VERMONT

Department of Disabilities, Aging and Independent Living
Division of Licensing and Protection
280 State Drive/HC 2 South
Waterbury, VT 05671-2060
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AGENCY OF HUMAN SERVICES

April 29, 2025

Ms. Alyssa Maker-Lawal, Administrator
St Johnsbury Health & Rehab
1248 Hospital Drive
Saint Johnsbury, VT 05819-9248

Dear Ms. Maker-Lawal:

Enclosed is a copy of your acceptable plans of correction for the complaint investigation conducted on **March 28, 2025.** 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, BS
Assistant Division Director
State Survey Agency Director

Enclosure

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	475019	A. BUILDING _____ B. WING _____	C 03/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST JOHNSBURY HEALTH & REHAB	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 The Division of Licensing and Protection conducted an unannounced, onsite investigation of one complaint (ACTS #23798) on 3/18/25 with additional record review that ensued through 3/28/25 to determine compliance with 42 CFR Part 483 requirements for Long Term Care Facilities. The following regulatory deficiency was identified:	F 000	St. Johnsbury Center for Living and Rehab and Rehabilitation provides this plan of correction without admitting or denying the validity or existence of the alleged deficiencies. The plan of correction is prepared and executed solely because it is required by federal and state law.	3/29/25
F 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure residents remained as free from accidents as possible related to falls for 2 of 3 sampled residents (Residents #1 and #2) by failing to provide adequate supervision and create and implement effective, timely interventions that would reduce the likelihood of future falls. As a result, Resident #1 suffered a fall that resulted in pain and a hip fracture that required surgery. This is a repeat deficiency for this facility, with violations cited during the previous recertification survey dated 12/11/24 and a partial survey dated 10/25/23. Findings include: 1. Per record review, Resident #1 has diagnoses that include history of falls, abnormalities of gait	F 689	Resident #1 and Resident #2 fall care plans have been updated to reflect current needs to address past falls and to prevent/avoid future falls. 1. All Residents residing in the facility have the potential to be affected by the alleged deficient practice. . The facility held an Ad HOC QAPI on 3/27/2025. The team reviewed frequent fallers and did a root cause analysis. The team put in place a new practice that all care plans will be updated within 24 hours post falls for all residents. Education was provided to the team on this change. The facility alleged compliance on 3/29/2025. 2. Education was provided on the facility practice update on fall management to include care plans needing to be updated with new intervention immediately/no later than 24 hours post fall. 3. The DON or designee will audit Risk Mangement in PCC daily for four (4) weeks, then monthly for two (2) months	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
	LNHA	4/25/25

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 689	Continued From page 1 and mobility, muscle weakness, Alzheimer's disease, and paranoid schizophrenia. A 2/3/25 Physician admission note reads, Resident #1 is "transferred here with [his/her spouse] due to increased care needs and inability to perform ADLs [activities of daily living]. [S/He] is [primarily] bed bound at times. [S/He] can and will ambulate in the [facility] with a front wheeled walker." Per record review, Resident #1 has care plan focuses that read, "Resident is at risk for falls: cognitive loss, lack of safety awareness," initiated on 1/31/25, "At risk for falls due to weakness, impaired mobility, history of falls," revised on 2/20/25, and, "[Resident #1] requires assistance/is dependent for ADL care in bathing, grooming, personal hygiene, dressing, eating, bed mobility, transfer, locomotion, toileting) related to: Alzheimer's," initiated on 1/31/2025. Per review of facility risk management reports since 2/1/25, Resident #1 had falls on 2/14/25, 2/17/25, 2/25/25, 3/5/25, 3/6/25, 3/22/25, and 3/24/25. The reports indicate that the falls on 2/14/25, 2/17/25, 3/5/25, 3/6/25, 3/22/25, and 3/24/25 were unwitnessed by staff. A 3/6/25 progress note reads, "Resident observed on the floor by bedside upon entering room after wife calls for help. Resident noted to be lying down on floor by bedside." A 3/7/25 progress note reveals that Resident #1 was transferred to the hospital "[status post] fall evaluation per MD and resident." A 3/7/25 hospital Emergency Room Nurse Practitioner note indicates that Resident #1 presented with right hip pain and was found to have an acute fracture of the right hip requiring	F 689	to review falls and ensure interventions have been put into place and care plans have been updated and to monitor effectiveness of the plan. 4. Monthly fall meetings will be held monthly with the IDT to review past falls to monitor the effectiveness of the interventions. 5. Results of the audits will be reported to the QAA committee x3 months at which time the QAA committee will determine further frequency of the audits. 6. Corrective action was completed by March 29, 2025. **Tag F 689 POC accepted on 4/28/25 by S. Stem**	3/29/25

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surgery. A 3/11/25 facility progress note indicates that Resident #1 returned to the facility on 3/11/25.

A 3/14/25 Nurse Practitioner note reveals Resident #1 is being seen for a follow-up related to "hip pain." The note states, "[S/He] was recently in the hospital due to a fall in which he experienced a right hip fracture. [S/He] had it surgically repaired on 03/08/2025 ... re-orient and more frequent patient checks recommended." A 3/16/25 "Pain Assessment Interview" reveals that Resident #1 reported to have experienced pain frequently over the past 5 days.

Per record review, Resident #1's care plan was not revised after the falls on 3/5/25 and 3/6/25 until 3/10/25, 4 and 5 days after his/her previous falls. The new intervention put into place was "Encourage resident to ring call be to assist with ambulation." Following Resident #1's fall on 3/22/25, Resident #1's care plan was revised with a duplicate intervention, "Encourage resident to ring call bell and wait when assistance is needed." Following Resident #1's fall on 3/24/25, his/her care plan was revised to include "Place walker near bed to encourage use when resident ambulates." This intervention was already added to Resident #1's care plan on 2/20/25. No interventions were put into place following any of the above falls related to providing additional supervision for Resident #1.

Per interview on 3/18/25 at 12:29 PM, Resident #1's roommate and spouse explained that Resident #1 keeps falling because s/he tries to be as independent as possible when s/he should be getting help from staff. S/he explained that staff do not check on Resident #1 enough and worries

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that s/he can't leave the room because Resident #1 will not be supervised and will fall again. S/He stated that Resident #1 has been in "extreme pain" since his/her recent fall.

Facility policy titled "Falls Management," undated, reads "Patients experiencing a fall will receive appropriate care and post-fall interventions will be implemented ... Implement and document patient-centered interventions according to individual risk factors in the patient's plan of care. Adjust and document individualized intervention strategies as the patient condition changes." The policy does not speak to how soon after a fall that a resident's care plan would be required to be updated.

Per interview on 3/27/25 at 10:30 AM, the Director of Nursing and the Vice President of Operations explained that new care plan interventions should be immediate, if possible, but the expectation is that a care plan is updated after a fall within 24 hours.

Per an email from the Administrator on 3/28/25, the facility was unable to produce evidence of timely, effective care plan interventions following Resident #1's falls on 3/5/25, 3/6/25, 3/22/25, and 3/24/25.

2. Per record review, Resident #2's care plan reads, "[Resident #2] is at risk for falls: cognitive loss, lack of safety awareness, Impaired mobility, Parkinson's disease, Osteoarthritis," initiated on 5/30/2024, and "[Resident #2] requires assistance/is dependent for ADL care in bathing, grooming, personal hygiene, dressing, eating, bed mobility, transfer, locomotion, toileting) related to: Impaired balance, Limited mobility,

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F 689	Continued From page 4 unsteady gait, weakness, Dementia, Parkinson," initiated on 5/30/2024. Per review of facility risk management reports since 2/1/25, Resident #2 had falls on 2/3/25, 2/10/25 at 7:45 AM, 2/10/25 at 3:30 PM, 2/23/25, 2/25/25, 2/26/25, 3/12/25, 3/14/25, 3/17/25, and 3/23/25. The reports indicate that the falls on 2/3/25, 2/10/25 at 7:45 AM, 2/10/25 at 3:30 PM, 2/23/25, 2/25/25, 2/26/25, 3/12/25, and 3/23/25 were unwitnessed by staff and Resident #2 suffered a left elbow skin tear following the fall on 2/3/25. Per record review, Resident #2's care plan was not revised following the falls on 2/3/25, 3/15/25, and 3/23/25. Per an email from the Administrator on 3/28/25, the facility was unable to produce evidence of timely, effective care plan interventions following Resident #2's falls on 2/3/25, 3/15/25, and 3/23/25.	F 689		