

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 475019	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/28/2025
NAME OF PROVIDER OR SUPPLIER St. Johnsbury Health & Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0554</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Allow residents to self-administer drugs if determined clinically appropriate.</p> <p>Based on observation, interview, and record review, the facility failed to ensure 1 resident [Resident #1] of 3 sampled residents did not self-administer medications despite physician orders forbidding this.</p> <p>Findings include:</p> <p>Review of Physician orders for Resident #1 dated 4/14/25 include Resident MAY NOT administer own meds. Further review of medication orders for Resident #1 includes Zenpep Oral Capsule Delayed Release Particles-give 5 capsules by mouth before meals for pancreatic enzymes. Start date 5/1/25. The scheduled administration times are 7:30 AM, 11:30 AM, & 4:30 PM. Review of Resident #1's Medication Administration Record [MAR] for May 2025, also includes an order for the Zenpep Oral Capsules- Give 3 capsules by mouth as needed for PM with snacks, 21 max caps a day, starting 5/1/25. There were no entries documented for the as needed for PM dose from the start dated of 5/1/25 to the day of the survey 5/14/25.</p> <p>Per observation and interview with Resident #1 on 5/14/25 at 9:37 AM, the resident stated [s/he] was in possession of the prescribed medication Zenpep Oral Capsule Delayed Release Particles and proceeded to show the surveyors multiple capsules in a clear plastic medicine cup. The resident stated this was the only medication [s/he] was allowed to keep by [h/herself], and that all the other medications were kept by nursing. Resident #1 stated that [s/he] took the medication whenever [s/he] wanted when [s/he] was about to eat something. The resident stated [s/he] did not report to nursing when [s/he] took the medication or how many times [s/he] took it.</p> <p>An interview was conducted with the facility's Administrator [ADM], the Regional Director of Nursing [RDN], and [NAME] President of Operations [VPO] on 5/14/25 at 1:56 PM. The facility staff confirmed that physician orders prohibited the resident from self-administering the Zenpep medication, and that Resident #1's MAR did not accurately reflect how many times the medication was administered, despite an order for a maximum of 21 caps a day.</p>

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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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to protect the resident's right to be free from neglect for 1 [Resident #1] of 3 sampled residents regarding staff having the knowledge and ability to provide care and services, but choosing not to do it, or acknowledge the request for assistance from a resident resulting in care deficits to a resident. Resident #1 suffered serious harm that rose to the immediate jeopardy level due to the facility's failure to prevent neglect. As a result, Resident #1 experienced symptoms related to very high, unsafe blood sugar and psychosocial harm.</p> <p>Findings include:</p> <p>Review of the admission Packet given to every resident in the facility includes the facility's Abuse, Neglect and Exploitation Policy. The policy defines Neglect as the intentional or reckless failure or omission by a caregiver to: Provide care or arrange for goods or services necessary to maintain the health or safety of a vulnerable adult, including, but not limited to . medicine . supervision and medical services.</p> <p>Review of the facility's Annual Mandatory Education-All Staff includes training titled Resident Neglect. The training reads Neglect is the failure to provide the required structures and processes in order to meet the needs of one or more residents. This may include .the facility's failure to provide necessary staff .services .or staff supervision and oversight to meet the resident's needs. Neglect of goods or services may occur when staff are aware, or should be aware, of residents' care needs, based on assessment and care planning, but are unable to meet the identified needs due to other circumstances .</p> <p>Review of Resident #1's medical record reveals the resident has diagnoses that include:</p> <p>Diabetes mellitus [a disease in which the body's ability to produce or respond to the hormone insulin is impaired, resulting in elevated levels of glucose in the blood and urine] due to a underlying condition with hyperglycemia [high blood sugar], a history of a pancreatectomy [surgical procedure involving the removal of the pancreas]- [Your pancreas makes hormones (like insulin) that help control the levels of sugar in your bloodstream. When your blood sugar is too high, your pancreas makes insulin to lower it. Your body needs balanced blood sugar to run properly.] (https://my.clevelandclinic.org/health/body/21743-pancreas). Resident #1's medical history also includes hyperglycemic-hyperosmolar coma [a serious complication of diabetes characterized by extremely high blood sugar, significant dehydration, and altered mental state that can lead to coma. It's a life-threatening emergency]. According to the Mayo Clinic: It's important to treat High blood sugar, also called hyperglycemia. If it's not treated, hyperglycemia can become severe and cause serious health problems that require emergency care, including a diabetic coma. Hyperglycemia that lasts, even if it's not severe, can lead to health problems that affect the eyes, kidneys, nerves and heart.</p> <p>Hyperglycemia usually doesn't cause symptoms until blood sugar (glucose) levels are high - above 180 to 200 milligrams per deciliter (mg/dL).</p> <p>When to see a doctor:</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Seek immediate help from your care provider or call 911 if:</p> <p>Your blood glucose levels stay above 240 milligrams per deciliter (mg/dL)</p> <p>(https://www.mayoclinic.org/diseases-conditions/hyperglycemia/symptoms-causes/syc-20373631)</p> <p>Review of the facility's NURSING CARE OF THE RESIDENT WITH DIABETES MELLITUS policy [revised 1/2024] reads, The purposes of this guideline are to: Recognize, manage, and document the treatment of complications commonly associated with diabetes. The policy includes Glucose Monitoring, which lists The management of individuals with diabetes mellitus should follow relevant protocols and guidelines and Residents whose blood sugar is poorly controlled or those taking insulin may require more frequent monitoring, depending on the situation. The Nursing Care lists Normal ranges are defined as 80-130 before meals and <180 after meals. Hyperglycemia is considered anything above target reference ranges.</p> <p>An interview was conducted with Resident #1 on 5/14/25 at 9:37 AM. The resident stated s/he had h/her pancreas removed, and utilized a Dexcom device to monitor h/her blood sugar levels at all times. The resident raised the sleeve on h/her right arm to show a small white disk affixed to their upper arm. [the Dexcom is a wearable sensor sending real-time glucose readings automatically to a compatible smart device (such as an I-phone) or Dexcom receiver] (https://www.dexcom.com/get-started-cgm). Resident #1 demonstrated their present blood sugar reading on their I-phone, listed as 149. Resident #1 stated Last Friday my Dexcom read >400. It only goes up to 400. I told my nurse [Staff LPN] that my blood sugar was high. I don't have a pancreas. [Staff LPN] said 'you're only scheduled for blood sugar checks before meals. There are no checks after 5:00 PM.' This was at approximately 8:00 PM. The nurse said to 'go sleep it off.' I kept bugging her about 8 times to check my sugar. She got pissed, checked my sugar and it was the high 300's. I was mortified. I said I need to go to the Emergency Room. She said, 'Absolutely not.' I talked on the phone with my [Representative], who told me to call 911. So, I called the 911. [EMT #1 & #2] (Emergency Medical Technician- is a healthcare professional trained to provide basic emergency medical care) came and took me to the Emergency Department [ED]. They checked my blood sugar and it was 563. The resident reported at the time s/he was suffering from massive headaches, blurry vision, dots in my vision, nausea, and feeling mentally fuzzy.</p> <p>Per interview with Resident #1's Representative on 5/14/25 at 2:59 PM, the Representative reported on the phone call the resident was slurring [h/her] words, which the Representative reported he/she had witnessed in the past when the resident's blood sugars were extremely high.</p> <p>Review of the facility's NURSING CARE OF THE RESIDENT WITH DIABETES MELLITUS policy includes: symptoms of hyperglycemia may include the following:</p> <ul style="list-style-type: none"> -Headache -Restlessness -Nausea and/or vomiting -Decreased awareness/senses <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>An interview was conducted on 5/14/25 at 3:30 PM with the EMT #1 who responded to Resident #1's 911 call on 5/9/25. The EMT provided a written statement regarding what occurred between themselves and the Staff LPN and Resident #1, and during the interview confirmed the accuracy of h/her written account. Per review of the EMT #1's written statement:</p> <p>On May 9, 2025, I responded to an emergency call along with my assigned partner, [EMT #2]. At approximately 9:25 PM, we were dispatched to (Health and Rehab facility) for a patient-reported emergency. The initial dispatch information stated that a patient at the facility had personally called 911 and reported that '[h/her] sugar is out of control and the staff won't give [h/her] [h/her] insulin; [s/he] is experiencing nausea and has a headache.'</p> <p>We were met by a facility staff member who would later be identified as Licensed Practical Nurse [Staff LPN].</p> <p>Upon requesting a report from [Staff LPN], [s/he] responded: 'We didn't call you guys. I told the patient if [s/he] really thought [h/her] sugar was a problem, [s/he] could call 911 themselves.'</p> <p>When asked to provide further details regarding the incident and the patient's condition, [Staff LPN] made the following statements:</p> <p>'[Resident #1] has been saying that [h/her] device, an implanted DexCom blood glucose monitor, shows [h/her] levels as 'High' and has been asking for me to check [h/her] blood sugar for a while. [S/he] doesn't have orders for [h/her] blood sugar to be checked after 5:00 PM., but [s/he] hounded me enough that I checked it anyways at 7:00 p.m., and it read 356.'</p> <p>When I, [EMT #1] asked what interventions were initiated to address the patient's elevated blood glucose, [Staff LPN] stated:</p> <p>'Well, I don't have orders for [h/her] insulin after 5:00 PM., I wasn't going to call the physician after hours, and I definitely wasn't going to call the ambulance.'</p> <p>'I wasn't even supposed to take a blood sugar after 5:00 PM., but [s/he] kept bugging me and if I hadn't, then it wouldn't be a problem now.' [S/he] further added:</p> <p>'[S/he] kept telling me that [s/he] needed to go to the hospital, but I wasn't going to send [h/her] out because [s/he] can just go to bed.'</p> <p>The patient reported multiple symptoms consistent with hyperglycemia, including but not limited to: Blurred vision with spots in the visual field, Excessive thirst and frequent urination, Headache and Nausea. The patient also presented [h/her] Dexcom continuous glucose monitor, which was actively displaying a reading of 'High.'</p> <p>The patient reported that [s/he] had repeatedly informed [Staff LPN] of [h/her] symptoms and the need for insulin to reduce [h/her] blood glucose levels. According to the patient, [Staff LPN] declined to provide insulin, did not consult with the on-call physician, and refused to initiate transport to the hospital. The patient reported that [Staff LPN's] only recommendation was to 'not worry and go to bed.' This is consistent with [Staff LPN's] own statements to [EMT #1 & #2].</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Prior to departing the facility with the patient, EMT personnel requested standard transfer documentation from [Staff LPN], including but not limited to:</p> <ul style="list-style-type: none"> -Patient's medical history -Current medications -Known allergies -Recent medication administration or dispensation records <p>In response, [Staff LPN] declined, stating:</p> <p>'We're not sending [h/her] out, so we're not sending any paperwork. [S/he] chose to do this [h/herself].'</p> <p>The patient was escorted to the ambulance, where EMT performed an independent blood glucose check, which yielded a reading of 563 mg/dL. This result is critically elevated, falling well outside the normal range, and indicative of a condition requiring immediate medical and pharmacological intervention. It is also more than 200 points higher than the level previously documented by [Staff LPN]: (356 at approximately 7:00 PM), indicating continued physiological deterioration over the period without intervention. Upon arrival at [the hospital], The patient was subsequently evaluated and treated in accordance with hospital protocols for severe hyperglycemia.</p> <p>Review of Emergency Department notes for Resident #1, dated 5/9/25 at 10:02 PM record This is a [AGE] year-old who currently resides at health and rehab. Patient states that [h/her] Dexcom is still on, it was registering high this evening. Patient states that [s/he] asked the nurse at health and rehab for insulin. Patient states that the nurse stated that [s/he] did not have an order for glucose check, or insulin and because [s/he] did not have these [s/he]was not going to give the insulin. Patient states that [s/he] requested that the facility doctor be contacted, and nursing recommended that if the patient wanted further evaluation [s/he] contact 911. Patient contacted EMS [Emergency Medical Services] they came to health and rehab and per EMS they also corroborated the story as well. Patient was then brought to the emergency department for further evaluation. [S/he] admits to feeling slightly dizzy and nauseous with a mild headache, and states that this is common when [h/her] sugars are high. Blood glucose was noted to be over 500. Concern for DKA versus HHNK. [DKA (Diabetic Ketoacidosis) and HHNK or Hyperosmolar Hyperglycemic Nonketotic Syndrome) are both serious complications of diabetes characterized by high blood sugar (hyperglycemia)] Will give a liter of normal saline, will give 12 units of insulin .</p> <p>Physician notes at 12:36 AM on 5/10/25 continue: We recommend to health and rehab staff that regular orders of glucose checks and as needed insulin be part of the patient's continued medical regimen. This was made clear in the discharge instructions.</p> <p>Review of Discharge Instructions for Resident #1 read: When you arrived your blood glucose level was over 500. You were given an appropriate amount of insulin which has now brought your glucose levels back down to a more normal limit. Please continue to monitor your sugars closely.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>ORDERS FOR HEALTH AND REHAB: It is critical that the patient has his blood sugars monitored regularly. Please make sure that there are in place orders from your facility physician for administration of insulin if the patient becomes hyperglycemic. If the patient does have concern for hyperglycemia, please reach out to your staff physician for insulin orders for administration.</p> <p>Review of the only progress note written by Staff LPN regarding Resident #1's care and treatment that evening, dated 5/10/25 at 2:40 AM reveals: Requested blood sugar check around 7:30 PM. Result 391. Resident requesting nurse contact physician for orders for insulin. Resident educated that it might not be a great idea to take short acting insulin at bedtime, that blood sugar might drop too low during night. Resident informed that I could check blood sugar in the AM if [s/he] wants. Resident spoke to [h/her] [Representative] and [Representative] told [h/her] to go to hospital if [s/he] wants this issue addressed. Resident then called 911 to bring [h/her] to ED across street. EMTs arrived for resident and nurse informed them of situation. Resident transported to ED. Around 2:00 AM ED called with report on resident stating that they checked [h/her] blood sugar and it was >500. Resident given 1 liter of saline and 12 units of insulin that was effective bringing down blood sugar to 130. Resident returned to facility with no further complaints. DON [Director of Nursing] made aware of situation.</p> <p>Further review of progress notes reveals no documentation of when or what information the DON was made aware of or any actions taken by the DON or Staff LPN upon Resident #1's return. Per review of Resident #1's medical record, there was no documentation of any materials received from the hospital after Resident #1's emergency room visit, or any required documents given to the resident prior to their transfer.</p> <p>Per the interview with EMT #1 on 5/14/25 at 3:30 PM, the EMT stated that he transported Resident #1 both to and from the Emergency Department on 5/9/25 and early morning 5/10/25. Per interview the EMT stated that Discharge Instructions including new physician orders were hand delivered upon Resident #1's return to the facility to the same Staff LPN who was responsible for Resident #1's care prior to the ED visit. The EMT stated that the new physician orders were handed directly to the Staff LPN and were highlighted and underlined and included orders for the resident's physician to be notified.</p> <p>Per interview with the facility's Administrator [ADM], the Regional Director of Nursing [RDN], and [NAME] President of Operations [VPO] on 5/14/25 at 1:56 PM, The [NAME] President of Operations [VPO] stated that the usual situation of a resident being sent to the hospital would include the facility documenting a change in condition and the physician being notified and confirmed this was not done for Resident #1. After reviewing Resident #1's medical record, the VPO stated that on 5/9/25 the resident's presentation was out of the 'norm' for the patient, with ADM adding In my opinion, the nurse should have called the doctor.</p> <p>Further review of Resident #1's medical record revealed 2 days earlier, on 5/7/25, Resident #1's blood sugar level at 7:53 PM was elevated and recorded at 346, and Resident #1's nurse at the time contacted the on-call physician service and received insulin orders to address the resident's elevated blood sugar level.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Regarding the actions on 5/9/25, The ADM, RDN, and VPO stated the Staff LPN's actions toward Resident #1 were not handled professionally and the Staff LPN was not listening to [h/her] education, including the facility's Annual Mandatory Education-All Staff regarding resident Abuse and Neglect, and professional standards regarding staff having the knowledge and ability to provide care and services, but choosing not to do it, or acknowledge the request for assistance from a resident resulting in care deficits to a resident. The ADM, RDN, and VPO confirmed that despite the Staff LPN being handed ED notes and physician orders, the Staff LPN failed to enter any documentation of the ED visit in Resident #1's medical record, and no new physician orders were entered into the record or implemented in the resident's care and treatment, and no documentation that Resident #1's physician was notified of the ED visit or of elevated blood sugar levels.</p>		

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<p>F 0628</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies.</p> <p>Based on interview and record review, the facility failed to ensure for 1 of 3 sampled residents [Resident #1], that prior to transfer to an Emergency Department, appropriate information was communicated to the receiving health care institution or provider, and before a nursing facility transfers a resident to a hospital the nursing facility must provide written information to the resident or resident representative that specifies the nursing facility's policies regarding bed-hold periods, during which the resident is permitted to return and resume residence in the nursing facility.</p> <p>Findings include:</p> <p>Review of Resident #1's medical record reveals the resident has diagnoses that include: Diabetes mellitus [a disease in which the body's ability to produce or respond to the hormone insulin is impaired, resulting in elevated levels of glucose in the blood and urine] due to a underlying condition with hyperglycemia [high blood sugar], a history of a pancreatectomy [surgical procedure involving the removal of the pancreas]- [Your pancreas makes hormones (like insulin) that help control the levels of sugar in your bloodstream. When your blood sugar is too high, your pancreas makes insulin to lower it. Your body needs balanced blood sugar to run properly] (https://my.clevelandclinic.org/health/body/21743-pancreas). Resident #1's medical history also includes hyperglycemic-hyperosmolar coma [a serious complication of diabetes characterized by extremely high blood sugar, significant dehydration, and altered mental state that can lead to coma. It's a life-threatening emergency].</p> <p>According to the Mayo Clinic:</p> <p>It's important to treat High blood sugar, also called hyperglycemia. If it's not treated, hyperglycemia can become severe and cause serious health problems that require emergency care, including a diabetic coma. Hyperglycemia that lasts, even if it's not severe, can lead to health problems that affect the eyes, kidneys, nerves and heart.</p> <p>Hyperglycemia usually doesn't cause symptoms until blood sugar (glucose) levels are high - above 180 to 200 milligrams per deciliter (mg/dL).</p> <p>When to see a doctor:</p> <p>Seek immediate help from your care provider or call 911 if:</p> <p>Your blood glucose levels stay above 240 milligrams per deciliter (mg/dL)</p> <p>(https://www.mayoclinic.org/diseases-conditions/hyperglycemia/symptoms-causes/syc-20373631)</p> <p>(continued on next page)</p>		

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<p>F 0628</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>An interview was conducted with Resident #1 on 5/14/25 at 9:37 AM. The resident stated s/he had h/her pancreas removed, and utilized a Dexcom device to monitor h/her blood sugar levels at all times. The resident raised the sleeve on h/her right arm to show a small white disk affixed to their upper arm. [the Dexcom is a wearable sensor sending real-time glucose readings automatically to a compatible smart device (such as an I-phone) or Dexcom receiver] (https://www.dexcom.com/get-started-cgm). Resident #1 demonstrated their present blood sugar reading on their I-phone, listed as 149. Resident #1 stated Last Friday my Dexcom read &gt;400. It only goes up to 400. I told my nurse [Staff LPN] that my blood sugar was high. I don't have a pancreas. [Staff LPN] said 'you're only scheduled for blood sugar checks before meals. There are no checks after 5:00 PM.' This was at approximately 8:00 PM. The nurse said to 'go sleep it off.' I kept bugging her about 8 times to check my sugar. She got pissed, checked my sugar and it was the high 300's. I was mortified. I said I need to go to the Emergency Room. She said, 'Absolutely not.' I talked on the phone with my [Representative], who told me to call 911. So, I called the 911.</p> <p>An interview was conducted on 5/14/25 at 3:30 PM with the EMT #1 who responded to Resident #1's 911 call on 5/9/25. The EMT provided a written statement regarding what occurred between themselves and the Staff LPN and Resident #1, and during the interview confirmed the accuracy of h/her written account.</p> <p>Per review of the EMT #1's written statement:</p> <p>On May 9, 2025, I responded to an emergency call along with my assigned partner, [EMT #2]. At approximately 9:25 PM, we were dispatched to (Health and Rehab facility) for a patient-reported emergency. The initial dispatch information stated that a patient at the facility had personally called 911 and reported that '[h/her] sugar is out of control and the staff won't give [h/her] [h/her] insulin; [s/he] is experiencing nausea and has a headache.' We were met by a facility staff member who would later be identified as Licensed Practical Nurse [Staff LPN].</p> <p>Upon requesting a report from [Staff LPN], [s/he] responded: 'We didn't call you guys. I told the patient if [s/he] really thought [h/her] sugar was a problem, [s/he] could call 911 themselves.' Prior to departing the facility with the patient, EMT personnel requested standard transfer documentation from [Staff LPN], including but not limited to:</p> <ul style="list-style-type: none"> -Patient's medical history -Current medications -Known allergies -Recent medication administration or dispensation records <p>In response, [Staff LPN] declined, stating: 'We're not sending [h/her] out, so we're not sending any paperwork. [S/he] chose to do this [h/herself].' The patient was escorted to the ambulance, where EMT performed an independent blood glucose check, which yielded a reading of 563 mg/dL. Upon arrival at [the hospital], The patient was subsequently evaluated and treated in accordance with hospital protocols for severe hyperglycemia.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 475019	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/28/2025
NAME OF PROVIDER OR SUPPLIER St. Johnsbury Health & Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE 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.			
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<p>F 0628</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Emergency Department notes for Resident #1, dated 5/9/25 at 10:02 PM record We recommend to health and rehab staff that regular orders of glucose checks and as needed insulin be part of the patient's continued medical regiment. This was made clear in the discharge instructions.</p> <p>Review of Discharge Instructions for Resident #1 read: When you arrived your blood glucose level was over 500. You were given an appropriate amount of insulin which has now brought your glucose levels back down to a more normal limit. Please continue to monitor your sugars closely. ORDERS FOR HEALTH AND REHAB: It is critical that the patient has his blood sugars monitored regularly. Please make sure that there are in place orders from your facility physician for administration of insulin if the patient becomes hyperglycemic. If the patient does have concern for hyperglycemia, please reach out to your staff physician for insulin orders for administration.</p> <p>Review of the only progress note written by Staff LPN regarding Resident #1's care and treatment that evening, dated 5/10/25 at 2:40 AM reveals: Around 2:00 AM ED called with report on resident stating that they checked [h/her] blood sugar and it was >500. Resident given 1 liter of saline and 12 units of insulin that was effective bringing down blood sugar to 130. Resident returned to facility with no further complaints. DON [Director of Nursing] made aware of situation.</p> <p>Further review of progress notes reveals no documentation of when or what information the DON was made aware of or any actions taken by the DON or Staff LPN upon Resident #1's return. Per review of Resident #1's medical record, there was no documentation of any materials received from the hospital after Resident #1's emergency room visit, or any required documents given to the resident prior to their transfer.</p> <p>Per the interview with EMT #1 on 5/14/25 at 3:30 PM, the EMT stated that he transported Resident #1 both to and from the Emergency Department on 5/9/25 and early morning 5/10/25. Per interview the EMT stated that Discharge Instructions including new physician orders were hand delivered upon Resident #1's return to the facility to the same Staff LPN who was responsible for Resident #1's care prior to the ED visit. The EMT stated that the new physician orders were handed directly to the Staff LPN and were highlighted and underlined and included orders for the resident's physician to be notified.</p> <p>(continued on next page)</p>		

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<p>F 0628</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Per interview with the facility's Administrator [ADM], the Regional Director of Nursing [RDN], and [NAME] President of Operations [VPO] on 5/14/25 at 1:56 PM, the [NAME] President of Operations [VPO] stated that the usual situation of a resident being sent to the hospital would include the facility documenting a change in condition and the physician being notified and confirmed this was not done for Resident #1. The facility's Administrator [ADM], the Regional Director of Nursing [RDN], and [NAME] President of Operations [VPO] stated the facility's expectation was to receive treatment information and a visit summary after any resident's transfer and return from the hospital. The facility's process includes scanning the materials into the electronic record and entering and immediately implementing any new orders received. The facility confirmed they did not possess any paperwork or discharge information after Resident #1's ED visit on 5/9/25. At 4:15 PM on 5/14/25, the facility contacted the ED for copies of Resident #1's ED visit record. The facility immediately received copies of Resident #1's Hospital Record and ED Visit Note, dated 5/9/25, which included new physician orders from the ED. The ADM, RDN, and VPO confirmed that despite the Staff LPN being handed ED notes and physician orders, the Staff LPN failed to enter any documentation of the ED visit in Resident #1's medical record, and no new physician orders were entered into the record or implemented in the resident's care and treatment, and no documentation that Resident #1's physician was notified of the ED visit or of elevated blood sugar levels. Additionally, it was confirmed that Resident #1 was transferred out of the facility without any documentation from [Staff LPN], including the resident's medical history, current medications, known allergies, recent medication administration or dispensation records, and no required bed hold notification allowing the resident to return to the facility after the ED visit.</p>		

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<p>F 0658</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Ensure services provided by the nursing facility meet professional standards of quality.</p> <p>Based on interview and record review, the facility failed to ensure 1 [Resident #1] of 3 sampled residents received care and services according to accepted standards of clinical practice. Resident #1 suffered serious harm that rose to the immediate jeopardy level due to the facility's failure to provide care in accordance with professional standards, As a result, Resident #1 experienced symptoms related to very high, unsafe blood sugar and psychosocial harm.</p> <p>Findings include:</p> <p>According to the American Nurses Association: Scope and Standards of Practice (http://www.Nursingworld.org &copy; 2010 American Nurses Association)</p> <p>The Standards of Professional Nursing Practice are authoritative statements of the duties that all registered nurses, regardless of role, population, or specialty, are expected to perform competently.</p> <p>The Standards of Professional Nursing Practice include:</p> <p>1.) Recognizes the healthcare consumer as the authority on her or his own health by honoring their care preferences.</p> <p>An interview was conducted with Resident #1 on 5/14/25 at 9:37 AM. The resident stated s/he had h/her pancreas removed, and utilized a Dexcom device to monitor h/her blood sugar levels at all times. The resident raised the sleeve on h/her right arm to show a small white disk affixed to their upper arm. [the Dexcom is a wearable sensor sending real-time glucose readings automatically to a compatible smart device (such as an I-phone) or Dexcom receiver] (https://www.dexcom.com/get-started-cgm). Resident #1 demonstrated their present blood sugar reading on their I-phone, listed as 149. Resident #1 stated Last Friday my Dexcom read &gt;400. It only goes up to 400. I told my nurse [Staff LPN] that my blood sugar was high. I don't have a pancreas. [Staff LPN] said 'you're only scheduled for blood sugar checks before meals. There are no checks after 5:00 PM.' This was at approximately 8:00 PM. The nurse said to 'go sleep it off.' I kept bugging her about 8 times to check my sugar. She got pissed, checked my sugar and it was the high 300's. I was mortified. I said I need to go to the Emergency Room. She said, 'Absolutely not.'</p> <p>2.) Derives the diagnoses or issues from assessment data.</p> <p>- Uses standardized classification systems and clinical decision support tools, when available, in identifying diagnoses.</p> <p>- Initiates and interprets diagnostic tests and procedures relevant to the healthcare consumer's current status.</p> <p>(continued on next page)</p>		

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<p>F 0658</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Review of Resident #1's medical record reveals the resident has diagnoses that include:</p> <p>Diabetes mellitus [a disease in which the body's ability to produce or respond to the hormone insulin is impaired, resulting in elevated levels of glucose in the blood and urine] due to a underlying condition with hyperglycemia [high blood sugar], a history of a pancreatotomy [surgical procedure involving the removal of the pancreas]- [Your pancreas makes hormones (like insulin) that help control the levels of sugar in your bloodstream. When your blood sugar is too high, your pancreas makes insulin to lower it. Your body needs balanced blood sugar to run properly] (https://my.clevelandclinic.org/health/body/21743-pancreas).</p> <p>Resident #1's medical history also includes hyperglycemic-hyperosmolar coma [a serious complication of diabetes characterized by extremely high blood sugar, significant dehydration, and altered mental state that can lead to coma. It's a life-threatening emergency].</p> <p>According to the Mayo Clinic:</p> <p>It's important to treat High blood sugar, also called hyperglycemia. If it's not treated, hyperglycemia can become severe and cause serious health problems that require emergency care, including a diabetic coma. Hyperglycemia that lasts, even if it's not severe, can lead to health problems that affect the eyes, kidneys, nerves and heart.</p> <p>Hyperglycemia usually doesn't cause symptoms until blood sugar (glucose) levels are high - above 180 to 200 milligrams per deciliter (mg/dL)</p> <p>When to see a doctor:</p> <p>Seek immediate help from your care provider or call 911 if:</p> <p>Your blood glucose levels stay above 240 milligrams per deciliter (mg/dL)</p> <p>(https://www.mayoclinic.org/diseases-conditions/hyperglycemia/symptoms-causes/syc-20373631)</p> <p>Per interview with Resident #1 on 5/14/25 at 9:37 AM, the resident stated after Staff LPN refused to call the physician, the resident spoke with [h/her] [Representative] on the phone and followed their instructions to call 911. Resident #1 reported So, I called the 911. [EMT #1 & #2] (Emergency Medical Technician- is a healthcare professional trained to provide basic emergency medical care) came and took me to the Emergency Department [ED]. They checked my blood sugar and it was 563. The resident reported at the time s/he was suffering from massive headaches, blurry vision, dots in my vision, nausea, and feeling mentally 'fuzzy'.</p> <p>Per interview with Resident #1's Representative on 5/14/25 at 2:59 PM, the representative reported on the phone call the resident was slurring [h/her] words, which the Representative reported s/he had witnessed in the past when the resident's blood sugars were extremely high.</p> <p>3.) Modifies expected outcomes according to changes in the status of the healthcare consumer or evaluation of the situation.</p> <p>(continued on next page)</p>		

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<p>F 0658</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<ul style="list-style-type: none"> - Develops an individualized plan to provide direction to other members of the healthcare team. - Demonstrates caring behaviors toward healthcare consumers - Utilizes community resources and systems to implement the plan. <p>An interview was conducted on 5/14/25 at 3:30 PM with the EMT #1 who responded to Resident #1's 911 call on 5/9/25. The EMT provided a written statement regarding what occurred between themselves and the Staff LPN and Resident #1, and during the interview confirmed the accuracy of h/her written account.</p> <p>Per review of the EMT #1's written statement:</p> <p>On May 9, 2025, I responded to an emergency call along with my assigned partner, [EMT #2]. At approximately 9:25 PM, we were dispatched to (Health and Rehab facility) for a patient-reported emergency. We were met by a facility staff member who would later be identified as Licensed Practical Nurse [Staff LPN]. Upon requesting a report from [Staff LPN], [s/he] responded:</p> <p>'We didn't call you guys. I told the patient if [s/he] really thought [h/her] sugar was a problem, [s/he] could call 911 themselves.' When I, [EMT #1] asked what interventions were initiated to address the patient's elevated blood glucose, [Staff LPN] stated: 'Well, I don't have orders for [h/her] insulin after 5:00 PM., I wasn't going to call the physician after hours, and I definitely wasn't going to call the ambulance.' 'I wasn't even supposed to take a blood sugar after 5:00 PM., but [s/he] kept bugging me and if I hadn't, then it wouldn't be a problem now.' [S/he] further added: '[S/he] kept telling me that [s/he] needed to go to the hospital, but I wasn't going to send [h/her] out because [s/he] can just go to bed.'</p> <p>Prior to departing the facility with the patient, EMT personnel requested standard transfer documentation from [Staff LPN], including but not limited to:</p> <ul style="list-style-type: none"> -Patient's medical history -Current medications -Known allergies -Recent medication administration or dispensation records <p>In response, [Staff LPN] declined, stating: 'We're not sending [h/her] out, so we're not sending any paperwork. [S/he] chose to do this [h/herself].'</p> <p>(continued on next page)</p>		

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<p>F 0658</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>The patient was escorted to the ambulance, where EMT performed an independent blood glucose check, which yielded a reading of 563 mg/dL. This result is critically elevated, falling well outside the normal range, and indicative of a condition requiring immediate medical and pharmacological intervention. It is also more than 200 points higher than the level previously documented by [Staff LPN]. Upon arrival at [the hospital], The patient was subsequently evaluated and treated in accordance with hospital protocols for severe hyperglycemia.</p> <p>Review of Emergency Department notes for Resident #1, dated 5/9/25 record We recommend to health and rehab staff that regular orders of glucose checks and as needed insulin be part of the patient's continued medical regimen. This was made clear in the discharge instructions.</p> <p>Review of Discharge Instructions for Resident #1 read: When you arrived your blood glucose level was over 500. You were given an appropriate amount of insulin which has now brought your glucose levels back down to a more normal limit. Please continue to monitor your sugars closely.</p> <p>ORDERS FOR HEALTH AND REHAB: It is critical that the patient has his blood sugars monitored regularly. Please make sure that there are in place orders from your facility physician for administration of insulin if the patient becomes hyperglycemic. If the patient does have concern for hyperglycemia, please reach out to your staff physician for insulin orders for administration.</p> <p>4.) Assumes responsibility for the safe and efficient implementation of the plan.</p> <p>- Communicates consultation recommendations.</p> <p>Per review of the Lippincott Manual of Nursing, Common Departures from the Standards of Nursing Care include: failure to follow physician orders, follow appropriate nursing measures, communicate information about the patient.</p> <p>[Lippincott Manual of Nursing Practice-11th Edition 2018]</p> <p>Review of the only progress note written by Staff LPN regarding Resident #1's care and treatment that evening, dated 5/10/25 at 2:40 AM reveals: Around 2:00 AM ED called with report on resident stating that they checked [h/her] blood sugar and it was >500. Resident given 1 liter of saline and 12 units of insulin that was effective bringing down blood sugar to 130. Resident returned to facility with no further complaints. DON [Director of Nursing] made aware of situation. Further review of progress notes reveals no documentation of when or what information the DON was made aware of or any actions taken by the DON or Staff LPN upon Resident #1's return. Per review of Resident #1's medical record, there was no documentation of any materials received from the hospital after Resident #1's emergency room visit, or any required documents given to the resident prior to their transfer.</p> <p>Per the interview with EMT #1 on 5/14/25 at 3:30 PM, the EMT stated that [s/he] transported Resident #1 both to and from the Emergency Department on 5/9/25 and early morning 5/10/25. Per interview the EMT stated that Discharge Instructions including new physician orders were hand delivered upon Resident #1's return to the facility to the same Staff LPN who was responsible for Resident #1's care prior to the ED visit. The EMT stated that the new physician orders were handed directly to the Staff LPN and were highlighted and underlined and included orders for the resident's physician to be notified.</p> <p>(continued on next page)</p>		

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<p>F 0658</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>An interview was conducted with the facility's Administrator [ADM], the Regional Director of Nursing [RDN], and [NAME] President of Operations [VPO] on 5/14/25 at 1:56 PM. Regarding the actions on 5/9/25, the ADM, RDN, and VPO stated the Staff LPN's actions toward Resident #1 were not handled professionally and the Staff LPN was not listening to [h/her] education, including professional standards regarding staff having the knowledge and ability to provide care and services, but choosing not to do it, or acknowledge the request for assistance from a resident resulting in care deficits to a resident.</p> <p>The facility staff confirmed they did not possess any paperwork or discharge information after Resident #1's ED visit on 5/9/25. At 4:15 PM on 5/14/25, the facility contacted the ED for copies of Resident #1's ED visit record. The facility immediately received copies of Resident #1's Hospital Record and ED Visit Note, dated 5/9/25, which included new physician orders from the ED.</p> <p>The ADM, RDN, and VPO confirmed that despite the Staff LPN being handed ED notes and physician orders, the Staff LPN failed to enter any documentation of the ED visit in Resident #1's medical record, and no new physician orders were entered into the record or implemented in the resident's care and treatment, and no documentation that Resident #1's physician was notified of the ED visit or of elevated blood sugar levels. Additionally, it was confirmed that Resident #1 was transferred out of the facility without any documentation from [Staff LPN], including the resident's medical history, current medications, known allergies, recent medication administration or dispensation records, and no required bed hold notification allowing the resident to return to the facility after the ED visit.</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.</p> <p>Based on observation, interview, and record review, the facility failed to ensure all drugs and biologicals were safely stored and accessible only by authorized personnel for 1 resident [Resident #1] of 3 sampled residents.</p> <p>Findings include:</p> <p>Review of Physician orders for Resident #1 dated 4/14/25 include medication orders for Zenpep Oral Capsule Delayed Release Particles-give 5 capsules by mouth before meals for pancreatic enzymes. Start date 5/1/25. Review of Resident #1's Medication Administration Record [MAR] for May 2025, also includes an order for the Zenpep Oral Capsules- Give 3 capsules by mouth as needed for PM with snacks, 21 max caps a day, starting 5/1/25.</p> <p>Per observation and interview with Resident #1 on 5/14/25 at 9:37 AM, the resident stated [s/he] was in possession of the prescribed medication Zenpep Oral Capsule Delayed Release Particles and proceeded to show the surveyors multiple capsules in a clear plastic medicine cup. The resident stated this was the only medication [s/he] was allowed to keep by [h/herself], and that all the other medications were kept by nursing. Resident #1 stated that [s/he] took the medication whenever [s/he] wanted when [s/he] was about to eat something. The resident stated [s/he] did not report to nursing when [s/he] took the medication or how many times [s/he] took it.</p> <p>An interview was conducted with the facility's Administrator [ADM], the Regional Director of Nursing [RDN], and [NAME] President of Operations [VPO] on 5/14/25 at 1:56 PM. The facility staff confirmed the resident should not be in the possession of the Zenpep medication at any time and nursing failed to ensure that medication was stored and administered as ordered.</p>		