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	05/04/2026

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to treat a resident in a manner that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's right to make choices, for 1 of 4 sampled residents (Resident #4) with the resident subsequently sustaining injury. Findings include: Per record review, Resident #4 has diagnoses that include unspecified dementia with agitation and cognitive communication deficit. Per an MDS (Minimum Data Set, a resident assessment tool) dated 12/9/25, Resident #4 has a BIMS (Brief Interview for Mental Status) score of 3, indicating severe cognitive impairment. Per record review, Resident #4 has a care plan focus initiated 5/13/25, which indicates that Resident #4 is resistive to care related to difficulty adjusting to facility, and cognitive loss and dementia, with an intervention to Allow time for expression of feelings; provide empathy, encouragement, and reassurance, last revised 8/3/25. Resident #4 has a care plan focus last revised on 8/3/25 which states, [Resident #4] is at risk for distressed/fluctuating mood symptoms related to: history of military experience, change in living environment, with an intervention to Provide with opportunities for choice during care/activities to provide a sense of control. Per record review, a behavior note dated 12/17/25 states the following, Resident found with feces covering body from head to toe before end of shift. Due to extensive soiling, resident was escorted to shower for hygiene care. Care was provided by nurse and three LNAs due to resident's known aggressive behavior. During care, resident became physically aggressive, including punching, trying to bite and pulling staff members' hair. Resident was physically digging into [his/her] skin and staff skin with [his/her] nails. Staff maintained safety precautions and continued care as tolerated. Resident remained physically aggressive throughout hygiene care. Care completed with staff assistance. Resident monitored post-care. A progress noted dated 12/18/25 states, notified by staff that resident had been combative with cares, when going into room for skin check, resident was noted with scattered bruising. Skin tears to right arm and left outer knee. A nursing post event skin condition assessment dated [DATE] notes new skin alterations identified including, Left lateral calf skin tear, right and left forearm skin tear, Scattered bruising on upper right arm, side and right lower extremity. Additionally stating, Recent illness with COVID now recovering from illness, recent falls, combative behavior, weight loss, (labs pending), having an increase in combative behaviors. Resident covered [himself/herself] in [his/her] feces, [s/he] was brought to the shower to receive care in which [s/he] became combative with staff, and was hitting [his/her] arms of [his/her] chair in the shower room. Resident was reported to have bit, scratched [himself/herself] and others in the shower room. MD notified, family notified. Per review of a facility disciplinary document given to LNA #1, dated 12/19/25, it stated that Resident #4 was not cooperative with care, the shower did not go well, and that the resident received scratches, skin tears, and bruising. Per an interview with the DON (Director of Nursing) on 5/4/26 at 12:00 PM, she confirmed that Resident #4 was refusing care, was combative and agitated and that staff then continued to bathe the resident. Per an interview with LNA #1 on 5/4/26 at 1:35 PM, she stated she had found the resident covered with BM (bowel movement) and attempted to bathe him/her. When the (continued on next page)

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	resident refused, she asked LPN #1 to assist in bathing him/her. When in the shower room, two additional LNA's also assisted in bathing Resident #4. LNA #1 confirmed that Resident #4 was combative throughout the entire process. The facility did not honor Resident #4's choice to not bathe and the resident subsequently sustained multiple skin tears and bruising.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to revise and implement a person-centered care plan for 1 of 4 sampled residents (Resident #4). The care plan was not revised and implemented to address Resident 4's physically aggressive behavior. This is a repeat deficiency for this facility, with the violation cited during a previous partial survey dated 7/25/25. Findings include: Per record review, Resident #4 has diagnoses that include dementia with agitation and cognitive communication deficit. Per an MDS (Minimum Data Set, a resident assessment tool) dated 12/9/25, Resident #4 has a BIMS (Brief Interview for Mental Status) score of 3, indicating severe cognitive impairment. Per record review, a nursing progress note on 11/3/25 noted that the resident displayed increased behavior and agitation. Resident made a fist and threatened to knock a staff member out, then proceeded to push a staff member out of the way. Resident #4 sustained a skin tear during this incident. A subsequent nursing note dated 11/3/25 stated The EMR call the state police department for rescue Resident was abusive with the entire staff even slap the police Versed (a medication used to induce relaxation or sleep) was administered IM [injected directly into the muscle]. The administered was notified and transport Resident to hospital via stretcher. A nursing progress noted dated 11/5/25 stated, Resident refused to allow LNA [Licensed Nursing Assistant] to change soiled brief. LNA made several attempts to change resident. Resident became agitated and aggressive and swatted LNA's hand multiple times. A nursing progress note dated 12/2/25 stated, Resident exhibited visible aggression toward both aides this morning. [s/he] was yelling and slamming doors, demanding that staff leave [his/her] room. The resident refused to take a shower or allow staff to provide hygiene care. Writer attempted to re-approach a few minutes later and received the same aggressive responses. Staff will continue to monitor and attempt care as tolerated. An MDS dated [DATE] stated that Resident #4 exhibited physical behavioral symptoms directed toward others on 1 to 3 days, The MDS defines such symptoms as Physical behavioral symptoms directed toward others (e.g., hitting, kicking, pushing, scratching, grabbing, abusing others sexually). A nursing progress note dated 12/12/25 stated that the resident was verbally and physically aggressive. Per record review, a behavior note dated 12/17/25 states the following, Resident found with feces covering body from head to toe before end of shift. Due to extensive soiling, resident was escorted to shower for hygiene care. Care was provided by nurse and three LNAs due to resident's known aggressive behavior. During care, resident became physically aggressive, including punching, trying to bite and pulling staff members' hair. Resident was physically digging into [his/her] skin and staff skin with [his/her] nails. Staff maintained safety precautions and continued care as tolerated. Resident remained physically aggressive throughout hygiene care. Care completed with staff assistance. Resident monitored post-care. A progress noted dated 12/18/25 states, notified by staff that resident had been combative with cares, when going into room for skin check, resident was noted with scattered bruising. Skin tears to right arm and left outer knee. A nursing post event skin condition assessment dated [DATE] notes new skin alterations identified including, Left lateral calf skin tear, right and left forearm skin tear, Scattered bruising on upper right arm, side and right lower extremity. Additionally stating, Recent illness with COVID now recovering from illness, recent falls, combative behavior, weight loss, (labs pending), having an increase in combative behaviors. Resident covered [himself/herself] in [his/her] feces, [s/he] was brought to the shower to receive care in which [s/he] became combative with staff, and was hitting [his/her] arms of [his/her] chair in the shower room. Resident was reported to have bit, scratched [himself/herself] and others in the shower room. MD notified, family notified. Per an interview with the DON (Director of Nursing) on 5/4/26 at 12:00 PM, she confirmed that during the incident on 12/17/25, Resident #4 was refusing care, was combative and agitated and that staff continued to bathe the resident. Per an interview with LNA #1 on 5/4/26 at (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1:35 PM, with regard to the incident on 12/17/25, she stated that she had found the resident covered with BM (bowel movement) and attempted to bathe him/her. When the resident refused, she asked LPN #1 to assist in bathing him/her. When in the shower room, two additional LNAs also assisted LNA #1 and LPN #1 in bathing Resident #4. LNA #1 confirmed that Resident #4 was combative throughout the entire time they were providing care. The facility did not revise Resident #4's care plan with interventions to address a pattern of physically aggressive behavior until 12/18/26, over 6 weeks after an increase in physical behaviors.