resident #37 was seated in his/her wheelchair with his/her neck/head flexed forward and to the left side with no support to the left neck/head. Per 5/6/13 3:52PM interview with Resident #37's family, who visits Resident #37 one to two times per day, he/she reported that Resident #37's head is not supported when he/she is sitting in his/her wheelchair. Per 5/7/13 3:15 PM interview with an LNA who provides direct care for Resident #37, he/she reported that he/she places a pillow behind the back of Resident #37's head for support; however, he/she does not position another pillow to provide support to his/her left neck/head.

Per interview on 5/8/13 at 9:45AM, the B wing

F 309

What measures will be put on place to ensure that the deficient practice will not occur

Licensed nursing staff have been reeducated on following the Plan of Care and keeping it updated to reflect the current needs of the residents.

How will the facility monitor its corrective actions to ensure that the deficient practice will not reoccur

An audit will be conducted for adherence Plans of Care for immobile residents.

There will be random weekly audits for 2 weeks. Then monthly audits x's 2.

Results will be reported through the QA process with interventions as appropriate.

The DNS or designee is responsible for this process

05/22/13

F309 POC accepted 5/23/13 KcamposRW/pml

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F 309	Continued From page 3 unit manager reported that Resident #37's family brought a foam neck support for Resident #37, but when it became soiled, it was discarded. He/she confirmed that no neck/head support was obtained to replace it and no left neck/head support is currently being provided.	F 309		
F 329 SS=O	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.	F 329	<u>F 329</u> <u>How will the corrective action be accomplished for those residents found to have been affected by the deficient practice.</u> Resident #99 medical record has been reviewed and Physician notified with request for GDR. Physician feels at this time that the Resident has had no periods of aggression and has chosen not to order a GDR at this time. Resident #158 had MD orders vicodan at two different dosages. One of the dosages have been discontinued per MD order. <u>How will the facility identify other residents having the potential to be affected by the same deficient practice</u> All residents are on antipsychotics have been reviewed for a GDR. Mars have been reviewed for pain medications and parameters.	

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F 329

Continued From page 4
This REQUIREMENT is not met as evidenced by:
Based on staff interview and record review the facility failed to assure that 2 of 10 residents (Residents # 99, #158) in the applicable stage 2 sample remained free from unnecessary medications. Findings include:

1. Per record review on 5/7/13 at 2:00 PM, facility staff failed to ensure a physician acted on the a pharmacy consultant's recommendation for a Gradual Dose Reduction (GDR). A faxed form to the physician on 12/14/13 identifies that resident # 99 currently receives Risperidone 0.25 milligrams (mg) twice a day and also receives Lorazepam 0.5 mg twice a day and as needed. Nursing staff requested that the physician consider a reduction of Risperidone to 0.125 mg twice a day. Physician's response: "Why?" Nursing staff responded "This is in conjunction with state mandated reductions in anti-psychotic meds-please advise". Nursing staff refaxed 12/17/12 and 12/27/13 with no response. A Unit Nurse confirmed on 5/7/13 at 2:30 PM that there has not been any response from the physician since December 2012. The Unit Nurse also confirmed on 5/7/13 at 2:30 PM that the nursing staff failed to communicate with the physician since December 2012 on the recommendation for GDR.
2. Per record review on 5/8/13 at 8:45 AM, Resident #158 had medication orders that included "(Vicodin) Hydrocodone 5 mg/APAP 500 mg. One tablet PO Q 4hrs PRN for pain", and "Lortab (Hydrocodone/APAP) 7.5 mg./500 mg. one tab by mouth every 4 hours as needed/pain." The resident had pain daily, and the medication

F 329

What measures will be put on place to ensure that the deficient practice will not occur
Nurses have been reeducated on GDR and the requirements. Nurses have been reeducated on the need for parameters for multiple dosage of the same pain medication.

How will the facility monitor its corrective actions to ensure that the deficient practice will not reoccur

An audit will be conducted for adherence to GDR and for obtaining parameters for pain medications with different dosages. There will be random weekly audits for 2 weeks. Then monthly audits x's 2. Results will be reported through the QA process with interventions as appropriate.

The DNS or designee is responsible for this process

F329 POC accepted 5/23/13 KComposRN/PMC 05/22/13

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F 329	Continued From page 5 was administered daily in May, sometimes at the lower prescribed dose and other times at the higher dose. Per review of the two orders, there were no parameters set for distinguishing which dose would be appropriate to administer to the resident, based on his or her needs for pain control. Per interview on 5/8/13 at 11:10 AM, the A-wing nurse confirmed that these were orders currently in use for two different doses of the same pain medication, and there was no parameters set for staff to determine whether the lower or higher dose was appropriate to administer to the resident.	F 329		
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to store, prepare, distribute and serve food under sanitary conditions. Findings include: Per observation on 5/6/13 at 10:32 AM during the initial tour, the following unsanitary condition was observed in the facility main kitchen:	F 371		

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F 371	<p>Continued From page 6</p> <p>The vents of a modine heater, positioned above a stainless steel prep table where raw vegetables were being prepared, were heavily soiled with dust. The heater was not on the scheduled cleaning list and was situated in direct line with air movement from an operating exhaust fan and an adjacent door.</p> <p>The observations above were confirmed by the Assistant Food Services Manager at the time of the observation.</p>	F 371	<p><u>F 371</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>The Modine heater was cleaned in its entirety. The heater has been placed on a weekly cleaning list.</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 ceiling mounted devices will be placed on a cleaning schedule, and monitored during monthly Unit Inspections. Unit Inspections will be performed by both the Food Service Director and District Manager, ensuring the sanitation of all prep areas.</p> <p><u>What measures will be put on place to ensure that the deficient practice will not occur</u></p> <p>Cleaning will be documented by each shift, and the Food Service Director and Assistant Food Service Director will monitor the cleaning list.</p> <p><u>How will the facility monitor its corrective actions to ensure that the deficient practice will not reoccur</u></p> <p>Food Service Director and District Manager will inspect the Cleaning List weekly to ensure the cleaning is being performed. The results of the weekly audits will be reported to and reviewed by QA monthly.</p>	05/22/13
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F371 PDC accepted 5/23/13 R.Campson/PMC