VERMONT

Department of Disabilities, Aging and Independent Living
Division of Licensing and Protection
280 State Drive/HC 2 South
Waterbury, VT 05671-2060
www.dlp.vermont.gov

[phone] 802-241-0344
[fax] 802-241-0343

AGENCY OF HUMAN SERVICES

June 25, 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 **April 8, 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,

PamelaMCotaRN
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 04/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST JOHNSBURY HEALTH & REHAB	1248 HOSPITAL DRIVE SAINT JOHNSBURY, VT 05819

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F 000	INITIAL COMMENTS The Division of Licensing and Protection conducted an unannounced, onsite investigation of 4 complaints (ACTS #23576, #23593, #23676, and #23703) on 3/5/25 with additional record review that ensued through 4/8/25 to determine compliance with 42 CFR Part 483 requirements for Long Term Care Facilities. The following regulatory deficiencies were identified:	F 000	Saint Johnsbury Center for Living 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	4/9/25
F 841 SS=F	Responsibilities of Medical Director CFR(s): 483.70(g)(1)(2) §483.70(g) Medical director. §483.70(g)(1) The facility must designate a physician to serve as medical director. §483.70(g)(2) The medical director is responsible for- (i) Implementation of resident care policies; and (ii) The coordination of medical care in the facility. This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to ensure that the medical director fulfilled her/his responsibilities to effectively implement resident care policies and coordinate medical care for residents in the facility regarding the surveillance of, and development of policies that reflect current professional standards of practice to prevent the spread of potential COVID-19 infection, and coordinate care of residents. This has the potential to impact all residents. Finding include: Per review of the facility documented COVID-19 outbreak line listing for residents revealed that 12 tested positive for COVID-19 during the period of	F 841	The facility onboarded a new Medical Director on April 4, 2025. The new Medical Director was provided guidance/ policy on coronavirus, prevention and control. All resident care records were reviewed to ensure any gaps in care oversight are identified and rectified. 1.Residents residing in the facility have the potential to be affected by the alleged deficient practice. 2. The DON and Administrator Were Provided Education on Following facilitypolicy on coronavirus, Prevention and control and CDC regulations. The Medical Director reviewed and received the facility policies. 3.The DON or designee will audit The care plans to ensurecare plan Is up to date post a positive covid Test. This will be done daily for 4 weeks and then Monthly for 3 months.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

LNHA | 5/12/25

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 841	Continued From page 1 1/14/25 and 1/26/25. There were no deaths or hospitalizations that resulted from this outbreak. Per interview with an Licensed Nursing Assistant (LNA) on 3/5/25 at 1:00 PM, she/he stated that they were given direction to pull all precaution carts, and to stop testing the residents and staff for COVID-19. She/he stated that these directives came from the DON (Director of Nursing) but she/he was telling staff based on the direction of the Medical Director. Per interview with a staff member on 3/5/25 at 1:20 PM, she/he stated that they were given guidance by the DON "that came down from the Medical Director" that all staff were to stop testing residents and themselves (staff) and that all precautions were stopped. She/he asked to remain anonymous for fear of retaliation. Per interview with an LNA on 3/5/25 at approximately 1:10 PM she/he stated that residents who test positive are placed on "droplet precautions" and that any resident that is placed on droplet precautions are required to stay in their room. She/he stated that there was a short outbreak of COVID-19 back in January of 2025. When asked how the outbreak was managed, she/he stated residents were tested and if they tested positive a precaution cart was placed outside of their room and staff were educated on how to use it's contents. She/he stated that some point, all the precaution carts were removed from the units and she/he had heard that the DON notified the nurses that they were not to test residents for COVID-19 and staff were directed to stop testing. Per interview with VP (Vice President) of	F 841	4. 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. 5. The facility alleges compliance as of April 9, 2025. **Tag F 841 POC accepted on 6/25/25 by J. Kendall/S. Stem**	

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F 841	Continued From page 2 Operations on 3/5/25 at approximately 4:15 PM, she/he confirmed that there was an outbreak at the facility and that the Medical Director did give direction to stop resident testing and staff were directed not to test also. She/he stated that the Medical Director "did not believe in COVID" and that she/he ".....did tell staff to pull the precautions and stop testing the residents for COVID and to treat symptoms like the cold." The surveyor asked if she/he felt this outbreak was well managed, she/he stated "no." She/he stated that the owners of the company met with the Medical Director and reviewed with her/him the Medical Director job description, their expectations of managing the facility, CMS (Centers for Medicare and Medicaid Services) guidelines, managing COVID outbreaks, documentation efficiency, responsibilities in the facility, provider schedule, and support for notes and physician services policy statement specific to job duties. The facility provided documentation specific to a meeting the facility owners had with the Medical Director which revealed the following topics were covered in this meeting: Medelite/Infinite policy Allaire policy CMS guidelines Discuss recent COVID outbreaks Documentation efficiency Responsibilities in the facilities Provider schedule Support for notes New pay structure" Per interview with the Administrator and DON on 3/5/25 at approximately 5:00 PM, both confirmed	F 841		

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F 841	Continued From page 3 that the Medical Director gave direction to pull all the precaution carts and stop testing residents for COVID-19. During this interview, the Administrator, DON, and VP (Vice President) of Operations confirmed that the Medical Director did not follow the facility policy related to Covid-19. Per interview on 3/5/25 at approximately 5:30 PM with the Administrator, DON, and VP (Vice President) of Operations, a request was made by the survey team for additional documentation regarding education that was provided to the Medical Director acknowledging her/his job duties. This documentation was received on 3/7/25 and revealed the Medical Director signed this acknowledgement on 2/21/25.	F 841		
F 880 SS=F	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals	F 880	Residents who were affected by infection control deficiencies have been identified. Immediate correction action was taken, including isolation precautions and updated infection control practices. 1.Residents residing in the facility have the potential to be affected by the alleged deficient practice. 2. Education provided to DON and the administrator on following outbreak criteria provided by the Vermont Department of Health and CDC guidance. 3.The DON or designee will audit the 24-hour report and discuss during clinical meeting for any new COVID-19 cases daily for four (4) weeks, then monthly for two (2) months to ensure the facility is	

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F 880	Continued From page 4 providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens.	F 880	following CDC guidance and infection control practices are being followed. 4. 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. 5. Compliance is alleged as of April 9, 2025. **Tag F 880 POC accepted on 6/25/25 by J. Kendall/S. Stem**	

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F 880	Continued From page 5 Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. This has the potential to impact all residents. Findings include: 1.) Review of the facility documented COVID-19 outbreak line listing revealed that 12 residents tested positive for COVID-19 between 1/14/25 and 1/26/25. Review of an email dated 1/23/25 from VDH (Vermont Department of Health) to this facility, which confirmed VDH's receipt on 1/23/25 of the facility notification of a COVID-19 outbreak with the first onset of symptoms being on 1/14/25. The facility reported to VDH that residents who were COVID-19 positive had "mild cold symptoms." On 1/23/25, the VDH nurse included a copy of a blank line listing and requested the facility "fill it in with as much detail as possible and send it back to me." On 1/27/25 a second email from the VDH nurse was sent to the DON (Director of Nursing) and a cc (carbon copy meaning the email was sent to	F 880		

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F 880	Continued From page 6 another recipient for informational purposes) again requesting the DNS to fill in the line list and return it to the VDH nurse. Review of VDH documentation, revealed on 1/28/25, a call was made to the VDH nurse from the facility administrator advising that the line listing was forthcoming. The facility submitted the line listing to the VDH nurse, which included a list of 13 residents. On 2/7/25, an email confirmation was sent to the DON from the VDH nurse that stated, "what we ask to be reported is any individual who appears to have gotten sick in the facility" and "Any individual who fits that category - staff or resident who appears to have gotten sick by exposure to COVID-19 add that type of individual to the list and forward to me." One resident on the facility's line list did not contract COVID-19 at the facility therefore should not have been on the line list. Review of the line list that was provided to VDH revealed only residents who had tested positive were included and did not include staff members who had tested COVID-19 positive. Interview on 3/5/25 at approximately 1:15 PM with the Administrator, DON, and VP (Vice President) of Operations, it was confirmed that the line listing was not sent to VDH until 1/28/25, two weeks after the first facility positive case of COVID-19, and that there were resident and staff who tested positive for COVID-19. Interview on 3/5/25 at approximately 4:15 PM with the Administrator, DON, and the VP (Vice President) of Operations, confirmed the line listing did not include staff members who had tested positive for COVID-19. The Administrator	F 880		

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F 880	Continued From page 7	F 880		

explained that the VDH nurse told her/him over the phone that if the facility had less than 3 staff members who tested positive for COVID-19 they did not need to be on the line listing. The Administrator stated that only 1 staff member tested positive for COVID-19 during this outbreak.

A phone call received on 3/11/25 at 3:18 PM from the facility VP (Vice President) of Operations, Administrator, DON, and VP (Vice President) of Operations, confirmed they were not able to provide written evidence to support the verbal direction provided by VDH specific to not including COVID-19 positive staff unless there were three or more positive staff cases. At this time it was also confirmed that staff were directed by the DON to stop testing themselves as well as residents per the direction of the Medical Director.

2.) The facility failed to follow facility policy specific to Coronavirus, prevention and control. The facility policy titled, "CORONAVIRUS, PREVENTION AND CONTROL", reviewed/revised 3/5/2025, reads, "The Infection Preventionist has established procedures for monitoring and reporting SARS-COV-2 activity in the facility. The Infection Preventionist maintains close communication and collaboration with local and state health authorities." "The facility will actively monitor every resident for signs and symptoms of SARS-COV-2. Frequency of monitoring will be determined based on guidance from the CDC (Centers for Disease Control), CMS (Centers for Medicare and Medicaid), and DOH (Department of Health). For any resident who develops symptoms of SARS-COV-2: - COVID-19 transmission-based precautions will be initiated in consultation with MD; Testing for SARS-COV-2 will be conducted; Other sources of

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F 880	Continued From page 8	F 880		

infection, including influenza, pneumonia, other respiratory viruses, and / or urinary tract infection will be ruled out, unless otherwise directed by local DOH and / or attending physician."

Per interview on 3/5/25 at approximately 1:00 PM, surveyors were approached by a staff member who requested to remain anonymous stated they were involved in the last COVID-19 outbreak. She/he stated that direction had been given to all staff during the outbreak that staff were to stop testing for COVID-19. She/he stated that this direction came from the DON who is no longer at this facility and originated from the facility's medical director. She/he stated that "they took away all of the precautions in one day." She/he stated that direction was given that all symptoms would be treated like the common cold.

Per interview on 3/5/25 at approximately 1:30 PM, with a staff member who requested to remain anonymous stated, "Dr. [proper name omitted] wanted all COVID testing stopped, that the test was also showing positive for Norovirus, and Influenza and that the test was not accurate. All patients were to be treated for the common cold, and that all testing and precautions were stopped in one day." She/he stated that the staff were not allowed to test themselves and all the N95 masks were pulled from the floor.

Per interview on 3/5/25 at approximately 2 PM, the VP (Vice President) of Operations stated, "the same issues you had with the doctor in Springfield Health and Rehab, you have the same issues with her here." She/he stated "yes, we know that things were not handled correctly with COVID, and things have been corrected." The VP (Vice President) of Operations stated that the

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F 880	Continued From page 9 Medical Director does not believe that COVID-19 is a thing and that treating for the common cold is appropriate in her/his medical opinion.	F 880		
F 882 SS=F	Infection Preventionist Qualifications/Role CFR(s): 483.80(b)(1)-(4) §483.80(b) Infection preventionist The facility must designate one or more individual(s) as the infection preventionist(s) (IP) (s) who are responsible for the facility's IPCP. The IP must: §483.80(b)(1) Have primary professional training in nursing, medical technology, microbiology, epidemiology, or other related field; §483.80(b)(2) Be qualified by education, training, experience or certification; §483.80(b)(3) Work at least part-time at the facility; and §483.80(b)(4) Have completed specialized training in infection prevention and control. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined that that facility failed to ensure the staff member designated as the facility's Infection Preventionist (IP) had obtained specialized Infection Prevention and Control training beyond initial professional training. This has the potential to impact all residents. Findings include: During an interview with the Director of Nursing (DON) on 3/5/25 at approximately 2:45 PM, s/he	F 882	Nursing home infection preventionist training course was completed by the DON on 3/5/25. 1. Residents residing in the facility have the potential to be affected by the alleged deficient practice 2. Education provided to the administrator and DON on infection prevention requirements. 3. The DON or designee will audit the current certifications to ensure that there is an active IP at all times. 4. Results of the audit will be reported to the QAA committee x3 months at which time the QAA committee will determine if any further action is needed. 5. The facility alleges compliance as of April 9, 2025. **Tag F 882 POC accepted on 6/25/25 by J. Kendall/S. Stem**	

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F 882	Continued From page 10 stated that s/he was working as the DON and the Infection Preventionist until they found a replacement for the Infection Preventionist. S/he was working on her/his Centers for Disease Control (CDC) Infection Prevention and Control certification. S/he confirmed that the facility did not currently have a qualified designated Infection Preventionist for this facility. S/he stated that the corporate DON was providing oversight once per week of the infection prevention program. Per interview with the Administrator and the VP (Vice President) of Operations on 3/5/25 at approximately 5:00 PM, it was confirmed that the Infection Preventionist position was being temporarily managed by the DON and that s/he was not currently qualified but was almost done with the CDC Infection Prevention and Control certification. The corporate DON was providing weekly oversight to this and one other facility. The Administrator was asked for documentation of the dates and times the corporate DON had been to this facility since the Infection Preventionist position became unfilled. S/he stated s/he would gather this information and send via email to the survey team. On 3/11/25 the Administrator emailed the survey team the corporate DON's mileage documentation form that included mileage to this facility on 2/20/25 and again on 2/26/25, only two days.	F 882		