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	03/22/2024

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48017 Based on record review and interview, the facility failed to protect residents' rights to be free of misappropriation of property related to medication for one applicable resident (Resident # 1). Findings include: Per review of the facility-reported investigation documentation, on 12/30/23, the facility was running low on the Oxycodone prescription for Resident #1 and was attempting to reorder the medication. The pharmacy reported they could not fill the prescription. Their records indicated the facility had received a 30-day supply on 12/11/23, which consisted of 180 tablets. Per record review of the Controlled Substance Logbook on B wing, it was revealed that an entry on 12/11/23, page 143, at 12:55 PM, Oxycodone, was signed by Licensed Practical Nurse #1 (LPN) and LPN #2. The number entered appears to be 90. However, this number is overwritten to indicate an amount of #120. The following four entries are overwritten to suggest that on 12/11 at 12:55 PM, #120 was entered instead of the original #90. Through an interview with LPN #1, the facility concluded that s/he had entered 90 into inventory rather than the #180 that was received from the pharmacy; when LPN #2 did not notice the discrepancy, s/he then overwrote the amount to reflect #120 and removed the remaining #60. Per record review, the facility completed a report with the [NAME] Board of Nursing for suspicion of narcotic diversion. by LPN #1. Per interview with Corporate Staff on 3/19/24 at approximately 4:20 PM, they confirmed that the LPN was terminated under suspicion of diversion; they agreed the facility had not protected Resident #1 from misappropriation of his/her medications.

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.

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. 48017 Based on Record review and interviews, the facility failed to implement its policy and thoroughly investigate the work history of prospective staff. Findings include: Per a record review of a facility-reported incident (FRI), a Licensed Practical Nurse (LPN) was found to be involved in an incident on 12/11/23 in which 60 tablets of Oxycodone were unaccounted for. The FRI also reveals another incident in March 2024 in which the same LPN was named as a person of interest and investigated by a different facility for discrepancies in narcotic administrations. The LPN was terminated from employment as a result. A policy titled PS 300 Abuse Prohibition, page 4, #3 states, The center will screen potential employees for a history of abuse, neglect or mistreating patients, including attempting to obtain information from previous employers and /or current employers and checking with appropriate licensing boards and registries. Per interview with the Clinical Marketing Advisor on 3/19/2024 at approximately 3:30 PM, s/he confirmed the facility did not know about the LPN's involvement with the prior facility regarding narcotics. The facility learned about it when the investigation into this incident was initiated. The facility did not contact previous employers to determine if there were performance issues. An interview with a Human Resources representative on 3/22/24 at approximately 9:40 AM revealed that the LPN was terminated from employment by another facility as a person of interest in misappropriation of narcotics in March 2024. The facility that employed her/him at the time is a sister facility. The LPN was then placed at two more sister facilities, where s/he was terminated for various reasons before employment with this facility. Per interview with the Market Operations Advisor on 3/22/24 at approximately 10:30 AM, s/he revealed that it is the responsibility of the agency placing the employee to check with prior employers for performance, and the facility did not follow their own policy by failing to obtain information about previous performance issues.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48017 Based on record review and staff interviews, the facility failed to implement a system to reconcile controlled medications consistently and accurately for one applicable resident (Resident #1). Findings include: Per review of the facility-reported investigation documentation, on 12/11/23, the facility was running low on the Oxycodone prescription for Resident #1 and attempted to reorder the medication. The pharmacy reported they could not fill the prescription. Their records indicated the facility had received a 30-day supply of 180 tablets on 12/11/23. Per record review of the Controlled Substance Log Book on B wing, it was revealed that an entry on 12/11/23, page 143, at 12:55 PM, Oxycodone, was signed by Licensed Practical Nurse #1 (LPN) and LPN #2. The number entered appears to be 90. However, this number is overwritten to indicate an amount of #120 and signed by LPN #3. The following four entries are overwritten to suggest that on 12/11 at 12:55 PM, #120 was entered instead of the original #90. Those following four entries were signed off with a quantity left of 119, 118, 117, 116 by LPN #2 and LPN #3. The following entry on 12/12/2023 shows the remaining amount of Oxycodone as 115 without overwriting. Per a record review of the facility investigation report, the facility contacted the pharmacy on 12/31/23 and received written confirmation that the original amount of Oxycodone tablets delivered to the facility on , d+[DATE] was 180. The facility policy titled NSG300Controlled Substances: Management of, last reviewed on 4/1/22 states: Storage: Two licensed nurses and/or authorized nursing personnel, per state regulations, are required to document the placement of controlled substances into inventory. Ongoing inventory: A complete count of all Schedule ii-IV controlled substances is required at the change of shifts per state regulation or at any time when narcotic keys are surrendered from one licensed nursing staff to another. The count must be performed by two licensed nurses and/or authorized nursing personnel, per state regulations. Discrepancies noted at any step of the process will be reported to appropriate persons. If a discrepancy is noted, the nursing supervisor will be notified and immediately initiate an investigation using the: Controlled Substances Discrepancy Investigation Form. The Administrator and Director of Nursing are responsible for notifying appropriate enforcement agencies, according to state and federal regulations, of any controlled substance discrepancy that cannot be clarified satisfactorily. Per interview with LPN#2 on 3/19/24 at approximately 2:20 PM, it was revealed that LPN #2 did not follow the procedure as outlined by the facility policy. LPN#2 did not count the inventory of Oxycodone as per the facility policy and did not make sure the narcotic count of Oxycodone was correct between shifts. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A record review of the facility investigation revealed that the facility had reported the incident to the local police and Adult Protective Services and filed a complaint with the [NAME] Board of Nursing for suspicion of narcotic diversion. Per interview with the Clinical Market Consultant on 3/19/24 at approximately 4:20 PM, it was confirmed that the facility concluded that LPN#1 received #180 of Oxcycodone from the pharmacy, s/he submitted #90 into inventory. When LPN #2 did not notice the error, s/he overwrote the amount of Oxycodone inventory to reflect the amount of #120. LPN #2 and LPN#3 continued to enter the incorrect remaining amount of Oxycodone without counting the entire inventory.