

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/28/2009
FORM APPROVED
OMB NO. 0938-0321

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 475025	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 01/14/2009
--	--	--	---

NAME OF PROVIDER OR SUPPLIER SPRINGFIELD HEALTH & REHAB	STREET ADDRESS, CITY, STATE, ZIP CODE 105 CHESTER RD SPRINGFIELD, VT 05156
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 000 INITIAL COMMENTS

A complaint investigation was initiated onsite on 11/13/08 and was concluded on 1/14/09

F 280 483.20(d)(3), 483.10(k)(2) COMPREHENSIVE CARE PLANS

The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.

A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative, and periodically reviewed and revised by a team of qualified persons after each assessment.

This REQUIREMENT is not met as evidenced by:
Based on record review, and confirmed by interview, the facility failed to revise the care plan for 1 applicable resident in the sample (Resident #1). Findings include:

Per review of the medical record, Resident #1 was at risk for choking, and received a Bedside Swallow Evaluation by a Speech Language

F 000

F 280

F 280

After this incident occurred our systems were reviewed, the delegation of duties and responsibilities better defined and dietary tray cards for all residents requiring supervision were flagged.

Dietary and nursing staffs were educated on the flagging of the tray cards.

All residents have the potential to be effected by the alleged deficient practice.

Resident #1 was transferred to the hospital and expired on 05/06/2008.

The care plans of all the residents at risk for aspiration have been and will continue to be audited and updated to reflect speech recommendations on an ongoing basis.

Upon completion of the evaluation the SLP is responsible for updating the speech care plan with any new recommendations or changes.

The SLP's have been educated regarding this process.

Random audits of aspiration risk care plans will be done weekly x 60 days and quarterly x 6 months.

Results of audits will be presented at the CQI meeting monthly x 6 months.

DNS or designee will be responsible for monitoring compliance. *for account 2-13-09*

2/14/2009

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Suzanne Swan</i>	TITLE Administrator	(X6) DATE 2/17/09
--	------------------------	----------------------

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.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/28/2009
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 475025	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 01/14/2009
--	--	--	---

NAME OF PROVIDER OR SUPPLIER SPRINGFIELD HEALTH & REHAB	STREET ADDRESS, CITY, STATE, ZIP CODE 105 CHESTER RD SPRINGFIELD, VT 05156
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 280 Continued From page 1

Pathologist (SLP) on 3/30/08 and 3/31/08. The evaluation made the following recommendations:
1. Supervision during meals. 2. Meat should be cut into small pieces. 3. Cue for second swallow to clear oral cavity/pharynx after food and liquid. 4. Alternate bites of food with sips of liquid. 5. Pt. should remain upright for 30-40 minutes after meals/snacks. 6. Re-evaluate for mechanical soft diet if choking is noted with these precautions.

Per telephone interview on 12/2/08, the SLP who conducted the evaluation stated that s/he communicated the results of the evaluation verbally to "a nurse", but did not document in Resident #1's medical record, or record to whom she reported the results to.

Per review, the comprehensive care plan dated 1/12/08 had not been revised to include the recommendations made by the SLP. The comprehensive care plan stated Resident #1 was able to eat independently. Per telephone interview on 1/14/09, when asked about updating the comprehensive care plan to include SLP recommendations, the Nurse Manager of that unit stated "There would have been an expectation that something be provided in writing. I'm not sure the system was understood by everybody. The [SLP] was per diem. I'm not sure s/he should have updated the care plan at that time".

Per telephone interview on 1/12/09, the Manager of the Rehabilitation Unit stated "At that time, because speech language pathology was only per diem, we expected nursing to update the care plan".

Per telephone interview at 5:40 AM on 12/3/08, LNA #1 stated I thought [Resident #1] could eat independently".

F 280

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/28/2009
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 475025	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 01/14/2009
--	--	--	---

NAME OF PROVIDER OR SUPPLIER SPRINGFIELD HEALTH & REHAB	STREET ADDRESS, CITY, STATE, ZIP CODE 105 CHESTER RD SPRINGFIELD, VT 05156
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 323 Continued From page 3
clear airway. At approximately 0920 Ambulance staff arrived, took over 'code'...Pt. transported to hospital via ambulance".

Per interview on 12/2/08, Registered Nurse #1 stated "We got suction at some point, I suctioned, I was getting egg out of her throat. It was in the back of her throat...We were getting a considerable amount of egg, approximately 1 cup out of her throat".

Per telephone interview at 5:40 AM on 12/3/08, LNA #1 stated "I came to [Resident #1's] room, I saw something was wrong. [Resident #1] was in there by herself. I sent someone to get [Registered Nurse #1]. Something was in [Resident #1's] mouth. The teeth were grinding together like is was locked shut. [Resident #1] was awake sitting right up in bed like we set [Resident #1] up. I thought [Resident #1] could eat independently".

Per interview, Registered Nurse #1 stated that s/he observed Resident #1 the morning of 5/5/08 and the Resident was alone in the bedroom eating from the breakfast tray set up on the table.

Per review of the medical record, Resident #1 was at risk for choking, and received a Bedside Swallow Evaluation by a Speech Language Pathologist (SLP) on 3/30/08 and 3/31/08. The evaluation made the following recommendations: 1. Supervision during meals. 2. Meat should be cut into small pieces. 3. Cue for second swallow to clear oral cavity/pharynx after food and liquid. 4. Alternate bites of food with sips of liquid. 5. Pt. should remain upright for 30-40 minutes after meals/snacks. 6. Re-evaluate for mechanical soft diet if choking is noted with these precautions. Per telephone interview on 12/2/08, the SLP who

F 323

2/14/2009

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/28/2009
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 475025	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 01/14/2009
--	--	--	---

NAME OF PROVIDER OR SUPPLIER SPRINGFIELD HEALTH & REHAB	STREET ADDRESS, CITY, STATE, ZIP CODE 105 CHESTER RD SPRINGFIELD, VT 05156
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 323 Continued From page 4

conducted the evaluation stated that Resident #1 was "at risk to choke. [Resident #1] just wasn't clearing the food from the mouth clearly". The SLP confirmed that by recommending "supervision" on the Swallow Evaluation, the expectation was that Resident #1 would have staff present at all times during meals. The SLP stated that s/he communicated the results of the evaluation verbally to a nurse, but did not document in Resident #1's medical record, or record to whom she reported the results to.

Per interview, all nursing staff that worked on 3/30/08 and 3/31/08 stated that they were not informed of the results of the Bedside Swallow Evaluation conducted by the SLP.

Based on review of medical records, Patient #1 expired at the hospital on 5/6/08. The Certificate of Death cited Aspiration Pneumonia as the cause of death. Per telephone interview on 1/14/09, the Medical Director of the Nursing Home, who signed the Death Certificate, stated "the cause of the aspiration was the eggs. I think the aspiration was the primary problem. She choked on the eggs and that's why she aspirated". The Medical Director further stated "I pointed out to the nurses, we were concerned that [Resident #1] was at increased risk of choking due to and increase in narcotic pain medication."

Per telephone interview on 1/12/09, the Chief Medical Examiner stated "This [Resident #1] choked on the eggs-that's what killed [Resident #1]. The scrambled eggs blocked off the airway." Per review of a Request to Correct a Death Certificate dated 12/31/09, the cause of death is listed as "Complications of Cerebral Anoxia due

F 323

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/28/2009
FORM APPROVE
OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 475025	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 01/14/2009
--	--	--	---

NAME OF PROVIDER OR SUPPLIER SPRINGFIELD HEALTH & REHAB	STREET ADDRESS, CITY, STATE, ZIP CODE 105 CHESTER RD SPRINGFIELD, VT 05156
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 323 F 514 SS=G	<p>Continued From page 5 to Choking on Food (scrambled egg)".</p> <p>483.75(l)(1) CLINICAL RECORDS</p> <p>The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.</p> <p>The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and confirmed by interview, the facility failed to keep complete medical records for 1 applicable resident in the sample (Resident #1). Findings include:</p> <p>Per record review, Resident #1 who was at risk for choking, received a Bedside Swallow Evaluation by a Speech Language Pathologist (SLP) on 3/30/08 and 3/31/08. The evaluation made the following recommendations: 1. Supervision during meals. 2. Meat should be cut into small pieces. 3. Cue for second swallow to clear oral cavity/pharynx after food and liquid. 4. Alternate bites of food with sips of liquid. 5. Pt. should remain upright for 30-40 minutes after meals/snacks. 6. Re-evaluate for mechanical soft diet if choking is noted with these precautions. Per telephone interview on 12/2/08, the SLP who conducted the evaluation stated that s/he communicated the results of the evaluation</p>	F 323 F 514	<p>F514</p> <p>All residents have the potential to be effected by the alleged deficient practice.</p> <p>Resident #1 was transferred to the hospital and expired on 05/06/2008.</p> <p>Upon completion of speech evaluation the SLP is responsible to follow the ST recommendation protocol and filing a copy in the resident's record.</p> <p>SLP's have been educated regarding the above protocol.</p> <p>Random audits of resident records will be done weekly x 60 days and quarterly x 6 months.</p> <p>Results of audits will be presented at the CQI meeting monthly x 6 months.</p> <p>DNS or designee will be responsible for monitoring compliance.</p> <p><i>POC accepted 2-13-09</i> <i>[Signature]</i></p>	2/14/2009
----------------------------	--	--------------------	--	-----------

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/28/2009
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 475025	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 01/14/2009
NAME OF PROVIDER OR SUPPLIER SPRINGFIELD HEALTH & REHAB		STREET ADDRESS, CITY, STATE, ZIP CODE 105 CHESTER RD SPRINGFIELD, VT 05156		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	
F 514	<p>Continued From page 6</p> <p>verbally to "a nurse", but did not document in Resident #1's medical record, or record to whom she reported the results to.</p> <p>Per review of nursing notes on 11/13/08, on 5/5/08 Registered Nurse #1 documented that Resident #1 was found in their room "sitting up in bed unable to speak, no body movement, drooling...Attempted to open jaw for finger sweep of mouth, Heimlich maneuver attempted approximately 20 times without effective results...Yankauer suction of oral cavity and back of throat. Food visible in back of throat. Compressions (chest) continue and attempt to clear airway. Approximately 0920 Ambulance staff arrived, took over 'code'...Pt. transported to hospital via ambulance".</p> <p>Per interview on 11/13/08, the Rehab Director stated "The day [Resident #1] choked, I went and looked. I couldn't remember if speech saw [Resident #1]. It (The Bedside Swallow Evaluation) wasn't in the chart. I reviewed the chart. It wasn't in the chart. I found the signed copy and a copy of it in the to be filed pile".</p> <p>Per interview on 11/13/08, the Nurse Manager of the unit stated "I don't believe we had the results of the SLP recommendations. It was found after the 5th (5/5/08)".</p> <p>Per telephone interview on 12/11/08, the LNA responsible for filing the SLP evaluations in the medical record stated "The SLP evaluation did not make it to the patient's record. The SLP would put it in [Resident #1's] chart, and I put it in the SLP's file. I was told not to file it, that the SLP was to do it".</p>	F 514		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/28/2009
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 475025	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 01/14/2009
--	--	--	---

NAME OF PROVIDER OR SUPPLIER SPRINGFIELD HEALTH & REHAB	STREET ADDRESS, CITY, STATE, ZIP CODE 105 CHESTER RD SPRINGFIELD, VT 05156
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 514 Continued From page 7
Per record review, Resident #1 expired on 5/6/08 due to choking on food.

F 514