

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 475019	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/06/2022
NAME OF PROVIDER OR SUPPLIER St Johnsbury Health & Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE 1248 Hospital Drive Saint Johnsbury, VT 05819	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0658</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Ensure services provided by the nursing facility meet professional standards of quality.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46135</p> <p>Based on interview and record review, the facility staff failed to provide services that meet professional standards of quality for 1 of 9 applicable residents in the sample (Resident #2). Findings include:</p> <p>Per record review, facility staff failed to follow advance directives and physician's orders to resuscitate Resident #2, whose code status was full code (if a person's heart has stopped beating and/or they stopped breathing, all resuscitation procedures are to be provided to keep them alive). Resident #2's medical record includes: a DNR/COLST (Clinician Order for DNR/CPR and Other Life Sustaining Treatment) indicating cardiopulmonary resuscitation (CPR), signed by the clinician on [DATE], and his/her care plan, last updated on [DATE], reveals [Resident #2] has an advanced directive of Full Code, with the goal listed as [Resident #2]'s advanced directives will be honored, and an intervention listed as CPR will be performed as need.</p> <p>Review of the facility's policy and procedure titled NSG208 Cardiac and/or Respiratory Arrest, under Policy reads: Centers support the right of every patient to accept or decline cardiopulmonary resuscitation (CPR) in the event of cardiac or respiratory arrest. The Center will perform CPR on all patients, except in limited circumstances, unless there is a written physician's order, agreed to by the patient or health care decision maker, not to resuscitate (DNR), in accordance with state regulation/law, and If a patient does not have a DNR order, CPR/AED certified staff will initiate CPR/AED and emergency medical services (EMS) will be activated. CPR is to be provided in the location where the patient is discovered as long as the location is safe for the responder and patient.</p> <p>A written statement to the facility given on [DATE] by the first staff member to find Resident #2 unresponsive stated that after s/he found Resident #2 unresponsive sometime between 10:00 PM and 10:10 PM, s/he located the A Wing Licensed Practical Nurse (LPN). S/he stated that this LPN assessed Resident #2 for heartbeat and breathing and then told him/her that '[Resident #2] passed and to start postmortem care.'</p> <p>A written statement to the facility given on [DATE] by the first licensed nurse present (A Wing LPN) after Resident #2 was found unresponsive stated that s/he confirmed Resident #2 was unresponsive sometime after 10:00 PM on [DATE] and that s/he did not know Resident #2's code status and did not immediately initiate CPR. This LPN then found out from other staff that Resident #2 is a full code. This LPN did not initiate CPR when finding out the code status. Instead, s/he called the weekend supervisor at 10:46 PM who instructed him/her to perform CPR immediately unless rigor mortis or lividity was present. This LPN was joined by another LPN who initiated CPR on Resident #2.</p> <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0658</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>On ,d+[DATE] at 12:16 PM, the LPN to first initiate CPR on Resident #2 confirmed that the first licensed nurse to discover that Resident #2 was unresponsive did not start CPR after knowing that Resident #2 is a full code. S/he stated that s/he, himself/herself, initiated CPR at approximately 10:47 PM and emergency medical services (EMS) were called. Shortly after EMS' arrival, EMS pronounced Resident #2 deceased .</p> <p>On [DATE] at 1:08 PM, the Director of Nursing confirmed that licensed nurses should follow facility policy about initiating CPR as indicated by their code status, and that staff did not initiate CPR according to policy for Resident #2.</p> <p>Ref: [NAME] Manual of Nursing Practice (9th ed.). Wolters Kluwer Health/ [NAME] & [NAME].</p>		

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<p>F 0678</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Provide basic life support, including CPR, prior to the arrival of emergency medical personnel , subject to physician orders and the resident's advance directives.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46135</p> <p>Based on staff interview and record review, the facility failed to ensure that staff were certified to provide basic life support, including Cardiopulmonary Resuscitation (CPR), and familiar with facility policies related to CPR. Findings include:</p> <p>1. Per record review, facility staff failed to follow advance directives and physician's orders to resuscitate Resident #2, whose code status was full code (if a person's heart has stopped beating and/or they stopped breathing, all resuscitation procedures are to be provided to keep them alive). Resident #2's medical record includes: a DNR/COLST (Clinician Order for DNR/CPR and Other Life Sustaining Treatment) indicating cardiopulmonary resuscitation (CPR), signed by the clinician on [DATE], and his/her care plan, last updated on [DATE], reveals [Resident #2] has an advanced directive of Full Code, with the goal listed as [Resident #2]'s advanced directives will be honored, and an intervention listed as CPR will be performed as need.</p> <p>Review of the facility's policy and procedure titled NSG107 Emergency: Medical Response, under Policy reads Response to medical emergencies will be delivered within the scope of practice of the licensed nursing staff. If the patient is in cardiac and/or respiratory arrest, refer to Cardiac and/or Respiratory Arrest policy and procedure. Systems will be in place for: Eliciting assistance from co-workers; and Identification of patient code status.</p> <p>Review of the facility's policy and procedure titled NSG208 Cardiac and/or Respiratory Arrest, under Policy reads: Centers support the right of every patient to accept or decline cardiopulmonary resuscitation (CPR) in the event of cardiac or respiratory arrest. The Center will perform CPR on all patients, except in limited circumstances, unless there is a written physician's order, agreed to by the patient or health care decision maker, not to resuscitate (DNR), in accordance with state regulation/law, and If a patient does not have a DNR order, CPR/AED certified staff will initiate CPR/AED and emergency medical services (EMS) will be activated. CPR is to be provided in the location where the patient is discovered as long as the location is safe for the responder and patient.</p> <p>A written statement given to the facility by the first staff member to find Resident #2 unresponsive on [DATE] stated that, after s/he found Resident #2 unresponsive sometime between 10:00 PM and 10:10 PM, s/he located the A Wing Licensed Practical Nurse (LPN). S/he stated that this LPN assessed Resident #2 for heartbeat and breathing and then told him/her that '[Resident #2] passed and to start postmortem care.'</p> <p>A written statement given to the facility by the first licensed nurse present (A Wing LPN) after Resident #2 was found unresponsive stated that, s/he confirmed Resident #2 was unresponsive sometime after 10:00 PM on [DATE], that s/he did not know Resident #2's code status, and did not immediately initiate CPR. This LPN then found out from other staff that Resident #2 is a full code. This LPN did not initiate CPR when finding out the code status. Instead, s/he called the weekend supervisor at 10:46 PM who instructed him/her to perform CPR immediately unless rigor mortis or lividity was present. This LPN was joined by another LPN who then initiated CPR on Resident #2.</p> <p>(continued on next page)</p>		

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<p>F 0678</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Per interview, on [DATE] at 12:16 PM, the LPN to first initiate CPR on Resident #2 confirmed that the first licensed nurse to discover that Resident #2 was unresponsive did not start CPR after knowing that Resident #2 is a full code. S/he stated that s/he, himself/herself, initiated CPR at approximately 10:47 PM and emergency medical services (EMS) were called. Shortly after EMS' arrival, EMS pronounced Resident #2 deceased .</p> <p>Per interview on [DATE] at 2:45 PM, the first licensed nurse present after Resident #2 was found unresponsive stated that s/he has not received any training about facility specific code status from the facility.</p> <p>On [DATE] at 1:08 PM, the Director of Nursing confirmed that licensed nurses should follow facility policy about initiating CPR as indicated by their code status, and that staff did not initiate CPR according to policy for Resident #2.</p> <p>2. Review of the facility's policy and procedure titled NSG208 Cardiac and/or Respiratory Arrest, under Policy reads: Licensed nursing staff must maintain current CPR certification for healthcare providers through CPR training that includes hands-on practice and in personal skills assessment, and Licensed nurses will be trained in the evaluation of the obvious clinical signs of irreversible death upon hire.</p> <p>On [DATE] at 10:40, a licensed nurse stated that s/he hasn't been recertified in CPR since before s/he was hired over three years ago, and that the facility doesn't follow up on these kinds of things.</p> <p>On [DATE] at 1:08 PM, the Director of Nursing stated that Human Resources (HR) should have CPR certifications for nursing staff on file, as they should get it upon hire. S/he is unsure if HR has CPR cards on file for contracted staff or if it is in their agency files. S/he stated that the Nurse Educator would be the person to go over facility policies about CPR.</p> <p>On [DATE] at 1:30 PM the Human Resource Director stated that s/he does not get CPR certification from employees, and s/he guesses that s/he should be. S/he was not able to produce CPR certification cards for four employees when requested by this surveyor.</p> <p>On [DATE] at 1:40 PM, the Nurse Educator stated that s/he does not get a CPR certification from new employees on hire and does not know who goes over facility policies, but it is probably HR (Human Resources). S/he could not produce cardiac and respiratory arrest competencies or trainings for any staff. S/he is unsure who oversees that staff are recertified when their certification expires. S/he confirmed there is no system in place to ensure that nursing staff are properly certified or trained to perform CPR.</p> <p>Per interview on [DATE] at 2:45 PM, an LPN stated that s/he has not received any training about facility specific code status from the facility.</p> <p>On the afternoon of [DATE], facility staff, including the Administrator and DON, agreed that their staff couldn't produce evidence that the facility has CPR certified staff on duty ,d+[DATE] as required or ensure that staff is familiar with facility policies related to CPR. The facility currently has 26 residents that are a full code. These 26 residents would require CPR certified staff in the event of cardiac arrest.</p>		