



AGENCY OF HUMAN SERVICES
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) 241-2345
To Report Adult Abuse: (800) 564-1612
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July 19, 2011

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 conducted on **June 15, 2011**.

Follow-up may occur to verify that substantial compliance has been achieved and maintained.

Sincerely,

Pamela M. Cota, RN
Licensing Chief

Enclosure



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

RECEIVED
Division of

PRINTED: 06/24/2011
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 _____ Licensing and Protection B. WING _____	JUL - 6 11 06/15/2011	(X3) DATE SURVEY COMPLETED
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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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F 000	INITIAL COMMENTS	F 000	<u>How will the corrective action be accomplished for those residents found to have been affected by the deficient practice.</u> Resident#99 Plan of Care has been reviewed and re-implemented. The LNA involved has been re-educated to follow the Plan of Care.	
F 282 SS=D	The Division of Licensing and Protection conducted an unannounced on-site annual recertification survey from 6/13/11 to 6/15/11. The following regulatory violations were identified. 483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on staff interview, observation and medical record review, the facility failed to implement the care plan for 1 of 20 residents in the sample (Resident #99). The findings include: Per record review on 06/14/2011 at 3:50 PM the nurses' notes dated 05/14/2011 describe Resident #99 as having been lowered to the floor by an LNA during delivery of care in the bathroom. The care plan indicates that Resident #99 is to have a 2 person assist when transferring. Per interview with staff on 06/15/2011 at 10:28 AM, the LNA did not follow the care plan in having 2 people assist with transfers. This is further confirmed by a written entry on the care plan that the reason for the resident needing to be lowered to the floor was because the "care plan was not implemented." Refer also to F323.	F 282	<u>How will the facility identify other residents having the potential to be affected by the same deficient practice</u> All residents have had their clinical records audited to identify those with falls and their Plans of Care have been reviewed. The Nursing staff have been re educated in following the Plan of Care. <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. <u>How will the facility monitor its corrective actions to ensure that the deficient practice will not reoccur</u> An audit will be conducted for adherence to fall Plans of Care. There will be random daily audits for 2 weeks. Weekly audits for 4 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 F282 POC Accepted 7/14/11 K. Campos RN P. M. O'Rourke	
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES	F 323		07/15/11

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE
Shawn T. Halliday ADMINISTRATOR TITLE
7.5.11 (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.

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F 323	Continued From page 1 The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to assure that 1 of 3 residents in the sample (Resident #99) received adequate supervision and assistance to prevent accidents. The findings include: Per record review on 06/14/2011 at 3:50 PM the nurses' notes dated 05/14/2011 describe Resident #99 as having been lowered to the floor by an LNA during delivery of care in the bath room. The care plan indicates that Resident #99 is to have a 2 person assist when transferring. Per interview with staff on 06/15/2011 at 10:28 AM, the LNA did not follow the care plan in having 2 people assist with transfers. This is further confirmed by a written entry on the care plan that the reason for the resident needing to be lowered to the floor was because the "care plan was not implemented." Refer also to F282.	F 323	<u>How will the corrective action be accomplished for those residents found to have been affected by the deficient practice.</u> Resident#99 Plan of Care has been reviewed and re-implemented. The LNA involved has been re-educated to follow the Plan of Care. <u>How will the facility identify other residents having the potential to be affected by the same deficient practice</u> All residents have had their clinical records audited to identify those with falls and their Plans of Care have been reviewed. The Nursing staff have been re educated in following the Plan of Care. <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. <u>How will the facility monitor its corrective actions to ensure that the deficient practice will not reoccur</u> An audit will be conducted for adherence to fall Plans of Care. There will be random daily audits for 2 weeks. Weekly audits for 4 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	
F 329 SS=D	483.25(I) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any	F 329		07/15/11

F323 POC Accepted 7/14/11
K.Campes RN / Ancota RN

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F 329	<p>Continued From page 2</p> <p>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.</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review, facility staff failed to assure 1 of 10 residents in the sample (Resident #150) were free from unnecessary medications. Findings include:</p> <p>Per record review on 6/14/11, Resident #150 was administered a duplicate dose of his/her 5:00 PM scheduled medications. A fax to the resident's physician dated 6/13/11 stated that the resident received duplicate doses of Coreg, Glipizide, Ferrous Sulfate, Senna and Colace on 6/13/11 at 5:00 PM/5:45 PM. Per a 6/15/11 9:00 AM</p>	F 329	<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 #150 has had no ill effects from the duplicate medications. The 2 nurses involved with the passing of medications have been instructed and observation has been done on the proper medication pass protocol.</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 have to potential to be at risk. After MAR review there were no other residents found to have medication errors.</p> <p><u>What measures will be put on place to ensure that the deficient practice will not occur</u></p> <p>Licensed nursing staff have been reeducated on the medication pass process which includes the signing off of medications.</p> <p><u>How will the facility monitor its corrective actions to ensure that the deficient practice will not reoccur</u></p> <p>An audit will be conducted for the adherence to Medication pass. There will be random daily audits for 2 weeks. Weekly audits for 4 then monthly audits times 2.</p> <p>Results will be reported through the QA process with interventions as appropriate.</p>	
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F 329	Continued From page 3 interview with the Unit Manager (UM), the UM confirmed that Resident #158 received duplicate doses of the above medications on 6/13/11.	F 329	The Director of Nurses or her designee will be responsible for this process F329 POC Accepted 7/14/11 K. Campos RN / J. McCall RN	07/15/11
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