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	07/24/2025

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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. (continued on next page)

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

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	07/24/2025

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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to protect the residents' right to be free from neglect by not providing goods and services to residents' that are necessary to avoid physical harm, pain, mental anguish or emotional distress by failing to develop and implement adequate systems to meet the care and service needs of residents.During the investigation the team identified many failures, some of which are widespread system failure, which included: providing adequate nursing staff to safely care for all residents;development of baseline care plans for newly admitted residents;development, revision, and implementation of comprehensive care plans to meet resident's needs;ensure all applicable residents have care plan interventions and supervision to prevent falls;administration of all ordered medications and treatments;ensure timely administration of all ordered medications and treatments;ensure ordered laboratory tests are performed timely and included in the residents' electronic health record (EHR);ensure ordered laboratory test results are reported to the ordering provider;ensure adequate treatment and prevention of pressure ulcers is provided to all applicable residents;ensure resident care is supervised by a physician;ensure all residents are receiving regulatory visits at the required intervals by the appropriate provider;provide 8 hours of consecutive RN coverage every day;ensure resident admitted or readmitted to the facility have admission orders to provide essential care to all residents;ensure the Medical Director is providing services per regulatory requirements;ensure the QAPI program is effective; and ensure the facility is adequately administered; ensuring all abuse and neglect allegations are reported to the Division of Licensing and Protection and Adult Protective Services in a timely manner; andensure the facility is administered in a manner that enables it to maintain the physical well-being of each resident.These failures put all residents at risk for serious harm and/or death. This is a repeat deficiency for this facility, with the violation cited during the previous complaint surveys dated 11/19/24, at a level D, and 5/28/25, at immediate jeopardy, level J. The facility was notified neglect at immediate jeopardy during this investigation on 7/18/25. The facility immediate Plan of Correction (POC) was accepted on 7/23/25 with a removal date of 7/23/25. Findings include:1.) A complaint investigation revealed that Resident #1, admitted to the facility on [DATE] with a diagnosis of insulin dependent diabetes, did not have admission orders for insulin or blood sugar checks as indicated in their discharge orders and did not have a care plan for diabetes management (baseline or comprehensive) until 5/28/25. There is no evidence that Resident #1 had any insulin during their stay at the facility and no evidence that his/her blood sugars were checked until 5/31/25, when it was asked to be done by their representative due to the significant decline in Resident #1's status, which lead the resident to be sent to the hospital. See F655 and F656 for more information. The complaint investigation also revealed that Resident #6, who was admitted to the facility on [DATE] with diagnoses that include diabetes, a right foot pressure ulcer, and a history of falls, did not have a baseline care plan or comprehensive care plan for diabetes management, fall prevention, or pressure ulcer prevention and treatment. Resident #6 also had laboratory service orders that were not preformed. As a result, the resident was sent to the Emergency Department to be treated for hyperglycemia, a stage two pressure ulcer of the right foot, and cellulitis of the right foot, which required antibiotics. This resident also suffered a fall at the facility. See F655, F656, F686, F689, F710, and F770 for more information.2.) During the investigation the team identified many widespread issues and system failures.a.) Laboratory services were not provided to Residents #2,# 3, #5, #6, and #7. A system issue was discovered that 30 laboratory orders had not been completed during the past 2 weeks. Also, providers were not being notified of results and lab results were not being entered into residents' medical records. These issues have the potential to impact all residents. See F770 and F773 for more information.b.) The Medical Director made clinical decisions to not manage Resident #1 and #6's diabetes with insulin and blood sugar monitoring based on a new protocol that he was implementing but had not been developed for facility staff to implement. Medical Director services were not being provided as per regulations regarding policy implementation, care coordination between all providers and the facility and have the potential to impact all residents. See F841 for more information.c.) Multiple issues were identified with medications not being administered or being administered late that have the potential to impact all residents. See F760 and F725 for more information.d.) Issues were identified related to insufficient nursing staff that have the potential to impact all residents. See F725 and F727 for more information.e.) Issues were identified related to the effectiveness of the QAPI program as evidenced by multiple repeat citations. The failure of the

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	07/24/2025

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based on record review and interview it was determined that the facility failed to report 2 allegations of abuse of a resident to the State Survey Agency in a timely manner. Findings include:1. Per review of complaint #24087 regarding Resident #13, received on 5/29/25 from a provider who stated in their complaint that Resident #13 had alleged abuse by a facility staff member. The complaint also stated that the allegations of abuse were reported to the facility Director of Nursing (DON) on 5/28/25 by the provider over the phone. During an interview on 6/4/25 at approximately 1:00 PM the Director of Nursing confirmed that she had been contacted by the provider, however, was not provided with specific details and did not think she needed to report the allegation to the State agency. The facility Administrator filed a report on 6/4/25 after learning of this incident from the survey team. 2. Per record review, Resident #12's physician progress notes dated 6/21/25 revealed the resident had mentioned to the provider an allegation of staff to resident abuse where a CNA slapped (pronoun omitted) in the face.Interview on 7/23/25 1:10 PM with the Administrator who stated she had reported this allegation on 6/20/25 at 5:00 PM. Review of the state's complaint computer system revealed the report had not been received. Further review on 7/23/25 of the State's computer log of received complaints and facility reported incidents revealed the report had not been received. A call/interview to the State's Complaint Coordinator on 7/23/25 revealed the report had not been received. Interview on 7/24/25 at approximately 1:15 PM with the Administrator and a request for confirmation that this report was sent and received by the State's complaint unit revealed that there was no documented evidence to support this report had been received.

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	07/24/2025

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 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to develop a baseline care plan that includes the instructions needed to provide effective and person-centered care that includes communication, behavioral symptoms, psychotropic medication drug use, activities, dental care, pressure ulcers, falls, and diabetic care needs for 6 of 14 residents in the sample (Residents #1, #2, #3, #4, #6, and #8). Findings include: 1.) Per record review, Resident #6 was admitted to the facility on [DATE] with diagnoses that include type 2 diabetes with diabetic neuropathy, unstageable pressure ulcer to the right heel, and history of repeated falls. A transfer of care note (TOC) dated 4/30/25 reveals that Resident #6 had a fall on 4/24/25. A fall assessment included in the 4/30/25 TOC indicated that s/he is a fall risk, scored at 10 (a score of 4 or more is considered a risk for falling) based on 3 or more diagnosis, prior history of falls within 2 months, incontinence, visual impairment, impaired functional mobility, environmental hazards, poly pharmacy, pain affecting level of functioning, and cognitive impairment. The TOC reveals that Resident #6 “has Accu-Chek Glucometer and Freestyle Libre (both are used to monitor blood sugars).” Active medications list daily insulin on “hold” but does have an active order for a glucose sensor. The TOC refers to a Primary Care Provider (PCP) note being sent with this information. This PCP note, dated 4/15/25, included in Resident #6’s medical record at the time of admission to the facility, indicates that s/he has well controlled diabetes with the use of daily insulin and is seen by podiatry for his/her pressure ulcer. Per record review, Resident #6’s baseline care plan does not include being at risk for falls, diabetes management, or skin management. Per record review, a Physician Progress note dated 5/1/25, completed by the (previous) Medical Director, indicated that Resident #6 has a diagnosis of diabetes. The progress note revealed under Assessment/Plan to “continue current care” for diabetes. There is other description in the note or in Resident #6’s medical record, including their care plan, for what “current care” for diabetes is for staff to follow. Per phone interview on 6/20/25 at 11:22 AM, a Nurse Practitioner (Provider #2) confirmed that Resident #6 should have had a baseline care plan for pressure ulcers, falls, and diabetes on admission. Per phone interview with the (previous) Medical Director on 6/23/25 at 1:19 PM, he explained that he decided to hold off on providing insulin and doing blood sugars for Resident #6 on admission. He explained that his plan was to hold on these orders for a month because insulin is a dangerous medication for this population (nursing home residents) and it would be more beneficial to manage symptoms. When asked how he communicated this with the facility and other providers, he explained that he doesn’t have a way to communicate with other providers properly and there is no place in the Electronic Health Record (EHR) to communicate with providers. When asked if this resident should have a plan of care related to diabetes management, he said yes and wasn’t aware that Resident #6 didn’t have a plan of care related to diabetes. When asked if the facility had a protocol related to diabetes management that reflected his clinical decisions, he confirmed that there was not as he was working on developing a new protocol. When asked how staff or other providers would know how Resident #6’s diabetes was to be managed, he explained that he talked to a nurse. (continued on next page)

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	07/24/2025

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 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Per phone interview on 6/20/25 at 11:22 AM, a Nurse Practitioner (Provider #2) was asked why Resident #6 did not have orders for insulin or blood sugar checks. He explained that he had not put in the admission orders. When asked how he knew that the (previous) Medical Director had decided not to consider an order for insulin or to perform blood sugars for Resident #6, he explained that he didn’t know this but had evaluated Resident #6 based on not having orders for insulin or diabetic medications. He stated that there is not enough collaboration with the care team, especially since residents are mostly receiving telehealth at the facility. When asked if he was aware that Resident #6 had just recently been on daily insulin (per the 4/15/25 PCP note in Resident #6’s medical record) and was not getting blood sugar checks as indicated in the 4/30/25 TOC (also in Resident #6’s medical record), he stated he was not sure that he saw that information. He explained that he is only in the facility every other week and needs to see 20 or more residents in a day and sometimes he does not get to review all the past medical documents. Provider #2 confirmed that Resident #6 should have had a baseline care plan for pressure ulcers, falls, and diabetes management on admission. A 5/24/25 telehealth Nurse Practitioner note reveals that Resident #6 was sent to the Emergency Department (ED) on 5/24/25 due to right leg edema from knee to toe. The ED Physician Visit note dated 5/24/25 reveals that Resident #6 has a stage 2 right foot ulcer, cellulitis of right foot requiring antibiotic treatment, and acute hyperglycemia. The note reads, “I noted that insulin was no longer on the patient’s MAR [Medication Administration Record]and [s/he] has not been receiving this. Fingerstick blood sugar 265 today. I am concerned that infection will worsen without tighter glucose control… I spoke with the NP on call at the [facility]. Discussed ED presentation course, She was surprised to hear insulin is not currently prescribed.” Record review also reveals in a 6/12/25 RMS (Risk Management System) report that Resident #6 suffered an unwitnessed fall on 6/12/25. At the time of the 5/24/25 ED event, Resident #6 still did not have a care plan for diabetes management or pressure ulcer prevention or treatment. At the time of the fall on 6/12/25 Resident #6 still did not have a care plan to prevent falls. 2. Per record review, Resident #1 was admitted to the facility on [DATE] after a fall at home resulting in hospitalization. Review of the resident’s hospital discharge information dated 5/10/25, page 1 under Diagnosis revealed…….“(6) Insulin dependent diabetes mellitus Status: Chronic.” Review of the resident's Baseline Care Plan revealed no care plan specific to the resident’s diagnosis of diabetes mellitus. (continued on next page)

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	07/24/2025

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 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the resident's admission MDS (Minimum Date Set assessment, a standardized comprehensive evaluation of a resident’s functional status, health, and preferences in a nursing home. Used to develop care plans, track resident progress, and for Medicare and Medicaid reimbursement), ARD (assessment reference date, the date that the assessment was completed) of 5/15/25 under MDS section I0020 revealed the following diagnoses: Non-Traumatic Brain Dysfunction; Hypertension; Renal insufficiency, renal failure, ESRD (end stage renal disease); Diabetes mellitus (DM); Hyperlipidemia; Thyroid disorder; Other fracture; Seizure disorder; Traumatic brain injury (TBI); Malnutrition (protein, calorie), risk of malnutrit [sic]; Depression; BENIGN NEOPLASM OF MENINGES, UNSPECIFIED; RHABDOMYOLYSIS; UNSPECIFIED CONVULSIONS; NEOPLASM OF COLON, UNSPECIFIED; VITAMIN D DEFICIENCY, UNSPECIFIED; HYPOMAGNESEMIA; UNSP FRACTURE OF RIGHT TALUS, SUBS FOR FX W ROUTN HEAL; [NAME] SUBDR HEM WITH LOC STATUS UNKNOW, SUBS. Interview on 7/24/25 at approximately 1:45 PM, the DON (Director of Nurses) confirmed the Resident #1 had a diagnosis of diabetes mellitus and the facility did not care plan her/him for this diagnosis. 3. Per record review, Resident #8 was admitted to the facility on [DATE] after a recent hospital stay. Review of the residents’ MDS revealed the following areas in which the resident required additional assistance: Communication, Behavioral Symptoms, Activities, Dental Care, and Psychotropic Drug Use. Review of the MDS CAA (Care Area Assessment, used to determine if a triggered area requires interventions and care planning) revealed that the facility stated it would proceed to creating a care plan for the above noted areas, however, did not. Interview on 7/18/25 at 12:15 PM, the current Medical Director confirmed that baseline care plans are to be completed and implemented within 48 hours of a resident's admission to the facility. Interview on 7/18/25 at 12:30 PM, the DON (Director of Nurses confirmed that baseline care plans are to be completed and implemented within 48 hours of a resident's admission to the facility. Interview on 7/24/25 at approximately 1:45 PM, the DON (Director of Nurses) confirmed the facility documented they would care plan this resident for the above areas and had not. 4. Per record review, Resident # 2 was admitted to the facility on [DATE] for rehabilitation services following a below-knee amputation (BKA) with diagnoses that include poorly controlled diabetes, coronary artery disease, and necrotizing fasciitis (Infection of the soft tissue). Per review, Resident #2’s baseline care plan does not document the Resident’s admission goals until 7/11/25. There is no documentation related to Resident # 2’s transfers, eating, toileting, dressing, personal hygiene, bathing, or therapy goals. Per interview on 7/17/25 at 2:29 PM, the Director of Nursing (DON) confirmed that Resident #2’s baseline care plan was not developed and implemented within 48 hours, and it also lacked the necessary information to properly care for the residents. (continued on next page)

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	07/24/2025

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 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	5. Per record review, Resident #3 was admitted to the facility on [DATE] after hospitalization for a fall. The baseline care plan does not document activities of daily living (ADL) assistance that includes bed mobility, eating, toileting, dressing, personal hygiene, or bathing. It also does not address personal preferences that include choosing between a tub or shower, choosing a bedtime, including family in care, reading, and listening to music until 6/25/25. There was no care plan to address fall risks initiated until 6/30/25. Per interview on 7/17/25 at 2:29 PM, the Director of Nursing (DON) confirmed that Resident #2’s baseline care plan was not developed and implemented within 48 hours, and it also lacked the necessary information to properly care for the Resident. 6. Per record review, Resident # 4 was admitted to the facility on [DATE] with diagnoses that include a fracture of the right femur. Review of the care plan reveals that there are no ADLs documented, including bed mobility, eating, toileting, assistance for transfers and ambulation, personal hygiene, dressing, and bathing. Further review indicates there are no personal choice interventions that include personal belongings, choosing between a tub or shower, taking a nap, including family or friends in care, benefitting from cognitive limitations by using reminders, using adaptive material, or using glasses, until 6/26/25. Per interview on 7/17/25 at 2:29 PM, the Director of Nursing (DON) confirmed that Resident #2’s baseline care plan was not developed and implemented within 48 hours, and it also lacked the necessary information to properly care for the Resident.

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	07/24/2025

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, it was determined that the facility failed to develop and implement comprehensive person-centered care plans for 2 residents of 14 (Residents #1 and #8). This is a repeat deficiency for this facility, with the violation cited during the previous complaint survey, dated 11/19/24. Findings include:1.) Per record review, Resident #6 was admitted to the facility on [DATE] with diagnoses that include type 2 diabetes with diabetic neuropathy, unstageable pressure ulcer to the right heel, and history of repeated falls. A transfer of care note (TOC) dated 4/30/25 reveals that Resident #6 had a fall on 4/24/25. A fall assessment included in the 4/30/25 TOC indicated that s/he is a fall risk, scored at 10 (a score of 4 or more is considered a risk for falling) based on 3 or more diagnosis, prior history of falls within 2 months, incontinence, visual impairment, impaired functional mobility, environmental hazards, poly pharmacy, pain affecting level of functioning, and cognitive impairment. The TOC reveals that Resident #6 “has Accu-Chek Glucometer and Freestyle Libre (both are used to monitor blood sugars).” Active medications list daily insulin on “hold” but does have an active order for a glucose sensor. The TOC refers to a Primary Care Provider (PCP) note being sent with this information. This PCP note, dated 4/15/25, included in Resident #6’s medical record at the time of admission to the facility, indicates that s/he has well controlled diabetes with the use of daily insulin and is seen by podiatry for his/her pressure ulcer. Per record review, a Physician Progress note dated 5/1/25, completed by the (previous) Medical Director, indicated that Resident #6 has a diagnosis of diabetes. The progress note revealed under Assessment/Plan to “continue current care” for diabetes. There is other description in the note or in Resident #6’s medical record, including their care plan, for what “current care” for diabetes is for staff to follow. Per record review, Resident #6 has a MDS (Minimum Data Set; a comprehensive assessment used as a care-planning tool) dated 5/8/25 which include CAAs [Care Area Assessments; key issues identified from the MDS used to identify areas for care planning] triggered for care planning for “pressure ulcer/injury” and “falls.” Based on the MDS date, the comprehensive care plan should be implemented within 7 days following the MDS assessment (5/15/25). Per a 5/15/25 care plan meeting note, part of the interdisciplinary team met with the Resident #6 to review his/her plan of care. The Attending Physician is not listed as being in attendance and there is no documentation that they provided information to the team regarding Resident #6’s plan of care. Per phone interview with the (previous) Medical Director on 6/23/25 at 1:19 PM, he explained that he decided to hold off on providing insulin and doing blood sugars for Resident #6 on admission. He explained that his plan was to hold on these orders for a month because insulin is a dangerous medication for this population (nursing home residents) and it would be more beneficial to manage symptoms. When asked how he communicated this with the facility and other providers, he explained that he doesn’t have a way to communicate with other providers properly and there is no place in the Electronic Health Record (EHR) to communicate with providers. When asked if this resident should have a plan of care related to diabetes management, he said yes and wasn’t aware that Resident #6 didn’t have a plan of care related to diabetes. When asked if the facility had a protocol related to diabetes management that reflected his clinical decisions, he confirmed that there was not as he was working on developing a new protocol. When asked how staff or other providers would know how Resident #6’s diabetes was to be managed, he explained that he talked to a nurse. (continued on next page)

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	07/24/2025

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Per phone interview on 6/20/25 at 11:22 AM, a Nurse Practitioner (Provider #2) was asked why Resident #6 did not have orders for insulin or blood sugar checks. He explained that he had not put in the admission orders. When asked how he knew that the (previous) Medical Director had decided not to consider an order for insulin or to perform blood sugars for Resident #6, he explained that he didn’t know this but had evaluated Resident #6 based on not having orders for insulin or diabetic medications. He stated that there is not enough collaboration with the care team, especially since residents are mostly receiving telehealth at the facility. When asked if he was aware that Resident #6 had just recently been on daily insulin (per the 4/15/25 PCP note in Resident #6’s medical record) and was not getting blood sugar checks as indicated in the 4/30/25 TOC (also in Resident #6’s medical record), he stated he was not sure that he saw that information. He explained that he is only in the facility every other week and needs to see 20 or more residents in a day and sometimes he does not get to review all the past medical documents. Provider #2 confirmed that Resident #6 should have had a care plan for pressure ulcers, falls, and diabetes management on admission. Per an email dated 6/23/25, a Licensed Practical Nurse confirmed that Resident #6 did not have a care plan for: pressure ulcer treatment and prevention until 5/23/25 (8 days after the comprehensive care plan was created); falls until 6/13/25 (28 days after the comprehensive care plan was created, and diabetes until 6/3/25 (18 days after the comprehensive care plan was created). A 5/24/25 telehealth Nurse Practitioner note reveals that Resident #6 was sent to the Emergency Department (ED) on 5/24/25 due to right leg edema from knee to toe. The ED Physician Visit note dated 5/24/25 reveals that Resident #6 has a stage 2 right foot ulcer, cellulitis of right foot requiring antibiotic treatment, and acute hyperglycemia. The note reads, “I noted that insulin was no longer on the patient’s MAR [Medication Administration Record]and [s/he] has not been receiving this. Fingerstick blood sugar 265 today. I am concerned that infection will worsen without tighter glucose control… I spoke with the NP on call at the [facility]. Discussed ED presentation course, She was surprised to hear insulin is not currently prescribed.” Record review also reveals in a 6/12/25 RMS (Risk Management System) report that Resident #6 suffered an unwitnessed fall on 6/12/25. At the time of the 5/24/25 ED event, Resident #6 still did not have a care plan for diabetes management or pressure ulcer prevention or treatment. At the time of Resident #6’s fall on 6/12/25, s/he still did not have a care plan to prevent falls. 2. Per record review, Resident #1 was admitted to the facility on [DATE] after a fall at home resulting in hospitalization. Review of the Resident’s hospital discharge information dated 5/10/2025 revealed that the Resident had a diagnosis of chronic insulin dependent diabetes mellitus.) Review of the resident's admission MDS (Minimum Date Set assessment, a standardized comprehensive evaluation of a resident’s functional status, health, and preferences in a nursing home. Used to develop care plans, track resident progress, and for Medicare and Medicaid reimbursement), ARD (assessment reference date, the date that the assessment was completed) of 5/15/25 under section I0020 revealed that Resident #1 had a diagnosis of Diabetes mellitus (DM). (continued on next page)

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	07/24/2025

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the resident's Comprehensive Care Plan revealed there was no care plan specific to the care needed to address Resident #1’s diagnosis of diabetes mellitus until 5/28/25. During an interview on 7/24/25 at approximately 1:45 PM, the DON (Director of Nurses) confirmed that Resident #1 had a diagnosis of diabetes mellitus, and the facility did not develop a base line care plan related to this diagnosis. 3. Per record review, Resident #8 was admitted to the facility on [DATE] after a recent hospital stay. Review of the Resident’s MDS revealed the following areas in which the resident required additional assistance: Communication, Behavioral Symptoms, Activities, Dental Care, and Psychotropic Drug Use. Review of the MDS Care Area Assessment (CAA, used to determine if a triggered area requires interventions and care planning) revealed that the facility stated it would proceed to creating a care plan for the above noted areas. However, further review of Resident #8’s care plan revealed that it did not. Interview on 7/24/25 at approximately 1:45 PM, the DON (Director of Nurses) confirmed the facility documented in the MDS that they would care plan Resident #8 for the above areas and had not.

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	07/24/2025

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. Based on record review and interview the facility failed to update comprehensive care plans in a timely manner for 6 of 14 sampled residents. (Resident ID #'s 2, 3, 4, 5, 9, and 10). Findings include: Per record review on 7/21/25 of Resident #2's current care plan revealed the review due date was 7/3/25 and the target completion date was 7/10/25. Per record review on 7/21/25 of Resident #3's current care plan revealed the review due date was 6/25/25 and the target completion date was 7/7/25.Per record review on 7/21/25 of Resident #4's current care plan revealed the review due date was 6/24/25 and the target completion date was 7/1/25.Per record review on 7/21/25 of Resident #5's current care plan revealed the review due date was 6/24/25 and the target completion date was 7/8/25.Per record review on 7/21/25 of Resident #9's current care plan revealed the review due date was 6/5/25 and the target completion date was 6/12/25.Per record review on 7/21/25 of Resident #10's current care plan revealed the review due date was 7/1/25 and the target completion date was 7/8/25.Interview on 7/22/25 at 5:00 PM, the DON confirmed these care plans had not been updated by their due dates.

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	07/24/2025

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide safe and effective skin and wound care consistent with facility policy and professional standards of practice for preventing and treating existing pressure ulcers for 1 of 1 sampled residents (Resident #6). As a result, a resident with an admitting diagnosis of an unstageable pressure ulcer was sent to the emergency room related to cellulitis of the right foot requiring antibiotic treatment, and a stage 2 (Partial thickness loss of dermis presenting as a shallow open ulcer with a red or pink wound bed, without slough or bruising. May also present as an intact or open/ruptured blister) right foot ulcer. 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, Resident #6 was admitted to the facility on [DATE] with diagnoses that include type 2 diabetes with diabetic neuropathy, unstageable pressure ulcer to the right heel, and history of repeated falls. A transfer of care note (TOC) dated 4/30/25 reveals that Resident #6 has Accu-Chek Glucometer and Freestyle Libre (both used to monitor blood sugars). Active medications list daily insulin on hold but does have an active order for a glucose sensor. The TOC refers to a Primary Care Provider (PCP) note as being sent with this information. This PCP note, dated 4/15/25, included in Resident #6's medical record at the time of admission to the facility, indicates that s/he has well controlled diabetes with the use of daily insulin and is seen by podiatry for his/her pressure ulcer.Per record review, Resident #6's baseline care plan does not include pressure ulcer treatment and prevention or diabetes management.Per record review, Resident #6 has a MDS (Minimum Data Set; a comprehensive assessment used as a care-planning tool) dated 5/8/25 which include CAAs [Care Area Assessments; key issues identified from the MDS used to identify areas for care planning] that triggered pressure ulcer/injury for care planning. Resident #6's comprehensive care plan and physician orders did not include pressure ulcer treatment and prevention until 5/23/25.Per an email dated 6/23/25, a Licensed Practical Nurse confirmed that Resident #6 did not have a care plan for pressure ulcer treatment and prevention until 5/23/25. Per record review, there are no nursing notes or skin assessments that show documentation of Resident #6's heel pressure ulcer until 5/23/25, when a skin and wound evaluation was completed. The wound evaluation reveals that Resident #6 has a right heel blister that was present on admission, measuring 1.8 cm x 1.3 cm. Increased pain is marked off as evidence of infection. Per record review, there is no evidence in any of the 12 provider visits that Resident had from 5/1/25 through 5/24/25 that a physician supervised the care of their diagnosis of a pressure ulcer. See F710 for more information. Per phone interview on 6/20/25 at 11:22 AM, a Nurse Practitioner (Provider #2) confirmed that Resident #6 should have had a care plan for pressure ulcers on admission.A 5/24/25 telehealth Nurse Practitioner note reveals that Resident #6 was sent to the Emergency Department (ED) on 5/24/25 due to right leg edema from knee to toe.The ED Physician Visit note dated 5/24/25 reveals that Resident #6 has a stage 2 right foot ulcer, cellulitis of right foot requiring antibiotic treatment, and acute hyperglycemia. The note reads, I noted that insulin was no longer on the patient's MAR [Medication Administration Record] and [s/he] has not been receiving this. Fingerstick blood sugar 265 today. I am concerned that infection will worsen without tighter glucose control. I spoke with the NP [Nurse Practitioner] on call at the [facility]. Discussed ED presentation course, She was surprised to hear insulin is not currently prescribed.

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	07/24/2025

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to develop and implement relevant, consistent, and individualized interventions to prevent falls from occurring for 1 applicable resident at risk for falls (Resident #6). This is a repeat deficiency for this facility, with the violation cited during the previous recertification survey, dated 12/11/25, and cited at a harm level during a complaint survey dated 3/28/25. Findings include:Based on interview and record review, the facility failed to develop and implement relevant, consistent, and individualized interventions to prevent falls from occurring for 1 applicable resident at risk for falls (Resident #6). This is a repeat deficiency for this facility, with the violation cited during the previous recertification survey, dated 12/11/25, and cited at a harm level during a complaint survey dated 3/28/25. Findings include:Per record review, Resident #6 was admitted to the facility on [DATE] with diagnoses that include type 2 diabetes with diabetic neuropathy, dementia, and history of repeated falls, muscle weakness, hearing loss, knee pain, and constipation. A transfer of care note (TOC) dated 4/30/25 reveals that Resident #6 had a fall on 4/24/25. A fall assessment included in the 4/30/25 TOC indicated that s/he is a fall risk, scored at 10 (a score of 4 or more is considered a risk for falling) based on 3 or more diagnosis, prior history of falls within 2 months, incontinence, visual impairment, impaired functional mobility, environmental hazards, poly pharmacy, pain affecting level of functioning, and cognitive impairment.Per record review Resident #6's baseline care plan does not have a focus for being at risk for falls and does not include interventions to prevent falls that are identified in the fall risk assessment. A 5/2/25 Nurse Practitioner note states s/he is at risk for falls, ambulates with the use of [his/her] walker. We will draw labs including vitamin D to see if there are any contributing factors. A 5/8/25 MDS indicated that Resident #6 had a fall in the last month prior to admission, triggering on the CAA [Care Area Assessment] Triggers Summary that falls should be addressed in his/her comprehensive care plan. Progress notes indicate that a care plan meeting occurred on 5/15/25. The comprehensive care plan created prior to this meeting did not address fall risks, prevention, or interventions. Per phone interview on 6/20/25 at 11:22 AM, a Nurse Practitioner (Provider #2) confirmed that Resident #6 should have had a care plan for falls on admission.Per record review, a 6/12/25 RMS (Risk Management System) report reveals that Resident #6 suffered an unwitnessed fall on 6/12/25. Resident #6 did not have a care plan to prevent falls until 6/13/25, after the 6/12/25 fall.

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	07/24/2025

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 0710 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Obtain a doctor's order to admit a resident and ensure the resident is under a doctor's care. (continued on next page)

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	07/24/2025

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 0710 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure that residents' care is supervised by a physician for 1 of 14 sampled residents (Resident #6) by not ensuring a plan was in place to manage the resident's diabetes or pressure ulcer. As a result, a resident with an admitting diagnosis of an unstageable pressure ulcer was sent to the emergency room related to cellulitis of the right foot requiring antibiotic treatment, and a stage 2 (Partial thickness loss of dermis presenting as a shallow open ulcer with a red or pink wound bed, without slough or bruising. May also present as an intact or open/ruptured blister) right foot ulcer. Findings include:Per record review, Resident #6 was admitted to the facility on [DATE] with diagnoses that include type 2 diabetes with diabetic neuropathy, an unstageable pressure ulcer to the right heel, and history of repeated falls. A transfer of care note (TOC) dated 4/30/25 reveals that Resident #6 has Accu-Chek Glucometer and Freestyle Libre (both are used to monitor blood sugars). Active medications list daily insulin on hold but does have an active order for a glucose sensor. The TOC refers to a Primary Care Provider (PCP) note being sent with this information. This PCP note, dated 4/15/25, included in Resident #6's medical record at the time of admission to the facility, indicates that s/he has well controlled diabetes with the use of daily insulin and is seen by podiatry for his/her pressure ulcer. The PCP note [NAME] Resident #6's last A1c value to be 8.2 on 1/22/25 (a blood test that reflects average blood sugar levels over the past two to three months).Per record review, Resident #6 does not have a baseline or comprehensive care plan that includes pressure ulcer treatment and prevention or diabetes management.Per record review, a Physician Progress note dated 5/1/25, completed by the (previous) Medical Director, indicated that Resident #6 has a diagnosis of diabetes. The progress note revealed under Assessment/Plan to continue current care for diabetes. There is no other description in the note or in Resident #6's medical record, including their care plan, for what current care for the Resident's diabetes is for staff to follow. There is also no mention of Resident #6's right heel.Per phone interview with the (previous) Medical Director on 6/23/25 at 1:19 PM, he explained that he decided to hold off on providing insulin and doing blood sugars for Resident #6 on admission. He explained that his plan was to hold on these orders for a month because insulin is a dangerous medication for this population (nursing home residents) and it would be more beneficial to manage symptoms. When asked how he communicated this with the facility and other providers, he explained that he doesn't have a way to communicate with other providers properly and there is no place in the Electronic Health Record (EHR) to communicate with providers. When asked if this resident should have a plan of care related to diabetes management, he said yes and wasn't aware that Resident #6 didn't have a plan of care related to diabetes. When asked if the facility had a protocol related to diabetes management that reflected his clinical decisions, he confirmed that there was not as he was working on developing a new protocol. When asked how staff or other providers would know how Resident #6's diabetes was to be managed, he explained that he talked to a nurse.A 5/2/25 Nurse Practitioner History and Physical Note addresses Resident #6's diabetes as Stable, diet controlled. [S/He] is not on any insulin or oral diabetic medications There is no mention of Resident #6's right heel.Per phone interview on 6/20/25 at 11:22 AM, a Nurse Practitioner (Provider #2) was asked why Resident #6 did not have orders for insulin or blood sugar checks. He explained that he had not put in the admission orders. When asked how he knew that the (previous) Medical Director had decided not to consider an order for insulin or to perform blood sugars for Resident #6, he explained that he didn't know this but had evaluated Resident #6 based on not having orders for insulin or diabetic medications. He stated that there is not enough collaboration with the care team, especially since residents are mostly receiving telehealth at the facility. When asked if he was aware that Resident #6 had just recently been on daily insulin (per the 4/15/25 PCP note in Resident #6's medical record) and was not getting blood sugar checks as indicated in the 4/30/25 TOC (also in Resident #6's medical record), he stated he was not sure that he saw that information. He explained that he is only in the facility every other week and needs to see 20 or more residents in a day and sometimes he does not get to review all the past medical documents. Provider #2 confirmed that Resident #6 should have had a baseline care plan for pressure ulcers and diabetes management on admission.Resident #6 was seen a total of 12 times by providers between 5/1/25 and 5/23/25 for comprehensive exams or acute provider visits. S/He was seen on 5/1/25 by an MD, twice on 5/2/25 by two different NPs, one of which was a telehealth visit, on 5/4/25 by a NP for a telehealth visit, on 5/5/25 by a NP, on 5/6/25 by a NP for a telehealth visit, on 5/7/25 by a NP for a telehealth visit, on 5/8/25 by

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	07/24/2025

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 0712 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that the resident and his/her doctor meet face-to-face at all required visits. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, it was determined that the facility failed to ensure all regulatory provider visits were completed for 1 of 14 residents. (Resident #8). Findings include:Per record review for Resident #8 revealed that the resident was admitted on [DATE] with diagnosis of Unspecified Atrial Fibrillation, Hypokalemia, Acute on [sic] Chronic Diastolic (Congestive) Heart Failure, Hypomagnesemia, Urinary Tract Infection, Sepsis, Pain in left Shoulder, COPD, OSA, Major Depressive Disorder, Recurrent Severe Psychotic Features and Unspecified Open Wound of Lower Back and Pelvis without Penetration into retroperitoneum, Presence of Prosthetic Heart Valve, Severe Sepsis without Septic Shock, Chronic Respiratory Failure with Hypoxia, and Dependence on Supplemental Oxygen. Review of practitioner notes revealed the first physician visit occurred on 6/27/25, this does not meet the regulatory requirement of a 30 days physician onsite visit. Interview on 7/23/25 at approximately 4:10 PM, the current DON (Director of Nurses), confirmed that Resident #8 did not receive the required 30-day regulatory visit by a physician.

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	07/24/2025

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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. Based on the interview and record review, the facility failed to provide a sufficient number of Licensed Nursing Assistants (LNAs) and Registered Nurses (RN) for 8 consecutive hours a day to provide nursing services, considering the number, acuity, and diagnoses of the facility's resident population in accordance with the facility assessment. This is a repeat deficiency cited during a facility Recertification Survey on 12/11/24. Findings include:Per interview on 7/16/2025 at 12:19 PM, the Assistant Director of Nursing (ADON) revealed that she frequently works overtime to provide the facility with RN coverage. She is one of the two staff members who are trained to draw blood for labs. The facility has 30 outstanding labs that were ordered between 6/30/25 and 7/14/25 that have not been processed. She states she cannot keep up with them as there are not enough staff.Per record review, a Missed Medications Report between the dates of 5/17/25-7/17/25 revealed 2,177 pages of missed medications and treatments.Per review of the late medication report provided on 7/17/25, contained 6,017 pages of various late administered medications and treatments. Per interview on 7/18/25 at approximately 12:15 PM, the current DON, confirmed that the medications and treatments on the above noted late medication and treatment report were not administered per the prescriber's order or per the facility policy. Per interview on 7/18/25 at 2:51 PM, a Licensed Practical Nurse (LPN) revealed that she is a traveler, medication passes are late due to a lack of staff, and she encounters many interruptions to assist residents who need care.Per review of the facility's Hours Per Patient Day (PPD) report, the facility was below the minimum requirement staffing level to allow for 2.0 hours of direct care per resident per day on a weekly average by Licensed Nursing Assistants (LNAs) for 6 of the 10 sampled weeks. It failed to maintain required minimum staffing levels to allow 3.0 hours of direct care per resident per day (PPD) on a weekly average, including nursing, care, personal care, and restorative nursing care for 6 of 10 sampled weeks. See S321.Per the interview on 7/18/25 at 2:05 PM, the Administrator revealed she had requested more staff several times from corporate. She explained that the company has an internal agency staffing group that provides staff. She was told that the agency could not offer RN staff. The company will only procure staff from the internal agency.

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	07/24/2025

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 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. Based on interview and record review, the facility failed to ensure it used the services of a Registered Nurse (RN) for at least 8 consecutive hours a day, 7 days a week, for 18 days from 5/1/2025 to 7/13/2025. Findings include:A review of the facilities' staffing schedules from 5/1/25 to 7/13/25 revealed 8 days with no RN scheduled [6/21, 6/28, 6/29, 7/4, 7/5, 7/6, 7/12, 7/13] and 10 days [6/24, 6/30, 7/1, 7/2, 7/3, 7/7, 7/8, 7/9, 7/10, 7/11], where there were not 8 consecutive hours of RN services.Per interview with the Administrator on 7/17/2025 at 4:09 PM, where she confirmed that the facility did not have a Registered Nurse scheduled or present in the building for a minimum of 8 consecutive hours daily as required by regulation on the 18 days above.

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	07/24/2025

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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure that residents are free from significant medication errors. (continued on next page)

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	07/24/2025

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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, it was determined that the facility failed to ensure that residents were free from significant medication errors by not administering all medications as prescribed, and in a timely manner. This issue was determined to be widespread, potentially impacting all residents in the facility. Findings include: 1. Review of Resident #'1's diagnosis list revealed s/he had a diagnosis of diabetes mellitus. The Resident's hospital Discharge summary dated [DATE] revealed that the Resident was a long-term user of insulin and Insulin dependent diabetes mellitus: Status: Chronic. The hospital discharged the Resident to this facility with a medication list titled, Home Medication List that included insulin glargine [Lantus Solostar U-100 Insulin] 28 unit subcutaneous every morning. Last Taken: [DATE] 07:57 28 units. This Home Medication List consisted of 13 medications with dose and instructions/orders. Next to each medication was a check mark and on page #1 handwritten Entered PCC [Point Click Care] 5.10.25 1300 [nurse's signature]. Review of the Resident's MAR (medication administration record) for [DATE] revealed that the Resident had not been receiving insulin or finger sticks to check blood sugars. The residents list of current orders did not include the insulin order or an order to perform finger sticks to check the residents blood sugar levels. There were no orders in PCC for insulin administration for this resident or for finger sticks to monitor the residents blood glucose levels. During an interview on [DATE] at approximately 2:00 PM, with the nurse who signed their name to the Home Medication List stated she remembered entering these orders when she admitted the Resident to the unit at this facility. She confirmed she was the weekend Unit Manager.2. A request was made of the Director of Nursing (DON) on [DATE] at 3:59 PM via email for a 60-day report for missed medications and late medications. A 2,177-page missed medication report was received on [DATE] at 1:56 PM, this report also included missed treatments. Per review of the missed medication report, there were numerous missed medications. The missed medications would include the following:Gabapentin for painMetformin for diabetes managementXarelto an anticoagulantClozapine for schizophreniaClonazpam for anxietyAdvair Diskus for asthmaEliquis an anticoagulant (A-fib)Lisinopril for high blood pressureTopiramate for seizuresLevothyroxine for hypothyroidism (underactive thyroid)Lorazepam for anxietyRena - Vite a supplement for a resident on dialysisAmlodipine for high blood pressureZoloft for depression/moodOxycontin for chronic painLevetiracetam for seizuresProzac for depression/moodBreo-Ellipta for asthma or COPD (Chronic Obstructive Pulmonary Disease)Prazosin for high blood pressureDivalproex Sodium for anxietyDiazepam for anxietyDuloxetine for neuropathyOlanzapine for schizophreniaZiprasidone for bi-polar disorderCarbidopa - Levodopa for Parkinsons DiseaseApixaban an anticoagulantMetropolol Tartrate for high blood pressurePregabalin for neuropathyTizanidine for spasmsRopinerole for restless leg syndromeAlfuzosin for Benign Prostatic Hyperplasia (BPH)Oxycodone for painNovolog pen for the treatment of diabetes mellitus Included in this report were treatments and assessments that were not done and include:Wound care pain monitoringmonitoring for signs and symptoms of depressionmonitoring for effects of anti-coagulant useFluid intakeMonitoring vital signs Weekly weight checksMonitoring hemodialysis site for bleedingoxygen saturation and pulse monitoringapplication of oxygen at the right amountnight time snack offering and acceptancediabetic foot checks/monitoringWanderguard checks to ensure they are in place, have not expired, and are functioning appropriatelyApplication/removal of TED stocking (compression hose/stockings)Offloading of heels, bottom and other bony prominencesPer review of the facility policy and procedure titled, ADMINISTERING MEDICATIONS under the heading of Policy Interpretation and Implementation .3. Medications must be administered in accordance with the orders, including any required time frame. 4. Medications must be administered within one (1) hour of their prescribed time, unless otherwise specified (for example, before and after meal orders). Per interview on [DATE] at approximately 12:15 PM, the current DON (Director of Nursing), confirmed that the medications and treatments on the above noted report were not administered per the prescriber's order and per the facility policy. Per review of the late medication report provided on [DATE], contained 6,017 pages of various late administered medications and treatments. Per interview on [DATE] at approximately 12:15 PM, the current DON, confirmed that the medications and treatments on the above noted late medication and treatment report were not administered per the prescriber's order or per the facility policy. Per interview on [DATE] at approximately 12:30 PM, the Medical Director stated, they were not aware of the magnitude of the late and missed medications and treatments. He confirmed that nursing staff should be notifying the prescriber's when

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	07/24/2025

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 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide timely, quality laboratory services/tests to meet the needs of residents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interviews and record reviews, the facility failed have a functioning system to obtain laboratory services which has the potential to impact all residents and failed to obtain laboratory services to meet the needs of its residents for 4 of 14 sampled residents (Residents # 3, #5, #6, and #7). Findings include:1.) Per record review, Resident #6 was admitted to the facility on [DATE] with diagnoses that include type 2 diabetes with diabetic neuropathy, unstageable pressure ulcer to the right heel, and history of repeated falls. A transfer of care note (TOC) dated 4/30/25 reveals that Resident #6 had a fall on 4/24/25. A fall assessment included in the 4/30/25 TOC indicated that s/he is a fall risk, scored at 10 (a score of 4 or more is considered a risk for falling) based on 3 or more diagnosis, prior history of falls within 2 months, incontinence, visual impairment, impaired functional mobility, environmental hazards, poly pharmacy, pain affecting level of functioning, and cognitive impairment. The TOC reveals that Resident #6 “has Accu-Chek Glucometer and Freestyle Libre (both are used to monitor blood sugars).” Active medications list daily insulin on “hold” but does have an active order for a glucose sensor. The TOC refers to a Primary Care Provider (PCP) note being sent with this information. This PCP note, dated 4/15/25, included in Resident #6’s medical record at the time of admission to the facility, indicates that s/he has well controlled diabetes with the use of daily insulin and is seen by podiatry for his/her pressure ulcer. The PCP note [NAME] Resident #6’s last A1c value to be 8.2 on 1/22/25 (a blood test that reflects average blood sugar levels over the past two to three months). Per record review, a 5/2/25 Nurse Practitioner (NP; Provider #2) note stated Resident #6 “is at risk for falls, ambulates with the use of [his/her] walker. We will draw labs including vitamin D to see if there are any contributing factors.” An order was put in for laboratory services for “BMP, BNP, CBC, TSH, Vit D, A1C” but was never completed. Review of physician orders reveals that this order was struck out. Per an email dated 6/23/25, a Licensed Practical Nurse confirmed that the above lab order had been struck out because of incomplete documentation. A new order was put in for laboratory services for “BMP, BNP, CBC, TSH, Vit D, A1C” on 5/23/25 which revealed that Resident #6 had a blood glucose on 330 (range 74-106) in addition to multiple other test results to be found out of range. The lab results did not include a result for A1c values. Per an email dated 6/23/25, a Licensed Practical Nurse confirmed that these lab values were not in Resident #6’s medical record. She indicated that the A1c result from this date was 11.8 (The American Association of Clinical Endocrinologists (AACE) recommends initiating insulin for patients with an A1C over 8. 0). A 5/24/25 telehealth Nurse Practitioner note reveals that Resident #6 was sent to the Emergency Department (ED) on 5/24/25 due to right leg edema from knee to toe. (continued on next page)

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	07/24/2025

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 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The ED Physician Visit note dated 5/24/25 reveals that Resident #6 has a stage 2 right foot ulcer, cellulitis of right foot requiring antibiotic treatment, and acute hyperglycemia. The note reads, “I noted that insulin was no longer on the patient’s MAR [Medication Administration Record]and [s/he] has not been receiving this. Fingerstick blood sugar 265 today. I am concerned that infection will worsen without tighter glucose control… I spoke with the NP on call at the [facility]. Discussed ED presentation course, She was surprised to hear insulin is not currently prescribed.” Per phone interview on 6/20/25 at 11:22 AM, the Nurse Practitioner (Provider #2) that ordered Resident #6’s labs on 5/2/25 stated he was not made aware that the labs ordered for Resident #6 on 5/2/25 had been struck out. He continued stating the labs would be valuable, including A1C values, which depending on the value, could change the medication management of diabetes for a resident. He has had problems with getting lab results from the facility. He explained that over the past two months, he has ordered around 250 labs and has only seen a few results. He explained that if lab results are not in the medical record, he has no way of knowing the results. He expressed that it is a big concern since lab work is necessary for this population (nursing home residents) and they deserve quality care. https://pmc.ncbi.nlm.nih. gov/articles/PMC6528396/#:~:text=The%20American%20Association%20of%20Clinical, the%20glycemic%20target%20(38). 2. Record review on 7/15/25, Resident #5 had a laboratory order that was entered on 6/30/2025 for the following labs: CBC (Complete Blood Count), CMP (comprehensive Metabolic panel that measures overall body function), a Lipid Profile (test that measures the overall cholesterol levels) and a TSH (blood test to measure how the thyroid is functioning). Interview on 7/16/2025 at 12:10 PM with the Assistant Director of Nursing (ADON), the labs ordered on 6/30/2025 for Resident #5 had not been drawn/collected. There were 30 outstanding lab orders between June 30, 2025, and July 15, 2025, that had not been processed. There was no documentation in the medical records that the provider was notified that these labs had not been drawn. 3. Record review on 7/15/25, Resident #7 had a laboratory order that was listed in their current orders and signed by the ordering prescriber on 2/14/25 that stated, CBC Lab draw monthly one time a day starting on the 1st and ending on the 3rd every month for resident is on clozapine with a start date of 2/14/2025 and was listed as an Active order. A new order was revealed during record review for a CBC law draw one day one dated 6/30/25 and there was no evidence in the resident's medical record that this had been drawn. Interview on 7/16/25 at approximately 12:12 PM with the ADON, for labs ordered on 6/30/25 for Resident #7 had not been drawn/collected and there were 30 outstanding lab orders between June 30, 2025, and July 15, 2025, that had not been processed. There was no documentation in the medical record that the provider had been notified that these labs had not been drawn. 4. Per record review, Resident #3 has diagnoses of disorder of the thyroid, hypertensive heart disease, and heart failure. Per the medical record, a lab order was entered on 6/30/2025 for the following labs: CBC (Complete Blood Count), CMP (comprehensive Metabolic panel), a screening blood test that measures overall body functions, a Lipid Profile (a blood test that measures the overall cholesterol levels) and a TSH (a blood test to measure how the thyroid is functioning). (continued on next page)

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	07/24/2025

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 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Per interview on 7/16/2025 at 12:10 PM with the Assistant Director of Nursing (ADON), the labs ordered on 6/30/2025 for Resident #3 had not been processed. There were 30 outstanding lab orders between June 30, 2025, and July 15, 2025, that had not been processed. There is no documentation in the medical records that the providers were made aware of the outstanding labs. She revealed that the facility staff’s responsibilities included performing venipunctures, obtaining and reviewing lab results, sending the results to providers, and following up on any interventions as determined by the providers. The facility has two staff members trained to perform venipunctures. She explained that there is one staff member with access to the hospital’s lab system. The facility has developed an internal system to track the outstanding labs. The same person has the only access to the system and is out of the building on vacation, leaving the facility without access to either program. Per interview on 7/18/20025 at 10:04 AM, Provider #1 revealed that she often has to “chase” lab results. She cannot locate the results in the medical record and notes that she frequently sees an outstanding order. She usually reorders them in a format that ensures they will be drawn that day. Per interview on 7/18/2025 at 10:39 AM, Provider #2 indicates the facility's system for obtaining labs is a multisystem failure. The facility does not have a system to ensure that labs are drawn promptly, results are obtained, provided to the provider, and entered into the medical records. He often reorders the same labs and submits his orders to be completed on that day to ensure they are done. He has to repeatedly call the facility to track down labs, discovering that the labs were never performed, results are not in the medical record, or the facility failed to notify him of the results. Per Facility Policy: “Lab and Diagnostic Test Results”, reviewed/revised 1/2024, “Nursing staff coordinate test processing, a nurse reviews all results, and all notifications are documented in the medical record…. The Director of Nursing (DON) or designee audits daily 24-hour reports for follow-up needs.” Per interview on 7/18/2025 at 10:02 AM with the DON and ADON, it was confirmed that the facility lacks a process to ensure they are meeting the needs of the residents by providing timely service, completing venipuncture, obtaining lab results, and ensuring the results are in the medical record. The facility does not have a policy that contains information about the timeliness of labs.

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	07/24/2025

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 0773 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide or obtain laboratory tests/services when ordered and promptly tell the ordering practitioner of the results. Based on record review and interview, it was determined that the facility failed to notify ordering physician's when ordered lab draws had not been performed and provider's were not notified when laboratory results had been received for 3 of 14 residents (Residents #5, #6, and #7) . This is a repeat deficiency from the recertification survey on dated on 12/11/24. Findings include: Per record review, Resident #6 has a diagnosis of diabetes. S/He had the following labs drawn, per physician order for “BMP, BNP, CBC, TSH, Vit D, A1C” on 5/23/25 which revealed that Resident #6 had a blood glucose on 330 (range 74-106) in addition to multiple other test results to be found out of range. The lab results in Resident #6 did not include a result for A1c values. Per review of a 6/26/25 Nurse Practitioner follow up note, the NP when discussing the resident and their blood sugar, the A1c results were still “pending.” Per an email dated 6/23/25, a Licensed Practical Nurse confirmed that the A1c value drawn on 5/23/25 was not in Resident #6’s medical record. She indicated that the A1c result from this date was 11.8 (The American Association of Clinical Endocrinologists (AACE) recommends initiating insulin for patients with an A1C over 8.0). There was no documented evidence that a provider was made aware of the A1c lab result. This result was not addressed by a provider until 7/7/25. Per phone interview on 6/20/25 at 11:22 AM, the Nurse Practitioner (Provider #2) that ordered Resident #6’s labs on 5/23/25 stated he has had problems with getting lab results from the facility. He explained that over the past two months, he has ordered around 250 labs and has only seen a few results. He explained that if lab results are not in the medical record, he has no way of knowing the results. He expressed that it is a big concern since lab work is necessary for this population (nursing home residents) and they deserve quality care. 2. Record review on 7/15/25, Resident #5 had a laboratory order that was entered on 6/30/2025 for the following labs: CBC (Complete Blood Count), CMP (comprehensive Metabolic panel that measures overall body function), a Lipid Profile (test that measures the overall cholesterol levels) and a TSH (blood test to measure how the thyroid is functioning). Interview on 7/16/2025 at 12:10 PM with the Assistant Director of Nursing (ADON), the labs ordered on 6/30/2025 for Resident #5 had not been drawn/collected. There were 30 outstanding lab orders between June 30, 2025, and July 15, 2025, that had not been processed. There was no documentation in the medical records that the provider was notified that these labs had not been drawn. 3. Record review on 7/15/25, Resident #7 had a laboratory order that was listed in their current orders and signed by the ordering prescriber on 2/14/25 that stated, CBC Lab draw monthly one time a day starting on the 1st and ending on the 3rd every month for resident is on clozapine with a start date of 2/14/2025 and was listed as an Active order. A new order was revealed during record review for a CBC law draw one day one dated 6/30/25 and there was no evidence in the resident's medical record that this had been drawn. Interview on 7/16/25 at approximately 12:12 PM with the ADON, for labs ordered on 6/30/25 for Resident #7 had not been drawn/collected and there were 30 outstanding lab orders between June 30, 2025, and July 15, 2025, that had not been processed. There was no documentation in the medical record that the provider had been notified that these labs had not been drawn. (continued on next page)

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	07/24/2025

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 0773 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4. Per interview on 7/18/25 at 10:04 AM, Provider #1 indicated she provides primarily telehealth visits to the residents. She reveals that she is frequently “chasing labs”. They are not filed in the residents' records; she feels that the facility lacks a system to obtain and properly document labs in the EMR. She is concerned that she will miss critical labs as the process seems to need structure. A second interview with Provider # 2 on 7/18/25 at 10:39 AM, where he indicated the facility has a multisystem breakdown when it comes to a process for labs. He has to order the same lab more than once to ensure it is completed. He frequently must contact the facility as the labs are not uploaded into the medical record. A third interview with Provider #3 on 7/18/25 at 11:15 AM revealed that she has been working full time for the facility since January, and lab values are difficult to obtain. The facility does not seem to have a good system. She can rarely find lab results in the record and frequently has to call the facility to access the hospital records to obtain the lab results.

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	07/24/2025

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 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Administer the facility in a manner that enables it to use its resources effectively and efficiently. Based on observation, interview, and record review, it was determined that the facility was not administered in a manner that enables it to maintain the physical well-being of each resident, whereby actions and decisions by the facility's leadership team directly contributed to deficiencies that resulted in immediate jeopardy (F600 and F841). In addition, there are several repeat deficiencies. The identified failures by the lack of administrative oversight for a large amount of regulatory requirements in multiple areas of compliance put all residents at risk for more than minimal harm. Findings include:1.Interviews with the Medical Director; past and present, VP of Clinical Services, Administrator, and facility staff reveal that Resident #1 did not receive quality care and services specific to their long-standing diagnosis of Diabetes Mellitus, and they did not receive insulin although they had been a chronic user of insulin per their hospital discharge summary, ED (Emergency Department) notes/documentation, and interview with the Resident's son. See F655 for additional information The facility failed to ensure it used the services of a Registered Nurse (RN) for at least 8 consecutive hours a day, 7 days a week, for 18 days from 5/1/2025 to 7/13/2025. See F727 for additional information The facility provided report of missed medications from 5/17/25 to 7/17/25 which revealed a 2177-page report, and a late medications and treatment reports for May 2025 through July 17, 2025, consisting of a combined total of 6,017 pages. See F760 for additional information There were 30 outstanding lab orders between June 30, 2025, and July 15, 2025, that had not been processed. There was no documentation in the medical records that the provider was notified that these labs had not been drawn. See F770 and F773 for additional information An onsite complaint investigation was conducted on 6/3/25 - 6/4/25 and an extended survey conducted on 7/15/25 - 7/24/25, the survey team identified and notified the facility of deficiencies at the immediate jeopardy level for violations around F600 related to neglect, F835 related to Administration, F841 related to medical director, and F865 related to QAPI. On 7/24/25 a revisit was mad to the facility and the IJ's were removed for the above 4 deficiencies. (continued on next page)

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	07/24/2025

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 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Multiple repeat deficiencies were identified during this survey. During a complaint survey on 11/19/24 the facility was cited for a deficiencies related to comprehensive care plans (F656) and abuse (F600), During a recertification survey dated 12/11/24, the facility was cited for deficiencies related to accidents, hazards, and supervision (F689), sufficient nursing staff (F725), notifying the ordering provider of laboratory results (F773), and state staffing requirements (S320). During a complaint survey dated 3/28/25 the facility was cited at a harm level for a deficiency related to accidents, hazards, and supervision (F689). During a complaint survey dated 4/9/25 the facility was cited at a widespread level for a deficiency related to the Medical Director (F841). During a complaint survey dated 5/28/25 the facility was cited at an immediate jeopardy level for a deficiency related to neglect (F600). See F865 for more information. The facility's plans of correction for all repeat deficiencies above identified that either the nursing leadership team (Director of Nursing/Assistant Director of Nursing) and/or the Administrator were responsible for both auditing to ensure that regulatory requirements were met and reporting the audit results to the Quality Assurance Committee. Also refer to F841 regarding failure to provide administrative oversight to the Medical Director. Per interview on 7/16/25 at approximately 3 PM, the previous Director of Nursing (DON) was asked by the survey team if they felt they had enough nursing staff to meet the needs of the residents. She stated she had been working every day to help cover the units, but they were still short staffed. She stated that she would often be working a medication cart and not able to perform their job duties as the DON. She explained that she was a fairly new nurse when they were put into the role of DON. She stated that she did not want to be in this role but was told she was the only one qualified to fill this role. She confirmed that the facility was experiencing some significant nursing shortages, and it had been impacting the care of the residents. Per interview on 7/24/25 at approximately 2:45 PM, the Administrator explained that she was aware that there were some significant nursing shortages and it was impacting the care of the residents. 2. During offsite review of the initial complaint, additional information was requested from the facility on 6/20/25. There was no one available to answer questions or provide information to the surveyor regarding Resident #6's care history. The Director or Nursing and Administrator were not at the facility and were unavailable. The [NAME] President of Operations was available for a phone interview on 6/20/25 at 3:22 PM but was unable to verify medical records during the interview and was unable to answer clinical questions. She confirmed that there would be no one else to answer clinical questions that day and responses to the questions were not received until 6/23/25.

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	07/24/2025

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 0841 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Designate a physician to serve as medical director responsible for implementation of resident care policies and coordination of medical care in the facility. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on document review and interview, it was determined that the facility failed to ensure the Medical Director duties per the Medical Director Agreement and Medical Director facility policy were performed, including ensuring resident care policies were implemented and coordination of care was provided to ensure resident care and services were provided to all resident that were consistent with current professional standards of practice for 2 of 2 units. On 7/18/25 the facility was notified of non-compliance at the immediate jeopardy (IJ) level for Medical Director. This is a repeat deficiency for this facility, with the violation cited during the previous complaint survey, dated 4/8/25. On 7/23/25 the facility's IJ plan of correction was accepted. An unannounced onsite assessment of the IJ removal was conducted on 7/24/25 and the IJ was confirmed to be removed as of 7/23/25. Findings include:Review of a document titled, MEDICAL DIRECTOR AGREEMENT, signed by the Sr (senior) Director of Human Resources on 6/17/2025 and signed by the new Medical Director on 6/16/2025. Within this document, titled, SCHEDULE A, states the Medical Director Services are as follows: * Performance of administrative tasks consisting of the establishment, maintenance, and updating of medical care policies * Participation in the quality assurance program of the Company in a manner that seeks to ensure the consistency and quality of medical services provided by the technical and professional personnel of the Company, including making recommendations regarding the competency of the licensed professionals employed by and/or under contract with the Company * Ensuring that each resident's responsible physician attends to the residents' medical needs, participates in care planning, and follows the Company's policies and procedures * Attendance at committee meetings as liaison / resource person as appropriate and reasonably required * Periodic review and development of medical care policies and procedures as required to ensure compliance with Federal, State, and local laws, rules, and regulations governing the performance of medical services provided by the Company * Supervision of high-level quality of care delivered to residents, with supervision exercised over medical, dental, nursing, pharmaceutical, dietary, and rehabilitative services * Maintenance of a health and accident surveillance program for residents, including reviews and evaluation of incident reports or summaries of incident reports, identifying hazards to health and safety [and making recommendations to the commissioner] * Provision of advisory services and consultations for medical and nursing staff * Performance of all necessary general administrative tasks including assigning medical duties and scheduling, and communication of this information to appropriate staff (continued on next page)

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	07/24/2025

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 0841 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	* Assistance in the resolution of resident, family, and staff concerns as they relate to medical care services provided by the Company * Assistance in planning and providing medically related in-service programs * Participation in policy decision-making and direct supervision regarding quality of care and delivery of medical services to residents * Taking necessary action and corrective measures when a physician fails to provide services, which meet generally accepted standards of practice, including referring to the appropriate regulatory agency * Ensuring that the delegation of physician tasks to non-physician providers complies with Federal, State, and local laws and the Company's policies and procedures * Communication of medical staff responsibilities and medical care policies, procedures, and guidelines to all providers involved in resident care; responsible for written rules and regulations for all providers involved in resident care Review of the Medical Director job description states that the Medical Director is Board Certified as an MD or DO who provides the following functions in a facility: * Clinical Oversight * Staff Supervision * Policy and Procedure Development * Program Development and Planning * Quality Improvement * Community Engagement 1.) A complaint investigation revealed that Resident #1, admitted to the facility on [DATE] with a diagnosis of insulin dependent diabetes, did not have admission orders for insulin or blood sugar checks as indicated in their discharge orders and did not have a care plan for diabetes management (baseline or comprehensive) until 5/28/25. There is no evidence that Resident #1 had any insulin during their stay at the facility and no evidence that his/her blood sugars checked until 5/31/25, when it was asked to be done by their representative due to the significant decline in Resident #1’s status. See F655 and F656 for more information. Per offsite phone interview on 7/18/25 at 12:30 PM with the Medical Director, he stated they started in this role on 6/9/2025. They were aware that there was a contract for Medical Director and confirmed they had signed it. The following was revealed during this interview: A. Development, revision, and implementation of facility policies and procedures (continued on next page)

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	07/24/2025

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 0841 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	When asked about the role in the development, and revision of facility policy and procedures, they stated that they had not yet reviewed any of the facility policy and procedures. The Medical Director stated they were not aware of this document until 2 days ago when he was asked by the survey team if he had reviewed the document. The Medical Director was asked if s/he was aware of a policy or procedure specific to the care for residents with the diagnosis of diabetes. He stated that insulin is a dangerous medication and is over utilized. He stated that he plans to wean residents off insulin and if the resident is on a low dose of insulin, he would just discontinue it. He confirmed he had not reviewed the current facility policy and procedure for diabetes. He stated he would be creating a new policy and procedure to reflect the process of discontinuing sliding scale insulin and weaning residents off insulin. He confirmed that they would discontinue insulin for residents currently receiving low doses. B. Coordination of care The Medical Director was asked if he was aware of telehealth services being utilized in this building and how the services were being provided, he stated, Yes, telehealth services are being used in this building just for putting out fires. When asked who the telehealth providers were and which ones he had met or introduced themselves to, he stated, If you could name them, I can tell you which ones I've met or contacted to introduce myself to. The Medical Director was able to name two of the current providers and stated he had met with them to discuss residents at this facility. The Medical Director was asked how many residents medical records he has reviewed or discussed with the providers; he was able to name one resident. The Medical Director was asked which residents’ medical records he had reviewed he provided one resident name. The Medical Director was asked how he was coordinating care with their providers. He stated they look at the QAPI (Quality Assurance Performance Improvement) pieces, looking at psychotropic medications and he will be meeting with the providers quarterly to talk about regulatory changes, and address any issues that arise. The Medical Director stated that the QAPI meeting was scheduled for “this week but you people came in and we had to change it”. Per interview with the Administrator on 7/18/25 at approximately 4 PM, when asked about the QAPI meeting that was scheduled for “this week”, s/he stated, “oh we hadn’t scheduled one yet. ” C. Medical Director oversight of other health care providers and facility staff The Medical Director was asked if he was aware of the 30 laboratory orders from 6/30/25 that had not yet been drawn, he stated that he had not been made aware of this issue until two days ago when he had attended a meeting with the surveyors and the previous DON (Director of Nurses) revealed this information. The Medical Director was asked at this time if he would consider this an acceptable practice or good resident care, he stated, this is not acceptable, and physician orders are to be carried out as ordered and in a timely manner. See F770 and F773 for more information. D. Participation in QAPI (continued on next page)

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	07/24/2025

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 0841 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Issues were identified at an immediate jeopardy level related to not having an effective QAPI program. Multiple repeat deficiencies were identified during this survey. During a complaint survey on 11/19/24 the facility was cited for a deficiencies related to comprehensive care plans (F656) and abuse (F600), During a recertification survey dated 12/11/24, the facility was cited for deficiencies related to accidents, hazards, and supervision (F689), sufficient nursing staff (F725), notifying the ordering provider of laboratory results (F773), and state staffing requirements (S320). During a complaint survey dated 3/28/25 the facility was cited at a harm level for a deficiency related to accidents, hazards, and supervision (F689). During a complaint survey dated 4/9/25 the facility was cited at a widespread level for a deficiency related to the Medical Director (F841). During a complaint survey dated 5/28/25 the facility was cited at an immediate jeopardy level for a deficiency related to neglect (F600). See F865 for more information. The Medical Director was asked what role they performed in the QAPI Program. The Medical Director stated they would be attending the monthly meetings. The Medical Director was asked how they are involved in issues that arise related to coordination of care and implementation of resident care policies that are identified in QAPI or the QAA (Quality Assessment and Assurance) process. The Medical Director stated, I will address issues as they come up. The Medical Director was asked how they will use these meetings to ensure the best care is provided to the residents. He stated they will be reviewing the CASPER reports and previous meeting minutes. The Medical Director was asked if they have reviewed the current CASPER report or any of the facility's previous QAPI meeting minutes, he stated, no, I have not. The Medical Director was asked if they were aware of the facility's current outstanding citations and they stated, No, I am not. The Medical Director was asked if they had attended a QAPI meeting since starting in the medical director role, they stated that the QAPI meeting was scheduled for “this week but you people came in and we had to change it.” E. Sufficient staffing and timely medication administration Issues were identified with not having sufficient staff to provide resident care and services, including administering medications on time. See F725 and F760 for more information. The Medical Director was asked if he was aware that over the last few months there were many days when staffing levels fell below the federal and state regulations, he stated they were not aware of this issue until 2 days ago when s/he was part of a meeting and the previous DON confirmed this issue. The Medical Director was asked if they were aware of the magnitude of the resident's late medications report for the past 90 days (6,017 pages), and/or the resident missed medication report for the last 60 days (2,177 pages), he stated they were not aware of the extent of the medication issues in this building. F. Assisting in the development of educational programs for facility staff (continued on next page)

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	07/24/2025

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 0841 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	The Medical Director was asked how they assist in the developing, updating, and revision of educational trainings for the facility staff or other health care providers working in the facility. The Medical Director stated they have not participated or developed any of the staff trainings since assuming the role of Medical Director. G. Development, revision, and review of the Facility Assessment The Medical Director was asked to share their part in creating, updating, and/or revision the Facility Assessment tool (a comprehensive evaluation used to determine the resources, including staffing, equipment, and services, needed to provide competent care to residents). He was not aware of what this document was and had not reviewed this document since accepting the role of Medical Director in this facility. The Medical Director stated, I was not aware of what a Facility Assessment was until two days ago when we were discussing my role as the Medical Director. 2.) A complaint investigation revealed that Resident #6, admitted to the facility on [DATE], did not have admission orders for blood sugar checks as indicated in their discharge orders and did not have a care plan for diabetes management (baseline or comprehensive) until 5/28/25. There is no documented evidence that a provider reviewed Resident #6’s latest PCP (primary care physician) note dated 4/15/25, (which reveals that Resident #6 has well controlled diabetes using daily insulin), created a plan of care for the resident to manage their diabetes without insulin, or discussed this with the facility staff or other providers managing his/her care. Resident #6 was seen at the emergency room on 5/24/25, having acute hyperglycemia. See F655 and F711 for more information. Per phone interview on 6/20/25 at 11:22 AM, a Nurse Practitioner (Provider #2) was asked why Resident #6 did not have orders for insulin or blood sugar checks. He explained that he had not put in the admission orders. When asked how he knew that the admitting provider (previous Medical Director) had decided not to consider an order for insulin or perform blood sugars for Resident #6, he explained that he wasn’t aware as it wasn’t communicated in the visit note. Provider #2 had evaluated Resident #6 based on not having orders for insulin or diabetic medications. He stated that there is not enough collaboration with the care team, especially since residents are mostly receiving telehealth at the facility. When asked if he was aware that Resident #6 had just recently been on daily insulin prior to admission as indicated in the 4/15/25 PCP note he stated he was not sure that he saw that information but he hopes that if he did see it, he would have addressed it. Provider #6 was not aware that Resident #6 wasn’t getting blood sugar checks as indicated in the 4/30/25 TOC (transition of care). He explained that he is only in the facility every other week and needs to see 20 or more residents in a day and sometimes he does not get to review all the past medical documents. Provider #2 confirmed that Resident #6 should have had a baseline care plan for diabetes management. (continued on next page)

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	07/24/2025

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 0841 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Per phone interview with the (previous) Medical Director on 6/23/25 at 1:19 PM, he explained that he decided to hold off on providing insulin and doing blood sugars for Resident #6 on admission. He explained that his plan was to hold on these orders for a month because insulin is a dangerous medication for this population (nursing home residents) and it would be more beneficial to manage symptoms. When asked how he communicated this with the facility and other providers, he explained that he doesn’t have a way to communicate with other providers properly and there is no place in the EHR (electronic health record) to communicate with other providers. When asked if this resident should have a plan of care related to diabetes management, he said yes and wasn’t aware that Resident #6 didn’t have a plan of care related to diabetes. When asked if the facility had a protocol related to diabetes management that reflected his clinical decisions, he confirmed that there was not as he was working on developing a new protocol. When asked how staff or other providers would know how Resident #6’s diabetes was to be managed, he explained that he talked to a nurse. However, there is no documented evidence that the Resident’s diabetes management had been discussed between any providers and nursing staff. 3.) Per interview on 7/18/25 at 10:04 AM, Provider #1 reveals that she is employed by a company contracted by the facility to provide medical staff. She has not collaborated with the Medical Director regarding resident care. A second interview with Provider # 2 on 7/18/25 at 10:39 AM reveals that he has been working in the facility since April. He does not regularly collaborate with the Medical Director regarding the care of the residents. He believes the current Medical Director is a Regional Medical Director who does not live in the state. When discussing the Medical Director, he referred to the previous Medical Director; was not aware that there was a new Medical Director. A third interview with Provider #4 on 7/18/25 at 2:00 PM revealed that he had been working in the facility on a day-by-day basis. He is scheduled to provide services regularly every other week. He spoke to the Medical Director for the first time in the morning of 7/18/2025. He has not collaborated with the Medical Director regarding resident care.

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	07/24/2025

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 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a plan that describes the process for conducting QAPI and QAA activities. (continued on next page)

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	07/24/2025

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 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Based on record review and interview of the facility's Quality Assurance and Performance Improvement Program (QAPI), the facility failed to address all systems of care in a comprehensive manner by identifying problems and opportunities for improvement in the areas of treatment/services specific to meeting required regulatory visits; appropriate staffing levels: ensuring there was an RN in the building for 8 consecutive hours 7 days/week; residents care supervised by a physician to include required regulatory visits; laboratory orders were performed timely; neglect (cited at immediate jeopardy level); administration; and Medical Director (cited at immediate jeopardy level). The identified failure to have an effective Quality Assurance and Performance Improvement Program to identify problems and provide system oversight has the potential put all residents at risk for more than minimal harm. Findings include:During a complaint investigation with 3 complaints the facility was found to have deficient practices that resulted in 2 citations at immediate jeopardy level and 15 deficient practices with potential for more than minimal harm. Multiple repeat deficiencies were identified during this survey. During a complaint survey on 11/19/24 the facility was cited for a deficiencies related to comprehensive care plans (F656) and abuse (F600), During a recertification survey dated 12/11/24, the facility was cited for deficiencies related to accidents, hazards, and supervision (F689), sufficient nursing staff (F725), notifying the ordering provider of laboratory results (F773), and state staffing requirements (S320). During a complaint survey dated 3/28/25 the facility was cited at a harm level for a deficiency related to accidents, hazards, and supervision (F689). During a complaint survey dated 4/9/25 the facility was cited at a widespread level for a deficiency related to the Medical Director (F841). During a complaint survey dated 5/28/25 the facility was cited at an immediate jeopardy level for a deficiency related to neglect (F600).The facility's plans of correction for all repeat deficiencies above identified that either the nursing leadership team (Director of Nursing/Assistant Director of Nursing) and/or the Administrator were responsible for both auditing to ensure that regulatory requirements were met and reporting the audit results to the Quality Assurance Committee.Also refer to F841 regarding failure to provide administrative oversight to the Medical Director. Per review of facility's QAPI plan, page 2 states, Vision: We aim to be a regional leader in the advancement of long-term and subacute care by integrating excellent resident care, quality professional development, and substantive engagement with residents, families, staff, providers, and partners on the care continuum. Mission: It is our sacred responsibility - our daily opportunity - to provide better care than we did the day before in a manner that is fresh, new, even revolutionary. Purpose: With QAPI as our guiding principle, our facility has a Performance Improvement Program which systematically monitors, analyzes, and improves its performance to improve resident/patient outcomes. Key issues will be addressed on an ongoing basis to improve overall outcomes in the following areas including but not limited to: i. Clinical Care - QI/QM results, internal monitors for falls medication errors, pressure ulcers, incidents/accidents, infections, rehospitalizations, significant weight loss. ii. Quality of Life (QOL)---resident/family satisfaction surveys, resident/family concerns brought up at Resident Council meetings, concerns from care conferences and individual rounding with residents and family members.iii. Resident Choice---Individualized goals for care are addressed at care conferences, resident satisfaction with dining, resident engagement in recreation opportunities. iv. Organizational management practices: staffing admissions, discharges, resident funds, in house transfers, medical records and privacy etc. Per interview on 7/16/25 at approximately 3:00 PM, the Medical Director stated that they had not yet participated in a QAPI meeting and confirmed that they had not reviewed the previous months QAPI meeting minutes or agenda. The Medical Director was asked what his role will be in the QAPI meetings, and they stated they would review the CASPER reports, previous meeting minutes, outstanding projects, and they would be attending the monthly meetings. They had not reviewed the facility's previous 2567's (statement of deficiency reports) to include the facility's plans of correction from the last 4 surveys or the current outstanding citations. The Medical Director confirmed that they lived in the state of Florida and would be attending the monthly QAPI meetings via an internet-based audio-visual program. Per interview on 7/17/25 at approximately 5:30 PM, that Administrator confirmed the QAPI team has been working on staffing, staff education, resident rights, and abuse prevention. See F600, F609, F655, F657, F686, F689, F711, F712, F725, F727, F760, F770, F773, F835, and F841 for more information.