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

March 6, 2026

Mr. Shawn Hallisey, Administrator
St. Johnsbury Health & Rehab
1248 Hospital Drive
Saint Johnsbury, VT 05819

Provider ID #: 475019

Dear Mr. Hallisey:

Enclosed is a copy of your acceptable plans of correction for the recertification survey conducted on **January 28, 2026.** 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
Pamela M. Cota, RN, BS
Assistant Division Director
State Survey Agency Director

Enclosure

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 475019	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 01/28/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St. Johnsbury Health & Rehab	1248 Hospital Drive , Saint Johnsbury, Vermont, 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
E0000	Initial Comments The Division of Licensing and Protection conducted an onsite, unannounced survey of the facility's emergency preparedness program on 1/28/2026 during a recertification survey. The following deficiency was identified:	E0000		
E0004 SS = F	Develop EP Plan, Review and Update Annually CFR(s): 483.73(a) §403.748(a), §416.54(a), §418.113(a), §441.184(a), §460.84(a), §482.15(a), §483.73(a), §483.475(a), §484.102(a), §485.68(a), §485.542(a), §485.625(a), §485.727(a), §485.920(a), §486.360(a), §491.12(a), §494.62(a). The [facility] must comply with all applicable Federal, State and local emergency preparedness requirements. The [facility] must develop establish and maintain a comprehensive emergency preparedness program that meets the requirements of this section. The emergency preparedness program must include, but not be limited to, the following elements: (a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be [reviewed], and updated at least every 2 years. The plan must do all of the following: * [For hospitals at §482.15 and CAHs at §485.625(a):] Emergency Plan. The [hospital or CAH] must comply with all applicable Federal, State, and local emergency preparedness requirements. The [hospital or CAH] must develop and maintain a comprehensive emergency preparedness program that meets the requirements of this section, utilizing an all-hazards approach. * [For LTC Facilities at §483.73(a):] Emergency Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually.	E0004	1.) All residents residing in the facility have the potential to be affected by the alleged deficient practice. 2.) The facilities Emergency Preparedness Plan was reviewed and education provided to all staff. 3.) Review and Education of the Emergency Preparedness Plan to all staff will be reviewed monthly @ QAPI	2/27/26

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 reverse for further 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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Shawn T. Tallisey	Administrator	3/2/26

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 475019	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 01/28/2026

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E0000	Initial Comments The Division of Licensing and Protection conducted an onsite, unannounced survey of the facility's emergency preparedness program on 1/28/2026 during a recertification survey. The following deficiency was identified:	E0000	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.	
E0004 SS = F	Develop EP Plan, Review and Update Annually CFR(s): 483.73(a) §403.748(a), §416.54(a), §418.113(a), §441.184(a), §460.84(a), §482.15(a), §483.73(a), §483.475(a), §484.102(a), §485.68(a), §485.542(a), §485.625(a), §485.727(a), §485.920(a), §486.360(a), §491.12(a), §494.62(a). The [facility] must comply with all applicable Federal, State and local emergency preparedness requirements. The [facility] must develop establish and maintain a comprehensive emergency preparedness program that meets the requirements of this section. The emergency preparedness program must include, but not be limited to, the following elements: (a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be [reviewed], and updated at least every 2 years. The plan must do all of the following: * [For hospitals at §482.15 and CAHs at §485.625(a):] Emergency Plan. The [hospital or CAH] must comply with all applicable Federal, State, and local emergency preparedness requirements. The [hospital or CAH] must develop and maintain a comprehensive emergency preparedness program that meets the requirements of this section, utilizing an all-hazards approach. * [For LTC Facilities at §483.73(a):] Emergency Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually.	E0004	1. All residents residing in the facility have the potential to be affected by the alleged deficient practice. 2. The facility's " Emergency Prepareness plan." was reviewed and education provided to all licensed nursing staff. 3. Corrective action will be completed by February 27, 2026. **Tag E 004 POC accepted on 3/6/26 by S. Freeman/S. Stem**	2/27/26

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 reverse for further 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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Shawn T. Hallisey	Administrator	2/20/26

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E0004 SS = F	Continued from page 1 * [For ESRD Facilities at §494.62(a):] Emergency Plan. The ESRD facility must develop and maintain an emergency preparedness plan that must be [evaluated], and updated at least every 2 years. . This STANDARD is NOT MET as evidenced by: Based on interview and record review the facility failed to review and update their emergency preparedness plan annually. Findings include: Per review of the facility Emergency Preparedness Plan (EPP) binder, there was no documented evidence that the EPP had been reviewed and updated during 2025. During an interview with the Licensed Nursing Home Administrator (LNHA) and the Director of Nursing on 1/28/2026 at 11:30 AM the LNHA stated that he had not had a chance to review the emergency preparedness plan since he started a few months ago. Per interview with the Regional Vice President of Operations on 1/28/2026 at 1:30 PM the previous LNHA had reviewed and updated the facility assessment on 7/18/2025 however, there was no documented evidence that the emergency preparedness plan had been reviewed and updated by the previous administration.	E0004		
F0000	INITIAL COMMENTS The Division of Licensing and Protection conducted an unannounced, onsite recertification survey and investigation of one complaint including report #2726979, from 1/25/2026 through 1/28/2026 to determine compliance with 42 CFR Part 483 requirements for Long Term Care Facilities. Deficiencies were cited as a result of this survey.	F0000		
F0552 SS = D	Right to be Informed/Make Treatment Decisions CFR(s): 483.10(c)(1)(4)(5) §483.10(c) Planning and Implementing Care. The resident has the right to be informed of, and participate in, his or her treatment, including: §483.10(c)(1) The right to be fully informed in	F0552	The facility could not retroactively correct the deficiency as it relates to Resident #43. 1. Residents residing in the facility that receive psychotropic medications have the potential to be affected by the alleged deficient practice. 2. The facility's " Informed Consent" and	

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F0552 SS = D	Continued from page 2 language that he or she can understand of his or her total health status, including but not limited to, his or her medical condition. §483.10(c)(4) The right to be informed, in advance, of the care to be furnished and the type of care giver or professional that will furnish care. §483.10(c)(5) The right to be informed in advance, by the physician or other practitioner or professional, of the risks and benefits of proposed care, of treatment and treatment alternatives or treatment options and to choose the alternative or option he or she prefers. This REQUIREMENT is NOT MET as evidenced by: Based on interview and record review the facility failed to ensure that a resident was provided informed consent for 1 of 5 residents (Resident #43). Findings include: Per record review, Resident #43 has a BIMS [Brief Interview of Mental Status] score of 15 as of 1/15/26, indicating they had no cognitive impairment. Resident #43 has major diagnoses of Type II Diabetes and a BKA [Below the knee amputation]. They are independent with ADLs [Activities of Daily Living] and hygiene. Per record review of Resident #43's MAR [Medication Administration Record] contains an order stating, "Venlafaxine HCl [a medication used to treat depression] ER [extended release] Oral Capsule Extended Release 24 Hour 75 MG [milligrams]: Give 75 mg [milligrams] by mouth one time a day." Per record review, the medication was written on 7/3/25 and was discontinued completely on 7/21/25. Per record review, a psychiatric note dated 7/2/25 at 9:19 AM states, "MDD [Major Depressive Disorder], severe, recurrent-start Venlafaxine as above, also helps anxiety." Per record review of the facility's "Psychotropic Medication Administration Disclosure" form [no revision date] states, "It is important that you are fully informed about psychotropic medications. If you have any questions regarding the information contained herein, please direct them to your attending physician or psychiatrist." An interview was conducted with Resident #43 on 1/25/26	F0552	" Antipsychotic Medication Use " policies were reviewed and education provided to all licensed nursing staff (RN's/LPNs) and prescribing providers on the above policies emphasizing that consents must be obtained before the initiation or dose increase of any psychotropic medication. 3. The DON or designee will conduct an audit on all residents currently receiving psychotropic medications to ensure a valid, documented informed consent " Psychotropic Medication Administration Disclosure Form" is on file for each resident with current medications in use. 4. The DON or designee will audit PCC dashboard " psychotropic medication ordered" daily to ensure a valid, documented informed consent " Psychotropic Medication Administration Disclosure Form" was put in place with any new psychotropic medications ordered. The DON or designee will also review physician notes with any changes in current psycotropic medications to ensure they documented consent was obtained from resident/patient and/or resident/patient representative prior to starting and new/changes in psychotropic medications four (4) weeks, then monthly for two (2) months to monitor effectiveness of the plan. 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 will be completed by February 27, 2026.	2/27/26

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F0552 SS = D	Continued from page 3 at 5:49 PM. The resident discussed that they did not receive notice of being put on Venlafaxine, and did not sign a consent form for this medication. On 1/28/26 at 8:49 AM a second interview was conducted with Resident #43. S/he discussed that s/he noticed an extra pill in his/her pill cup during medication administration. S/he was told it was Venlafaxine. S/he stated s/he never signed a consent form and the physician did not speak to him/her about adding Effexor. S/he stated that the facility then removed it from his/her medication list and never spoke to him/her about the medication. Per record review, there was no documented evidence that the resident was provided informed consent An interview was conducted with the DON [Director of Nursing] on 1/27/26 at approximately 1:35 PM. The DON confirmed they did not have a psychotropic consent form for the resident for his/her Venlafaxine.	F0552	**Tag F 552 POC accepted on 3/6/26 by S. Freeman/S. Stem**	
F0578 SS = D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, end/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still	F0578	Resident #3 care plan and physician order have been updated to reflect current code status per resident's COLST 1. All residents residing in the facility have the potential to be affected by the alleged deficient practice. 2. The facility's " Advanced Directives." policy was reviewed and education provided to all licensed nursing staff. 3. The DON or designee will conduct an audit on all residents Advance Directives/COLST status to ensure care plan and physcian order reflect current resident's choices . 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. Corrective action will be completed by February 27, 2026.	2/27/26

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F0578 SS = D	Continued from page 4 legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is NOT MET as evidenced by: Based on interview and record review, the facility failed to ensure accurate advanced directive choices were indicated in the electronic medical record for 1 of 3 sampled residents (Resident #3). This is a repeat deficiency for this facility, with the violation cited during the previous recertification survey dated 12/11/24. Findings include: Per record review of Resident # 3's COLST (Clinicians Orders for Life-Sustaining Treatment) form dated 7/1/2025 revealed the resident chose to decline CPR (cardiopulmonary resuscitation) and desires DNR (do not resuscitate) status. Resident # 3's care plan initiated 6/12/2025 and revised 9/10/2025 stated Resident #3 is a full code indicating the resident would want CPR. A physician's order dated 9/10/2025 reads full code. The EMR (electronic medical record) care profile for Resident #3 has a section for code status that reads full code. This does not match Resident #3's COLST. Per interview with RN Unit Manager of B wing on 1/26/2025 at 2:33 PM stated that they use the residents care profile to identify code status. The unit manager confirmed that the care profile, physician order and care plan did not match Resident #3's COLST form in the EMR. Per interview on 1/27/2026 at 10:40 AM LPN on B wing stated they use the residents care profile to obtain and confirm a resident's code status. Per interview on 1/27/2026 at 10:48 AM with Director of Nursing (DON) confirmed that a resident's code status in the care plan, physician orders, and care profile should match their current COLST form in the EMR.	F0578	**Tag F 578 POC accepted on 3/6/26 by S. Freeman/S. Stem**	
F0628	Discharge Process	F0628		

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F0628 SS = D	Continued from page 5 CFR(s): 483.15(c)(2)(III)(3)-(6)(8)(d)(1)(2); 483.21(c)(2) §483.15(c)(2) Documentation. When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(I)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider. (III) Information provided to the receiving provider must include a minimum of the following: (A) Contact information of the practitioner responsible for the care of the resident. (B) Resident representative information including contact information (C) Advance Directive information (D) All special instructions or precautions for ongoing care, as appropriate. (E) Comprehensive care plan goals; (F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care. §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (I) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman.	F0628	The facility cannot retroactively correct the deficiency as it relates to Residents #22 1. Residents residing in the facility have the potential to be affected by the alleged deficient practice. 2. The facility's policy has been updated to include information related to informing the LTC ombudsman of transfers and discharges. 3. A weekly email will be sent to the LTC ombudsman of all transfers and discharged that occurred that week. 4. Education provided to the Director of Nurses and Social Worker on the new bed hold form and requirements needed. 5.The Director of nurses or designee will review and discuss residents that were transferred out of the building during morning meeting with the IDT. The Director of nurses or designee will audit the transfer/bed hold process weekly for four (4) weeks, then monthly for two (2) months to monitor effectiveness of the plan. 6. 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. 7. Corrective action will be completed by February 27, 2026.	2/27/26
	(II) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (III) Include in the notice the items described in			

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F0628 SS = D	Continued from page 6 paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (I) Except as specified in paragraphs (c)(4)(II) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (II) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (I) The reason for transfer or discharge; (II) The effective date of transfer or discharge; (III) The location to which the resident is transferred or discharged; (IV) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone	F0628	**Tag F 628 POC accepted on 3/6/26 by S. Freeman/S. Stem**	

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F0628 SS = D	Continued from page 7 number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility;	F0628		

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F0628 SS = D	Continued from page 8 (II) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (III) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (Iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. §483.21(c)(2) Discharge Summary When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following: (I) A recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results. (II) A final summary of the resident's status to include items in paragraph (b)(1) of §483.20, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or resident's representative. (III) Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over-the-counter). This REQUIREMENT is NOT MET as evidenced by: Based on interview and record review the facility failed to provide notice of bed hold to 1 of 1 residents in the sample (Resident #22). This is a repeat deficiency for this facility, with the violation cited during a previous partial survey dated 5/28/25. Findings include: Per record review a nursing progress note dated 6/15/25 reflects that Resident #22 was sent to the hospital emergency department during an emergent medical event.	F0628		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 475019	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 01/28/2026

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F0628 SS = D	Continued from page 9 Per record review there was no bed hold notice in the resident's chart. There was no documented evidence showing the Long-Term Care Ombudsman was notified of the hospitalization. Per review of the facility's "Bed Holds and Returns" policy [no revision date] states, "In the event of an emergency transfer of a resident, the facility will provide written notice of the facility's bed hold policies to the resident and/or the resident representative as soon as practicable...The facility will keep a copy of the bed hold notice information given to the resident and/or resident representative in the medical records." The facility's policy did not include information related to informing the LTC ombudsman of transfers and discharges. On 1/27/26 at 11:58 AM the social worker confirmed that she could not find a bed-hold on computer or hard copy. On 1/27/26 at 3:00 PM the DON [Director of Nursing] and social worker confirmed the Ombudsman was not notified and that there was no bed-hold.	F0628		
F0689 SS = E	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 observation, interview, and record review the facility failed to ensure that 2 of 4 sampled residents were free from accident hazards related to supervision and fall hazards (Resident #25), wheelchair and device maintenance (Residents #25 and Resident #50), and smoking safety for 1 of 1 sampled resident (Resident #71). This is a repeat deficiency for this facility, with the violation cited during the previous recertification survey dated 12/11/24 and two partial	F0689	The facility could not retroactively correct the deficiency as it relates to Resident #25 fall interventions. Resident #25 anti-rollback device to W/C has been fixed. Resident #25 floor in room has been fixed. Resident #71 Cigerettes' and lighter have been removed from the room and placed in the medication cart. 1. Residents residing in the facility that are at risk for falls, have anti-rollback devices on their W/C and who smoke have the potential to be affected by the alleged deficient practice. 2. The facility's "Accidents and Incidents" and "Managing Falls and Fall Risk" policy was reviewed and education has been provided to licensed Nursing staff (RN's/LPNs), UM, DON emphasizing on timely interventions being put into place to	

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F0689 SS = E	Continued from page 10 surveys dated 3/28/25 and 7/24/25. Findings include: 1. Per a record review, Resident #25 has diagnoses that include Alzheimer's disease, cognitive communication deficit, abnormalities of gait and mobility, lack of coordination, muscle weakness, and history of falling. Resident #25 has a care plan focus of "ADL [activities of daily living] self-care deficit related to physical limitations" with an intervention dated 9/19/25 for extensive assist of 1 with transfers. Resident #25 also has a care plan focus of "At risk for falls due to history of falls, impaired balance/poor coordination" with interventions dated 9/19/25 of call bell in reach, encourage to transfer and change positions slowly, and therapy evaluation and treatment per physician orders. A nursing progress note dated 9/25/25 reflects that Resident #25 sustained a fall while attempting to self-transfer and states, "It was brought to this writers attention by staff that resident slid to the floor in front of the nursing station, Resident was trying to stand and grab on to the snack cart. This was a witnessed fall. Resident was assisted by staff back to wheelchair." There was no new fall interventions added to Resident #25's care plan at this time. A nursing progress note dated 1/18/26 references periods that the resident had been transferring themself to bed without staff assistance and reads, "Resident presented with increased confusion, weakness and foul smelling urine. new orders for u/a [urinalysis] to be obtained. spoke with [Resident #25's responsible party] via telephone and updated on orders and plan of care. Also spoke regarding periods of putting self into bed and removing own brief." There was no new fall interventions added to Resident #25's care plan at this time. Per observation on 1/25/2026 at 4:55 PM Resident #25 was self-propelling around the unit in a wheelchair. The wheelchair was noted to have an anti-rollback device (a safety mechanism that functions as a break and prevents backward movement of the wheelchair when a person attempts to stand from a seated position) installed. When the Resident was asked how s/he was s/he stated, "I fell today." S/he denied having any pain. The Director of Nursing approached and confirmed that the Resident had experienced a fall earlier that day.	F0689	prevent future falls. 3. The facility's "smoking policy" was reviewed and education provided to license nursing staff on proper storage of smoking material as per policy. 4. Education provided to staff on the TELS process ensuring work orders are inputted into TELS. 5. Schedule has been implemented for maintenance to inspect W/C breaks, W/C with anti-roll backs in place to ensure working properly. 6.The DON or designee will audit all new falls for (4) weeks, then monthly for two (2) months to ensure interventions are being put in place timely to relfect current needs and to monitor effectiveness of the plan. 7. The DON or designee will do random observational audit on residents that smoke to ensure smoking material is being kept with nursing and not in their rooms for (4) weeks, then monthly for two (2) months to monitor effectiveness of the plan. 8. Environmental rounds to be done for (4) weeks, then monthly for two (2) months to capture any ebvironmental issues/concerns and to monitor the effectiveness of the plan. 8. 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. 9. Corrective action will be completed by	2/27/26

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F0689 SS = E	Continued from page 11 Per observation on 1/25/26 at 5:50 PM, Resident #25 was observed walking alone in his/her room. An LNA (Licensed Nursing Assistant) entered the room and assisted her/him to the wheelchair and wheeled her/him out of their room. The LNA then parked her/him in the hall outside of her/his room, locked the left brake of the wheelchair, and walked away. As soon as the LNA walked away, Resident #25 began to self-propel down to the other nursing unit without difficulty with the left brake engaged. At 6:07 pm, Resident #25 returned to the nursing unit and was observed self-propelling their wheelchair backwards down the hallway without difficulty, with the left brake still engaged. Review of Resident #25's care plan revealed that the focus "At risk for falls due to history of falls, Impaired balance/poor coordination" was updated on 1/25/26 with an intervention stating, "Reinforce wheelchair safety as needed such as locking brakes." However, the left brake was currently defective. A late entry nursing progress note written on 1/26/26 states, "Late entry from 1/25/2026. At 1330 [1:30 PM] resident had an unwitnessed fall in [her/his] room. [S/he] was attempting to get out of bed with no assist. [S/he] was assessed for injury at this time with an abrasion noted to [his/her] left shoulder with no complaints of pain and or discomfort at this time. [S/he] was assisted up to [his/her] wheelchair." Per observations made on 1/26/26 at 2:49 pm, Resident #25's anti-rollback device was not engaging when the wheelchair was pulled backward without the Resident in it. Further observation revealed that when attempting to engage the left-hand standard brake it was very loose and unable to engage properly allowing the wheel to move freely. During an interview with the DON (Director of Nursing) and the Regional Director of Quality and Compliance on 1/26/26 at 3:49 pm, the Regional Director of Quality and Compliance confirmed that anti-rollback devices should engage when the person removes their weight by standing up prohibiting the chair from moving. The DON stated that the anti-rollback device had already been installed on Resident #25's wheelchair prior to the fall on 1/25/26, but it had been added to the care plan when she noted it was already on the wheelchair. She also stated that the devices are installed by their maintenance department after a work order is initiated.	F0689	**Tag F 689 POC accepted on 3/6/26 by S. Freeman/S. Stem**	

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F0689 SS = E	Continued from page 12 During the interview with the DON, Resident #25's wheelchair was observed by the DON who confirmed that the anti-rollbacks did not engage when the empty wheelchair was pulled backwards. The DON also confirmed that the left standard break was loose and did not engage correctly, allowing the wheelchair to move when the left break appeared to be locked. Per observation of the unit on 1/27/2026 at 8:51 AM Resident #25 was seen self-propelling into her/his room. The Resident stood from her/his wheelchair and self-transferred onto the unmade bed. There was an overbed table with the table-top positioned across the bed between the head and foot of the bed, impeding the Resident from putting their legs up on the bed. While lying on the bed, the Resident raised her/his legs and put them on top of the over-bed table. The Resident then took their legs off the over-bed table and brought themself to a sitting position on the window side of the bed and attempting to move the over-bed table out of their way. S/he stood up from the bed and tried to move the over-bed table without success. Resident #25 then lay down on their back positioned with their knees bent up on the top half of the bed. At 8:59 AM staff were unaware that the Resident had self-transferred into bed. At 9:00 AM the Resident was moving about in bed shifting around to move the over-bed table. At 9:01 AM an LNA entered the room with linens and closed the door. Per interview on 1/27/2026 at approximately 2:00 PM the DON stated that Resident #25 was being placed on 1-1 staff supervision for safety. Per interview on 1/28/26 at 8:41 am with the facility Director of Maintenance, when discussing the facilities preventative maintenance (PM) program he stated that wheelchairs are not inspected as part of their PM program. He stated that when a Resident requires anti-rollback devices to be installed, nurses complete a work order. The Director of Maintenance confirmed that on 1/27/2026 when he inspected Resident #25's anti-rollback device, they found that it was not working correctly. He stated that when the devices are installed, they are tested. If nursing staff or therapy add a cushion to the wheelchair, it changes the spring tension on the anti-rollback device making it ineffective. The wheelchair should be returned to maintenance for installation of a different spring and re-testing. He stated that they inspected 21 wheelchairs in the facility on the prior day (1/27/26)	F0689		

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F0689 SS = E	Continued from page 13 and found "2 or 3 more with the same issue." The Director of Maintenance stated he had not inspected or repaired the loose ineffective left standard brake on Resident #25's wheelchair as he had not been told to do so. Per observation with the Director of Nursing on 1/28/26 at 12:46 pm, she confirmed that the left standard brake on Resident #25's wheelchair was still not operating correctly. 2. Per observation on 1/26/26 at 2:52 pm, there was a carpeted/rubber entry style mat seen between Resident #25's bed and window. The mat was placed in a way that one corner of it was lifted several inches on the corner of the bed, creating a trip hazard. When the mat was lifted, it was revealed that the flooring was damaged with a large portion of flooring missing. Per interview with the DON on 1/26/26 at 3:49 pm, when asked if there were any repairs planned for Resident #25's room she was aware of the mat and the damaged flooring in Resident #25's room she stated that the plan was to move Resident #25 out of the room with the damaged floor but that right now, the "highly visible room is safer." During the interview the mat was observed with the corner still lifted on the corner of the bed and she confirmed that it should not be. Per interview on 1/27/2026 at 2:10 PM the facility Administrator stated that he had not been aware of the damaged flooring. He confirmed that there should not be a mat over the damaged flooring and that it should have been fixed when it occurred. Per an interview on 1/28/26 at 8:41 am with the facility Director of Maintenance, he became aware of the damaged floor in June 2025. There had been a plan to purchase the flooring, and a maintenance director from another one of their facilities would come and show them how to install the new floor. The Director of Maintenance stated there was communication back and forth for 5 to 6 weeks and it never happened. 3. Per record review Resident #71 has a BIMS [Brief Interview of Mental Status] score of 13 as of 11/5/25, indicating they have little cognitive impairment. Resident #71 has major medical diagnoses of hemiplegia	F0689		

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F0689 SS = E	Continued from page 14 (paralysis that affects one side of the body), nicotine dependence, and MDD [Major depressive Disorder]. S/he is independent with ADLs [Activities of Daily Living] and hygiene. Per record review, Resident #71 is a cigarette smoker. Resident #71's care plan states, "[Resident #71] may smoke independently per smoking evaluation. Goal: [Resident #71] will smoke safely per smoking assessment through the next review... Lighters, lighter fluid or matches must be maintained by center staff." An interview was conducted with Resident #71 on 1/28/26 at 12:10 PM. Resident #71 stated s/he keeps his/her cigarettes and lighter in his/her room. The resident was observed coming back into the facility after smoking and returning to his/her room without handing his/her cigarettes or lighter to a staff member on the unit. Per record review of the facility's "Smoking Policy-Residents" policy [last revised 3/21/16] states, "Residents who have independent smoking privileges shall not be permitted to keep cigarettes, pipes, tobacco, or other smoking articles in their possession. Resident smoking paraphernalia will be maintained in a locked area in the smoking cart to be distributed to the smoking monitors as per the smoking schedule. Residents will have limited access to smoking materials except as per policy and smoking schedule." Per observation of Resident #71's room on 1/27/26 at approximately 12:50 PM there was a used cigarette on the resident's bedside table. RN [Registered Nurse] #1 confirmed that the cigarette should not be in the resident's room. An interview was conducted with the Unit Manager on 1/27/26 at 12:46 PM. She stated the resident's cigarettes were kept in the medication room; and confirmed that the cigarettes were missing from the medication room.	F0689		
F0756 SS = D	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist.	F0756	The facility could not retroactively correct the deficiency as it relates to Resident #49. 1. Residents residing in the facility that receive medication have the potential to be affected by the alleged deficient practice. 2. The faciliy's "Pharmacy consultant	

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F0756 SS = D	Continued from page 15 §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (I) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (II) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (III) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is NOT MET as evidenced by: Based on interview and record review the facility failed to ensure that Medication Regimen Reviews were performed by the Consulting Pharmacist and acted on for one of five sampled residents (Resident #49). Findings include: 1.Per record review, Resident #49 did not have MRRs (Medication Regimen Reviews, a review of the resident's medications with recommendations from the pharmacist) for January 2025, February 2025, March 2025, and May 2025. Per review of "Pharmacy Consultant Policy & Procedure" policy [no revised or reviewed date] states, "The pharmacist will report any irregularities to the	F0756	policy & procedure" policy was reviewed and education provided to the Director of nurses and Providers emphasizing on ensuring the Medication Regimen Reviews are being addresed timely. 3. The Director of Nurses or designee will audit the pharmacy medication regimen reviews weekly for four (4) weeks for any new admission recommendations and monthly for two (2) months to monitor monthly pharmacy recommendations. 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. Corrective action will be completed by February 27, 2026. **Tag F 756 POC accepted on 3/6/26 by S. Freeman/S. Stem**	2/27/26

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F0756 SS = D	Continued from page 16 attending physician and the Director of Nursing, and these reports must be acted upon... The attending physicians are not required to agree with the pharmacist's report, nor are they required to provide a rationale for their "acceptance" or "rejection" of the report. They must, however, act upon the report. This may be accomplished by indicating acceptance or rejection of the report and signing their name." Additionally, it states "The pharmacy consultant will do a monthly review of the medication administration record to assure the accurate acquiring, receiving, dispensing, and administration of all drugs and biologicals to meet the needs of each individual resident." Per interview on 1/27/26 at 12:30pm, The Director of Nursing confirmed that there was no evidence that MRRs for the months of January, February, March, and May of 2025 had been conducted.	F0756		
F0761 SS = D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is NOT MET as evidenced by:	F0761	Verified that all nursing unit have access to the treatment cart key. 1. Residents residing in the facility have the potential to be affected by the alleged deficient practice. 2. The facility's " Storage of Medications" policy was reviewed and education provided to the licensed nursing staff (RNs, LPNs) emphasing on expired medications and ensuring the at medication carts/treatment carts are locked at all times. 3. The DON or designee will audit medicatior room for expired medication for (4) weeks, then monthly for two (2) months to monitor effectiveness of the plan. 4. The DON or designee will do random observational audit to ensure medication carts and treatment carts are locked at all times for (4) weeks, then monthly for two (2) months to monitor effectiveness of the plan. 4. Results of the audits will be reported to the QAA committee x3 months at which time the QAA committee will	

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F0761 SS = D	Continued from page 17 Based on observations and interviews the facility failed to ensure that drugs and biologicals used in the facility are within their expiration date and failed to secure medications for 1 of 2 medication treatment carts. This is a repeat deficiency for this facility, with the violation cited during a previous partial survey dated 5/28/25. Findings include: 1. Per observation on 1/26/2026 at 10:14AM Unit B's medication room contained five covid-19 vaccinations with an expiration date of 6/9/2025 in the freezer. Review of a policy titled "Storage of Medications" states: "Unused medications: The pharmacy and all medication rooms are inspected by the pharmacist consultant for discontinued, outdated, defective or deteriorated medications." Per interview on 1/26/2026 at approximately 10:30 AM the Registered Nurse (RN) Unit Manager of B wing confirmed the items were ready for use and expired. 2. Per observation on 1/26/26 at 3:52 PM, the medication treatment cart was observed to be unlocked at the nursing station. There were two residents at the nursing station, one who self-propels via wheelchair, and one who walked with a rolling walker. At 4:02 PM, nursing staff left the nursing station, no staff were observed interacting with the medication treatment cart. The medications observed in the medication treatment cart with a Licensed Practical Nurse (LPN) included a wound wash, nystatin, and medicated hemorrhoid cream. Per interview on 1/28/26 at 4:08 PM, a Licensed Practical Nurse (LPN) confirmed that there were medications in the treatment cart and stated that the medication treatment cart should be locked and then locked the medication treatment cart. Per review of the facility policy titled "Storage of Medications" policy [no revised or reviewed date] states, "All drugs and biologicals will be stored in locked compartments...Only authorized personnel will have access to the keys to locked compartments... During a medication pass, medications must be under the direct observation of the person administering medications or locked in the medication storage area/cart." Per review of the facility policy titled "Administering Medications" [no revised or reviewed date] states, "During administration of medications, the medication cart will be kept closed and locked when out of sight	F0761	determine further frequency of the audits 5. Corrective action will be completed by February 27, 2026. **Tag F 761 POC accepted on 3/6/26 by S. Freeman/S. Stem**	2/27/26

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 475019	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 01/28/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St. Johnsbury Health & Rehab	1248 Hospital Drive , Saint Johnsbury, Vermont, 05819

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F0761 SS = D	Continued from page 18 of the medication nurse or aid..."	F0761		
F0812 SS = F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(l)(1)(2) §483.60(l) Food safety requirements. The facility must - §483.60(l)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(l)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is NOT MET as evidenced by: Based on observation and interview, the facility failed to ensure that food items were stored in accordance with professional standards for food service safety by having unlabeled food available for use and not ensuring proper refrigerator temperatures. Findings include: Per review of the facility's "Food Procurement" policy [revised date 11/2025] states: *RESPONSIBILITIES: Food Service Director maintains the approved vendor list. Oversees purchasing and receiving practices. Ensures regulatory compliance. Dietary staff inspect deliveries up receipt. Reject unacceptable products. Ensure proper storage of accepted item." *Receiving 1. All food deliveries shall be inspected at the time of receipt for: *proper temperatures. *Signs of spoilage, contamination, or damage. *Expiration or use-by dates. 2.Products not meeting standards shall be rejected and documented. 3.Accepted food items shall be labeled and stored immediately according to temperature and storage	F0812	1. Residents residing in the facility have the potential to be affected by the alleged deficient practice. 2. The facility's " Food Procurement" policy was reviewed and Education provided to dietary staff on ensuring dirty buckets are discarded and cleaned after use, Kitchenette's are being checked for expired items and discard, items in refrigerators are labled and dated, temparture logs being completed to include personal refrigerators in residents rooms. 3. The administrator or designee will audit refridgerator weekly four (4) weeks, then monthly for two (2) months to ensure there is no expired items, and food/beverages are labeled and dated. 4. The administrator or designee will audit refrigerator temp logs weekly four (4) weeks, then monthly for two (2) months to ensure logs are being completed daily and within the correct tempature range. 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. Corrective action will be completed by February 27, 2026.	2/27/26

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F0812 SS = F	Continued from page 19 requirements." During the initial tour of the food service department on 1/25/26 at 4:22pm there was a very strong offensive odor noted on entry to the kitchen. At 4:35pm, a dirty bucket of liquid laundry stain remover was noted on some crates outside of the walk-in fridge. The Food Service Director was asked what it was and why it was there. She said that it should have been thrown away as they were using it for cleaning their dishwasher which was having some trouble getting up to temp. Per observation on 01/26/26 at approximately 11:21am, observed Balsamic vinaigrette in Wing B kitchenette with an expiration date of 1/18/26 11:24 AM Licensed Nurse #1 confirmed the Balsamic vinaigrette was expired with an expiration date of 1/18/26 and threw it away. Per observation on 01/27/26 at 10:33am, the refrigerator and freezer in the activity room was observed with activity staff and a bag of cookies was in the freezer with no dates. Staff stated that those were recently baked and someone will be getting a label for it. Unpackaged frozen bananas were also found in the freezer. The staff member confirmed she is not sure who's they were and thought they might be for residents. A bucket of ice with a water bottle was found in the freezer of which staff confirmed that she was not sure who's it was or who put it there. The items were not removed. On 01/28/2026 at 8:48am, the bag of cookies in the freezer were still not dated after the initial observation. Per interview on 01/28/2026 at 9:06am, the Food Service Director verbalized that she didn't know there were cookies in the freezer and thought that the residents had a bake day last Thursday and advised to check with the Activity Director. Per interview on 01/28/26 at 9:11am, the Maintenance Director verbalized that they do not keep temperature logs and that housekeeping is the one that takes care of that. Per unitobservations made on 1/27/2026 and 1/28/2026 it was noted that Resident #37 had a personal in room refrigerator. There was no evidence of a temperature log seen in the room.	F0812	**Tag F 812 POC accepted on 3/6/26 by S. Freeman/S. Stem**	

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F0812 SS = F	Continued from page 20 Per interview on 1/28/26 at 9:38am, a housekeeping staff member was asked if they keep temp log forms for the refrigerator for Resident #37. She stated that they do and took surveyors to the laundry department where the logs where kept. There we found the logs for several residents' fridges. The Housekeeping Director was asked why some of the dates were missing and she stated that it was because her office was locked one weekend and so staff could not access the logs. Per record review of the fridge temperature logs, there were six personal refrigerators that had missing documentation on 1/1, 1/17, 1/18, and 1/22/26. According to the facility temperature logs the fridge should be in a range between 32 to 40 degrees F (Fahrenheit). There were multiple days on each fridge that were elevated above 40 degrees. Per interview on 1/28/2026 at 10:06am, the Housekeeping Director confirmed that the temperatures were out of range. When asked what interventions were implemented when this occurs, she verbalized that they inform maintenance. Per interview on 1/28/2026 at 10:10am, the Maintenance Director confirmed that staff should be coming to him if they encounter any temps that are out of range. When asked if he has received any reports of temps being out of range, he verbalized no he has not.	F0812		
F0880 SS = D	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:	F0880	Education was immediately provided to the nurse involved in the deficiency practice hand hygiene. 1. Residents residing in the facility have the potential to be affected by the alleged deficient practice. 2. Education provided to the nursing staff on hand hygiene. 3. The DNS or designee will do random infection control observational rounds daily for (4) four weeks then, weekly for (2) months to monitor the effectiveness of the plan.	

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F0880 SS = D	Continued from page 21 §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 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. Personnel must handle, store, process, and transport	F0880	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. Corrective action will be completed by February 27, 2026. **Tag F 880 POC accepted on 3/6/26 by S. Freeman/S. Stem**	2/27/26

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F0880 SS = D	Continued from page 22 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 observation and interview, the facility failed to ensure proper infection prevention measures of hand hygiene were performed during medication administration for one of four residents in the applicable sample (Resident #24). This is a repeat deficiency for this facility, with the violation cited during a previous partial survey dated 4/25/25. Findings include: Per observation on 1/27/26 at 8:37 AM of medication administration the Licensed Practical Nurse (LPN) did not perform hand hygiene before or after administering Resident # 24 their medications. The LPN returned to her cart and proceeded with medication administration with non-washed hands. Per interview on 1/27/26 at approximately 8:45 AM, the LPN confirmed that she did not perform hand hygiene before or after medication administration. Per record review of the facility's "Administering Oral Medications" policy [no revised date] states: "Wash your hands..." prior to administration, and "Perform hand antisepsis." after administration.	F0880		