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	04/07/2023

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

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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 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** 46135 Based on interview and record review, the facility failed to develop a baseline care plan within 48 hours of admission that included the minimum healthcare information necessary to properly care for the resident for 4 applicable residents (Residents #2, #3, #4, and #5). Findings include: 1. Resident #2 was admitted to the facility on [DATE] and has diagnoses that include: heart failure, hypertension, history of stroke, type 2 diabetes, and neurogenic bladder. Resident #2's care plan for risk for skin break down was created on 3/22/2023, 51 days after admission, and his/her care plan for risk for falls was created on 3/30/2023, 59 days after admission. 2. Resident #3 was admitted to the facility on [DATE] and has diagnoses that include: heart failure, Alzheimer's disease, chronic embolism and thrombosis, osteoarthritis, hypertension, and anemia. Resident #2's care plan for risk for skin break down was created on 2/10/2023, 7 days after admission. 3. Resident #4 was admitted to the facility on [DATE] and has diagnoses that include: dementia, bipolar disorder, repeated falls, abnormalities of gait and mobility, COPD, major depressive disorder, and hypertension. Resident #4's care plan for risk for skin break down was created on 3/24/2023, 58 days after admission, and his/her care plan for risk for falls was created on 3/23/2023, 57 days after admission. 4. Resident #5 was admitted to the facility on [DATE] and has diagnoses that include: hypertension, repeated falls, osteoarthritis, type 2 diabetes, spinal stenosis, depression, and abnormalities of gait and mobility. Resident #5's care plans for risk for skin break down and risk for falls were created on 2/8/2023, 8 days after admission. Facility policy titled OPS416 Person-Centered Care Plan, last revised on 10/24/2023, states that a baseline care plan must be developed within 48 hours and include the minimum healthcare information necessary to properly care for a patient . On 3/23/2023 at 12:45 PM, the Director of Nursing confirmed that some baseline care plan areas have not been completed for all residents and stated that the unit manager had just received education on creating and revising care plans. (continued on next page)

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

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 3/23/2023 at 2:52 PM, the Unit Manager stated that s/he was made aware yesterday of the care areas that are required to be in baseline care plans. On 4/7/2023 at 11:12 AM, the Market Clinical Lead confirmed that the above residents did not have baseline care plans for the above areas within 48 hours of admission.

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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 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46135 Based on observation, record review, and interview, the facility failed to provide safe and effective skin and wound care consistent with facility policy and professional standards of practice for 1 applicable resident (Resident #1) with existing non-pressure ulcer wounds by failing to: accurately perform and document skin inspections (skin checks), accurately and regularly perform non-pressure ulcer wound evaluations per facility schedule, perform and document daily monitoring of non-pressure ulcer wounds or dressings, follow physician's orders for treatment and implement care plan interventions related to wound treatment. Findings include: Resident #1 was initially admitted to the facility on [DATE] and readmitted to the facility from the hospital on 3/20/2023 with diagnoses that include: type 2 diabetes, dementia, peripheral vascular disease, absence of two left toes, heart disease, major depressive disorder, and abnormalities of gait and mobility. A facility incident report reveals that Resident #1 had falls on 3/6/2023 and 3/10/2023. A provider note dated 3/9/2023 reveals that Resident #1 had complaints of pain to his/her left ankle/heel and right rib cage; and left foot bruising and swelling 3 days post fall. A change in condition note dated 3/10/2023 reveals the following nursing observations: LLE [left lower extremity] presents swollen bruised on 3/8 with open area to the planter area of the left foot, now red hot to touch, initial xray negative for fx [fracture], Resident with marked decreased in physical abilities and requires max assist with adls [activities of daily living], WBC [white blood cells] elevated. Refusing meals. Significant decline from usual baseline. A nursing note dated 3/11/2023 states that Resident #1 was sent to the hospital on 3/10/2023 for further evaluation. An emergency department provider note dated 3/11/2023 states that Resident #1's diagnosis of septic shock likely secondary to cellulitis and potential pneumonia. A Podiatry note dated 3/13/2023 reveals that Resident #1 had L [left] foot with full thickness ulceration plantar [bottom of the foot] L 2nd metatarsal [foot bones that connect to the toes] head present for months with probe to bone, exposed bone, and purulence, and recommendations were made for daily dressing changes, avoidance of anything but paper tape, and use of a prevalon or comparable heel offloading boot. A hospital provider progress note dated 3/14/23 states that the source Resident #1's septic shock was from a diabetic foot wound with osteomyelitis/cellulitis LLE. A hospital discharge summary dated 3/20/2023 reveals that Resident #'s 1 wound on the plantar surface of his/her left foot had been there for months, probed down to the bone, and had purulent drainage. It stated that Resident #1 did not want surgical management of his/her foot but agreed to wound treatment, dressing changes, pain medication, and antibiotics as needed. The note refers to the podiatrist's instructions regarding wound care/dressing changes to left foot and to consult a wound care nurse to evaluate and treat patient's foot wounds. A nurse note dated 3/20/2023 states that Resident #1 was readmitted from the hospital and had Dressing to left foot, moderate amount sero/sang drainage [Serosanguineous; pink watery fluid] to dressing. Dressing not removed at this time, awaiting wound care instructions. On 3/23/2023 at approximately 1:00 PM, Resident #1 was observed in bed. His/her legs were bare, and his/her left foot was dressed with multiple bandages and pressed into the footboard of the bed. The outer dressing was visibly bloody, along with the fitted bed sheet. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	On 3/23/2023 at 1:19 PM, a Licensed Nurse Aide (LNA) stated that Resident #1 needed supervision with some ADLs before s/he went to the hospital. Since Resident #1 has returned, they have had a change in ability and now require staff assistance for ADLs. The LNA noted that Resident #1 has not left his/her bed since s/he was readmitted . On 3/23/2023 at 1:55 PM, a Licensed Practical Nurse (LPN) and the Director of Nursing (DON) were observed inspecting Resident #1's dressings. A gauze wrap was removed from the lower section of the foot which was soiled with blood and fluid. Two padded bandages were revealed wrapping the back of Resident #1's left ankle area. These bandages were dated 3/19/23. At approximately 2:00 PM on 3/23/2023, an LPN stated that Resident #1 was not receiving appropriate wound care because the bandage that was on the wound was not appropriate for the amount of fluid that was coming out of it. S/he stated that sometimes s/he has to change the dressing twice in a shift because it gets so bad and that the wound has been there for a long time. On 3/23/2023 at 2:10 PM, the DON stated that Resident #1 does have a chronic diabetic foot ulcer and there are physician orders to treat it. S/He thinks that the wound has a history of opening and closing. S/he also thinks that the nursing staff were waiting to get dressing orders before doing a wound assessment and a dressing change per the nursing note on 3/20/23. Facility policy titled NSG236 Skin Integrity and Wound Management, last revised on 2/1/2023, states: A comprehensive initial and ongoing nursing assessment of intrinsic and extrinsic factors that influences skin health, skin/wound impairment, and the ability of a wound to heal will be performed. The plan of care for the patient will be reflective of assessment findings from the comprehensive patient assessment and wound evaluation. Staff will continually observe and monitor patients for changes and implement revisions to the plan of care as needed. Practice Standards include: 6. A licensed nurse will: 6.1 Evaluate any reported or suspected skin changes or wounds; 6.4 Perform and document skin inspection on all newly admitted /readmitted patients weekly thereafter and with any significant change of condition; 6.5 Complete wound evaluation upon admission/readmission, new in-house acquired, weekly, and with unanticipated decline in wounds; 6.6 Perform daily monitoring of wounds or dressings for presence of complications or declines. 6.6.1 Document daily monitoring of ulcer/wound site with or without dressing. Further review of Resident #1's medical record reveals the flowing: Resident #1's care plan includes the following focus: [Resident] has Diabetic Ulcer r/t Diabetes, Lack of sensation to affected area, created on 5/31/2022. Interventions include: Ensure appropriate protective devices are applied to affected areas, created on 5/31/2022, Monitor/document wound: Size, Depth, Margins: periwound skin, sinuses, undermining, exudates, edema, granulation, infection, necrosis, eschar, gangrene, Document progress in wound healing on an ongoing basis. Notify MD as indicated, created on 5/31/2022, and Treat wound as per facility protocol, created on 5/31/2022. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Skin checks on 2/7/2023, 2/10/2023, 2/17/2023, 2/25/2023, and 3/4/2023 do not include documentation of Resident #1's diabetic foot ulcer. There are no physician's orders for wound care in February or the beginning of March 2023. The following physician's orders started on 3/9/2023: Ball of left foot. Cleanse with wound cleanser, pat dry, apply double layer xeroform to wound bed. Cover with DPD. every 1 hours as needed for wound care, and 3/10/2023: Ball of left foot. Cleanse with wound cleanser, pat dry, apply double layer xeroform to wound bed. Cover with DPD. every day shift for wound. There is no documentation in the treatment administration record (TAR) or medication administration record (MAR) that the wound was treated when Resident #1 returned from the hospital on 3/20/2023 through 2:00 PM on 3/23/2023. There are no weekly wound assessments or documentation of daily wound monitoring, of Resident #1's diabetic foot ulcer in February or March prior to 3/24/2023. On 4/7/2023 at 11:12 AM, the Market Clinical Lead confirmed that skin assessments should include all wounds, even if they are not new, until they are resolved. S/He confirmed that Resident #1 did not have: accurate skin assessments prior to transferring to the hospital on 3/10/2023, physician orders for his/her diabetic ulcer until 3/9/2023, and that wound assessments and monitoring did not occur until 3/24/2023.

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F 0686 Level of Harm - 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** 46135 Based on observation, record review, and interview, the facility failed to provide safe and effective skin and wound care consistent with facility policy and professional standards of practice for 3 of 3 sampled residents (Residents #1, #2, and #3) to prevent and treat existing pressure ulcers by failing to: accurately perform and document skin inspections (skin checks), accurately and regularly perform pressure ulcer wound evaluations per facility schedule, perform and document daily monitoring of pressure ulcer wounds or dressings, obtain treatment orders from physician, follow physician's orders for treatment, implement care plan interventions related to wound treatment, and revise care plans to meet resident's skin and wound care needs. Findings include: 1. Record review and interview reveal that Resident #2 was at risk for developing pressure ulcers and developed three pressure ulcers after admission. The facility failed to provide timely and accurate skin and wound assessments, provide pressure ulcer treatment and dressing changes, create and revise his/her care plan to reflect his/her clinical skin condition and needs, and provide daily monitoring of existing pressure ulcers placing Resident #2 at increased risk for wound complications and developing additional pressure ulcers. Record review reveals that Resident #2 was admitted to the facility on [DATE] and has diagnoses that include: Heart failure, hypertension, history of stroke, type 2 diabetes, and neurogenic bladder. Resident #2's Minimum Data Set (MDS; a comprehensive assessment used as a care-planning tool) dated 2/6/2023 reveals that s/he is at risk for developing pressure ulcers. These clinical conditions and comorbidities are risk factors for developing pressure ulcers. On admission Resident #2 had the following physician orders: left heel protector to left heel at all times every shift, and calazimine to redness on coccyx [the lowest part of the back, directly below the sacrum], penis and scrotum two times a day for redness. On 2/7/2023, A skin assessment notes Pressure Area(s): Location(s): Redness/excoriation on sacrum and under both butt cheeks. Calazime cream applied. A progress note dated 2/12/23 reveals that a CNA [Certified Nurse Aide] alerted RN [Registered Nurse] of blister on left heel. No pain on assessment. Sponge dressing applied for protection. MD and DON [Director of Nursing] aware. Left voicemail for family. Foam foot protector in place. A 2/14/2023, a skin check notes that no skin injuries/wounds are identified. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Resident #2 was transferred to the hospital on 2/19/2023 due to an altered mental state. A wound consult note from the hospital reveals that Resident #2 has right and left heel deep tissue injuries, a reddened area to the sacrum, and a pink area to the right medial thigh. The following recommendations were made for treatment to the sacrum and right medial thigh: provide skin hygiene with soap and water, pat dry, apply zincoxide skin barrier (orange tube), apply skin prep to periwound skin, apply small sacral mepilex [foam dressing] to sacrum, apply 4x4 mepilex to right medial thigh, and change dressing every 3 days and prn [as needed]. The following recommendations were made for treatment to the heels: provide hygiene to the lower extremities, pat dry, apply Lubriderm to shins and feet, paint heels with betadine and allow to dry, cover with mepilex, apply booties to bilateral feet, change dressing every other day and prn. Resident #2 was readmitted to the facility on [DATE]. A readmission nursing assessment identifies the following Rash(es): Description: On buttock, red, fungal MASD [moisture associate skin damage]: Description: coccyx Skin Tear(s): Description: small abrasions on coccyx, healing Pressure(s): Description: Left heel has purple blisters and small scab .5 cm. On 2/27/2023, a provider note reveals the following Pressure ulcer of right and left heel: Stable. Skin of bilateral heels are intact. Continue with wound care and heel protector boot on left foot. Groin rash: Stable. A 3/4/2023 skin check reveals injury to the buttocks area. There is no documentation of right or left heel wounds. A 3/10/2023 wound evaluation reveals that Resident #2 has an unstageable left heel pressure ulcer. On 3/10/2023, the treatment administration record (TAR) shows the first physician order for wound treatment to Resident #2's left heel. On 3/11/2023, the TAR shows the first physician order for wound treatment to Resident #2's right heel. A 3/11/2023 skin check reveals a scratch on Resident #2's nose. There is no documentation of the injuries/wounds to Resident #2's heels or sacrum. On 3/15/2023, the first wound evaluation was completed for Resident #2, revealing an unstageable left heel ulcer. No evaluations were done for Resident #2's sacrum or right heel. On 3/22/2023, wound evaluations reveal an unstageable left heel ulcer and a stage 3 pressure ulcer [full thickness skin loss] to the coccyx. On 3/22/2023, the TAR shows the first physician order for wound treatment to Resident #2's coccyx. On 3/22/2023, 51 days after admission, a care plan was created for Resident #2 with the following focus: Resident at risk for skin breakdown related to advanced age (great than [AGE] years), frail fragile skin, impaired cognition, incontinence and has actual skin breakdown. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	On 3/24/2023, wound evaluations reveal an unstageable left heel ulcer, a stage 2 pressure ulcer [partial-thickness skin loss with exposed dermis] to the right heel, a stage 3 pressure ulcer to the coccyx, and a deep tissue injury to the left hand. There is no documentation of daily wound monitoring of Resident #2's wounds prior to 3/24/2023. 2. Record review and interview reveal that Resident #1 was readmitted to the facility from the hospital on 3/20/2023 with a stage 2 pressure ulcer. The facility failed to provide timely and regular skin and wound assessments, provide pressure ulcer treatment and dressing changes, revise his/her care plan to reflect his/her clinical skin condition and needs, and provide daily monitoring of existing pressure ulcers, placing Resident #1 at increased risk for wound complications and developing additional pressure ulcers. Resident #1 was initially admitted to the facility on [DATE] and readmitted to the facility from the hospital on 3/20/2023 with diagnoses that include: type 2 diabetes, dementia, peripheral vascular disease, absence of two left toes, heart disease, major depressive disorder, and abnormalities of gait and mobility. Resident #1's MDS dated [DATE] reveals that s/he is at risk for developing pressure ulcers. These clinical conditions and comorbidities are risk factors for developing pressure ulcers. A facility incident report reveals that Resident #1 had falls on 3/6/2023 and 3/10/2023. A nursing note dated 3/11/2023 states that Resident #1 was sent to the hospital on 3/10/2023 for further evaluation. A Podiatry note dated 3/13/2023 reveals that Resident #1 had Partial thickness wounds medial and lateral ankle areas and posterior heel, and recommendations were made for daily dressing changes, avoidance of anything but paper tape, and use of a prevalon or comparable heel offloading boot. A hospital wound assessment dated [DATE] reveals that Resident #1 had a stage 2 pressure ulcer on his/her left ankle. A hospital discharge summary dated 3/20/2023 refers to the podiatrist's instructions regarding wound care/dressing changes to left foot and to consult a wound care nurse to evaluate and treat patient's foot wounds. A nurse note dated 3/20/2023 states that Resident #1 was readmitted from the hospital on 3/20/2023 and had Dressing to left foot, moderate amount sero/sang drainage [Serosanguineous; pink watery fluid] to dressing. Dressing not removed at this time, awaiting wound care instructions. On 3/23/2023 at approximately 1:00 PM, Resident #1 was observed in bed. His/her legs were bare, and his/her left foot was dressed with multiple bandages and pressed into the footboard of the bed. The outer dressing was visibly bloody, along with the fitted bed sheet. At 1:55 PM, a Licensed Practical Nurse (LPN) and the Director of Nursing (DON) inspected the dressings. A gauze wrap was removed from the lower section of the foot which was soiled with blood and fluid. Two padded bandages were revealed wrapping the back of Resident #1's left ankle area. These bandages were dated 3/19/23. On 3/23/2023 at 2:10 PM, the DON stated that s/he thinks that the nursing staff were waiting to get dressing orders before doing a wound assessment and a dressing change per the nursing note on 3/20/23. S/He confirmed that the readmission skin assessment did not include the wound on Resident #1's ankle and that there were no physician orders for treatment of the wound on his/her ankle. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Further review of Resident #1's medical record reveals the flowing: Upon return to the facility, the 3/20/2023 nursing skin assessment does not document the pressure ulcer located on Resident #1's ankle. There are no physician's orders for wound care for Resident #1's pressure ulcer upon returning to the facility on [DATE] through 3/32/2023. There is no wound assessments or documentation of daily wound monitoring of Resident #1's pressure ulcer from 3/20/2023 through 3/24/2023. Resident #1's care plan was not revised to include actual skin breakdown related to his/her left ankle pressure ulcer until 3/23/2023. On 3/23/2023 at 2:10 PM, the DON confirmed that no one in the facility has assessed Resident #1's wound, treated his/her wound, or updated his/her care plan to reflect the actual wound. 3. Record review and interview reveal that Resident #3 was at risk for developing pressure ulcers and developed three pressure ulcers after admission. The facility failed to provide timely and accurate skin and wound assessments, revise his/her care plan to reflect his/her clinical skin condition and needs, and provide daily monitoring of existing pressure ulcers placing Resident #3 at increased risk for wound complications and developing additional pressure ulcers. Record review reveals that Resident #3 was admitted to the facility on [DATE] and has diagnoses that include: heart failure, Alzheimer's disease, chronic embolism and thrombosis, osteoarthritis, hypertension, and anemia. Resident #3's MDS dated [DATE] reveals that s/he is at risk for developing pressure ulcers. These clinical conditions and comorbidities are risk factors for developing pressure ulcers. Resident #3's care plan for risk for skin break down was created on 2/10/2023, 7 days after admission. On 3/7/2023, a skin check reveals that resident #3 has 3 blood filled blisters to left outer foot and heel and rt [right] heel. On 3/10/2023, wound evaluations reveal a deep tissue pressure injury of the right heel, a deep tissue pressure injury of the left lateral foot, and a deep tissue pressure injury of the left heel. Skin checks on 3/21/2023 and 3/22/2023 do not reveal any skin injuries/wounds for Resident #3. On 3/23/2023, a skin check reveals that resident #3 has deep tissue pressure injuries to the left and right heel and an unstageable pressure ulcer to the left malleolus [ankle area]. Resident #3's care plan was not updated to reflect actual wounds until 3/23/2023. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Facility policy titled NSG236 Skin Integrity and Wound Management, last revised on 2/1/2023, states: A comprehensive initial and ongoing nursing assessment of intrinsic and extrinsic factors that influences skin health, skin/wound impairment, and the ability of a wound to heal will be performed. The plan of care for the patient will be reflective of assessment findings from the comprehensive patient assessment and wound evaluation. Staff will continually observe and monitor patients for changes and implement revisions to the plan of care as needed.Practice Standards include: 6. A licensed nurse will: 6.1 Evaluate any reported or suspected skin changes or wounds 6.4 Perform and document skin inspection on all newly admitted /readmitted patients weekly thereafter and with any significant change of condition 6.5 Complete wound evaluation upon admission/readmission, new in-house acquired, weekly, and with unanticipated decline in wounds. 6.6 Perform daily monitoring of wounds or dressings for presence of complications or declines. 6.6.1 Document daily monitoring of ulcer/wound site with or without dressing. 9. Notify physician/APP to obtain orders. 11. Review care plan and revise as indicated. On 3/23/2023 at 2:10 PM, the Director of Nursing stated that skin checks should document all skin injuries and wounds, even if they have been there for a while. On 4/7/2023 at 11:12 AM, the Market Clinical Lead confirmed that skin assessments should include all wounds, even if they are not new, until they are resolved. S/He confirmed that Residents #1, #2, and #3 did not have consistently accurate skin checks, did not have daily monitoring of wounds and that their care plans were not updated to reflect actual wounds. S/He also confirmed the dates above for the creation of Resident #1, #2 wound treatment orders.

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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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 46135 Based on interview and record review, the facility failed to ensure 3 of 3 sampled residents (Residents #1, #4, and #5) remained free of accident hazards as possible regarding implementing interventions to reduces hazards and risks and assessing interventions for effectiveness. Findings include: 1. Resident #1 was initially admitted to the facility on [DATE] and readmitted to the facility from the hospital on 3/20/2023 with diagnoses that include: type 2 diabetes, dementia, peripheral vascular disease, absence of two left toes, heart disease, major depressive disorder, and abnormalities of gait and mobility. Resident #1's Minimum Data Set (MDS; a comprehensive assessment used as a care-planning tool) dated 3/11/2023 reveals that s/he needs staff supervision for transferring and toileting, had a fall since the last MDS assessment, and was receiving antidepressant medications. These clinical conditions and comorbidities are risk factors for falls. A facility incident report reveals that Resident #1 had falls on 3/6/2023 and 3/10/2023. A provider note dated 3/9/2023 reveals that Resident #1 had complaints of pain to his/her left ankle/heel and right rib cage; and left foot bruising and swelling 3 days post fall. A change in condition note dated 3/10/2023 reveals the following nursing observations: Resident with bruised right sided rib cage, with pain upon deep breathing and or cough, xrays on the 6th negative for FX [fracture] or infiltrates, LLE [left lower extremity] presents swollen bruised on 3/8 with open area to the planter area of the left foot, now red hot to touch, initial xray negative for fx [fracture], Resident with marked decreased in physical abilities and requires max assist with adls [activities of daily living], WBC [white blood cells] elevated. Refusing meals. Significant decline from usual baseline. A nursing note dated 3/11/2023 states that Resident #1 was sent to the hospital on 3/10/2023 for further evaluation. Resident #1's care plan includes the following focuses: [Resident #1] is at risk for falls, created on 8/31/2021, and [Resident #1] has an ADL Self Care Performance Deficit r/t [related to] Unsteady gait, back pain, dizziness/giddiness, created on 8/31/2021. Interventions reveal that Resident #1 is independent with ambulation, bed mobility, and toileting. No interventions were created or revised after 7/14/2022 for his/her fall or ADL care plan. On 3/23/2023 at 1:19 PM, a Licensed Nurse Aide (LNA) stated that Resident #1 needed supervision with some ADLs before s/he went to the hospital. Since Resident #1 has returned, they have had a change in ability and now require staff assistance for ADLs. The LNA noted that Resident #1 has not left his/her bed since s/he was readmitted . 2. Resident #4 was admitted to the facility on [DATE] and has diagnoses that include: dementia, bipolar disorder, repeated falls, abnormalities of gait and mobility, COPD, major depressive disorder, and hypertension. Resident #4's MDS dated [DATE] reveals that s/he needs staff assistance for transferring, toileting, and locomotion, had falls in the month prior to admission, wanders daily, and was receiving antianxiety and antidepressant medications. These clinical conditions and comorbidities are risk factors for falls. (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	04/07/2023

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 - Some	A facility incident report reveals that Resident #4 had falls on 1/29/2023, 3/6/2023, 3/8/2023, 3/9/2023, and 3/12/2023. Resident #4's care plan for risk for falls was created on 3/23/2023, 57 days after admission. 3. Resident #5 was admitted to the facility on [DATE] and has diagnoses that include: hypertension, repeated falls, osteoarthritis, type 2 diabetes, spinal stenosis, depression, and abnormalities of gait and mobility. Resident #5's MDS dated [DATE] reveals that s/he needs staff assistance for transferring and toileting, had falls in the month prior to admission, and was receiving antidepressant medications. These clinical conditions and comorbidities are risk factors for falls. A facility incident report reveals that Resident #5 had falls on 2/15/2023, 3/3/2023, and 3/11/2023. Resident #5's care plans for risk for falls was created on 2/8/2023, 8 days after admission, and was not revised after the above falls. Facility policy titled NSG215 Falls Management, last revised on 6/15/2022, states under practice standards to Implement and document patient-centered interventions according to individual risk factors in the patient's plan of care. Adjust and document individualized intervention strategies as patient condition changes. On 3/23/2023 at 12:45 PM, the Director of Nursing stated that s/he is aware care plans are not being created or revised consistently in the facility and that residents should have risk for falls on their baseline care plans. S/he confirmed that Resident #1, #4, and #5's care plans were not updated after the falls listed on the facility incident report. On 4/7/2023 at 11:12 AM, the Market Clinical Lead confirmed the following: revisions were not made to Resident #1's care plan after his/her falls and that his/her care plan interventions for ADLs did not reflect his/her actual need; Resident #4 did not have a care plan for falls until 3/23/2023 and should have been developed within 48 hours of admission; and revisions were not made to Resident #5's care plan after his/her falls.