

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  
Survey and Certification Fax (802) 241-0343  
Survey and Certification Reporting Line (888) 700-5330  
To Report Adult Abuse: (800) 564-1612

July 1, 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 **June 22, 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 **July 11, 2016**. Also note, this survey does not become part of the enforcement cycle that remains open.

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

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

PRINTED: 06/30/2016  
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. WING _____		(X3) DATE SURVEY COMPLETED  <b>06/22/2016</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
F 000	INITIAL COMMENTS  An unannounced, on-site recertification survey was conducted by the Division of Licensing and Protection between 6/20 and 6/22/2016. While the facility was found to be in substantial compliance related to this survey, the following issue was identified that requires 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 #  <b>475019</b>	MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	DATE SURVEY COMPLETE: <b>6/22/2016</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</b>		
ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES		
<b>F 315</b>	<p><b>483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER</b></p> <p>Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.</p> <p>This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility failed to ensure 1 of 2 sampled residents (Resident # 28) restore as much bladder function as possible. Findings include:</p> <p>1. Resident #1 was admitted to the facility on 06/10/16 with a Foley catheter in place following hospitalization. There is no documentation that a plan for services to restore or maintain normal bladder function to the extent possible or education to attempt to have the catheter discontinued as soon as clinically warranted was provided. Per review of the physician's Hospital history and physical (H&amp;P) dated 08/08/16, the resident's diagnoses include chronic atonic bladder, chronic shortness of breath (SOB) and Atrial fibrillation (A-fib). The H&amp;P further states that because of the exacerbation of the chronic SOB the resident was unable to perform the resident's program of intermittent self-catheterization. The physician wrote "interestingly (resident) bladder function has evidently returned to a degree as the residuals are fairly modest considering (his/her) prior history. We will leave the Foley cath in place for now particularly in that we are going to be diuresing."</p> <p>The Nursing Home's care plan states the Resident requires indwelling due to urinary retention and will have no signs and symptoms of urinary tract infection x 90 days. The care plan directs staff to provide catheter care only.</p> <p>Per interview on 06/20/16 Resident #28 stated "I would like to go to an Assisted Living facility, closer to my daughter, who lives (out of state)". The resident was unable to state the future plan for the move or when self catheterization will resume.</p> <p>Interview with the Unit Manager on the morning of 06/22/16 and later in the afternoon with the DNS [Director of Nursing Services], confirmed there is no documentation to show a plan for education to restore or maintain normal bladder function to the extent possible or attempt to have the catheter discontinued as soon as clinically possible.</p> <p>*This is an "A" level citation.</p>		

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The above isolated deficiencies pose no actual harm to the residents