

Division of Licensing and Protection
103 South Main Street, Ladd Hall
Waterbury, VT 05671-2306
<http://www.dail.vermont.gov>
Voice/TTY (802) 871-3317
To Report Adult Abuse: (800) 564-1612
Fax (802) 871-3318

October 22, 2012

Ms. Heather Presch, Administrator
Springfield Health & Rehab
105 Chester Rd
Springfield, VT 05156

Dear Ms. Presch:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **September 12, 2012**. Please post this document in a prominent place in your facility.

We may follow-up to verify that substantial compliance has been achieved and maintained. If we find that your facility has failed to achieve or maintain substantial compliance, remedies may be imposed.

Sincerely,



Pamela M. Cota, RN
Licensing Chief

PC:jl



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

PRINTED: 09/21/2012
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 08/12/2012
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NAME OF PROVIDER OR SUPPLIER SPRINGFIELD HEALTH & REHAB	STREET ADDRESS, CITY, STATE, ZIP CODE 105 CHESTER RD SPRINGFIELD, VT 05156
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F 000 INITIAL COMMENTS

An unannounced on-site recertification survey was conducted by The Division of Licensing and Protection from 9/10/12 through 9/12/12. There were regulatory deficiencies identified.

F 241 483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY

The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.

This REQUIREMENT is not met as evidenced by:

Based on observation, interview and record review the facility failed to promote care for 1 resident (#13) in an environment that maintains and enhances the resident's dignity and respect in full recognition of his/her individuality. The findings include:

1. Per direct observation on 9/10/12 at 4:40 PM, Resident #13 was sitting in his/her wheelchair at the end of a table during the dinner meal. Resident #13 pushed his/her wheelchair away from the table, the Licensed Nursing Assistant (LNA) told Resident #13 that if he/she wanted to eat dinner than he/she would have to stay at the table and if he/she did not behave than he/she would be removed from the dining room. The LNA was then observed removing Resident #13 from the dining room. Per interview with the LNA on 9/10/12 at the time of the observation, he/she indicated that Resident #13 had a history of aggressive behavior and sometimes kicks at other residents. Per interview the LNA confirmed

F 000

F 241 Dignity and Respect of Individuality

The LNA identified has been in serviced on Resident's Rights. Resident #13 care plan has been reviewed for behavioral interventions. Resident #13 had no adverse effects from the alleged incident.

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

All licensed staff will be in serviced on Resident's Rights on or before October 12, 2012.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Cheryl M. Pless, LNA</i>	TITLE Administrator	(X6) DATE 10/5/12
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F 241 Continued From page 1
that Resident #13 had not kicked at anyone and had not displayed any aggressive behavior. Per interview on 9/12/12 the LNA indicated he/she removed Resident #13 "just in case" and placed the resident in the hallway. Per interview with the Director of Nursing on 9/10/12, he/she indicated that the statement made by the LNA toward Resident #13 was not appropriate.

F 253 483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES

The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.

This REQUIREMENT is not met as evidenced by:
Based on observation and staff interview the facility failed to provide maintenance services necessary to maintain a sanitary, orderly and comfortable environment. The findings include:

1. Per observation on 9/10/12 at 11:41 AM, 2 ceiling mounted air conditioning units on the 1st floor nursing units were soiled with dust and spider webs. The units were operational at the time of the observation. The Unit Manager (UM) confirmed these observations at 5:15 P.M. on 9/10/12.
2. Per observation on 9/11/12 at 9:53 A.M., ceiling exhaust fans, currently operating, were soiled with caked on dust in the following 1st floor resident bathrooms; 103, 106, 107, 108, 110, 112. The observations were confirmed by the UM at 10:08 A.M. on 9/11/12.

F 241

F 253

Random audits of dining services will be conducted by the Staff Development Nurse or designee and reported on a monthly basis to the QAPI team for three months.

F241 POC accepted 10/15/12 M. C. [Signature]

F 253 Housekeeping and Maintenance Services

All residents have the potential to be affected by the alleged deficient practice. No residents were harmed by the alleged deficient practice.

Ceiling mounted air conditioning units were dusted on 9/10/12.

Ceiling exhaust fans were taken down and washed on 9/11/12.

Broken sheetrock on "C" wing was repaired on 9/11/12.

Plastic outlet cover on "C" wing was replaced on 9/11/12.

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F 253

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3. Per observation on 9/11/12 on the "C" wing, there was broken sheet rock midway up the wall from the floor located behind where the facility emergency cart was stored. A resident was observed to move the emergency cart and pick at the broken sheet rock. Per interview with the Environmental Services Manager (ESM) at 1:08 PM, he/she confirmed that the sheet rock was broken behind the emergency cart. The ESM confirmed that this caused a potential safety hazard for residents on the unit because a lot of residents on this unit have cognitive or memory impairment.

4. Per observation on 9/11/12 on the "C" wing, there was a wall outlet that was not flush to the wall and there was a gap created between the wall and the plastic covering on the outlet of approximately 1/2 inch. The outlet was observed to be within reach of a resident in a wheelchair. On 9/11/12 at 1:08 PM the Environmental Services Manager (ESM) confirmed that the wall outlet was not flush to the wall and a gap of approximately 1/2 inch was created. The EMS confirmed that this caused a potential safety hazard for residents on the unit.

5. Per observation on 9/11/12 on the "C" wing, there was a water fountain with an out of order sign on it. It was observed to be away from the wall approximately one inch. When the sides of the metal water fountain were felt the edge was sharp and the fountain could be moved toward the wall. Per interview with the Environmental Services Manager (ESM) on 9/11/12 at 1:08 PM, he/she confirmed that the metal water fountain was not flush to the wall and that the fountain could be moved. The ESM confirmed that this

F 253

Water fountain on "C" wing was readjusted and fixed in place on 9/11/12.

All air conditioning units have been moved from a monthly cleaning schedule to an every other week cleaning schedule.

All exhaust vents have been put on the annual cleaning schedule.

All housekeeping and maintenance service concerns were addressed and completely corrected before the survey team left the building 9/12/12.

All preventative maintenance schedules will be updated on or before October 12, 2012.

F253 POC accepted 10/15/12
McL.../fmc

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F 253 Continued From page 3
caused a potential safety hazard for residents on the unit because the metal edges of the water fountain were sharp and the fountain could move and this posed a potential safety hazard for residents.

F 282 483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN
SS=D
The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.

This REQUIREMENT is not met as evidenced by:
Based on staff interview and record review, the facility failed to provide services in accordance with the plan of care for 1 of 40 residents in the stage 2 sample (Resident #4). Findings include:

Per record review 9/12/12, the Minimum Data Set (MDS) for Resident #4 showed a decline in bladder continence between 5/27/12 and 8/27/12. Review of the care plan showed that the facility was to complete a bladder assessment on admission and with a change in continence status. There was no evidence in the clinical record that these assessments were done. Per interview with the Unit Manager (UM) on 9/12/12 at 2:18 PM, bladder assessments are to be done at admission and with any change in continence. The UM confirmed these assessments had not been done per the care plan.

F 329 483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS
SS=E
Each resident's drug regimen must be free from

F 253 F 282 Services by Qualified Persons/Per Care Plan
A bladder assessment will be completed for resident #4 to determine bladder incontinence level.

All residents have the potential to be affected by this alleged deficient practice. Resident #4 had no ill effects from the alleged deficient practice.

Bladder assessments will be completed upon admission, quarterly and in the event of a significant change. All resident care plans will be reviewed and updated on or before October 12, 2012 by the Nurse Manager for each unit.

An audit will be conducted monthly on a random selection of seven resident care plans and bladder assessments. The care plans and bladder assessments will be reviewed

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unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.

Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.

This REQUIREMENT is not met as evidenced by:

Based on record reviews and staff interviews, the facility failed to ensure 4 of 11 applicable stage 2 residents' drug regimens were free from unnecessary drugs. (Residents # 4, #24, #108 and #155) Findings include:

1. Per record review 9/12/12 at 10:25 A.M., there is no evidence that a Gradual Dose Reduction (GDR) for Fluoxetine (an anti-depressant) 20 milligrams by mouth daily was attempted for Resident #24. The resident has been taking this

F 329

for appropriateness and completion for a period of 3 months and findings

will be reviewed at the monthly QAPI meeting.

F282 PDC accepted 10/10/12 Maulman R. J. / PML

F329 Drug Regimen is Free from Unnecessary Drugs

Medications for Residents #4, #24, #18 and #155 were reviewed by the physician and pharmacist for appropriate diagnosis and appropriate monitoring of medication side effects. These residents have either received a Gradual Dose Reduction (GDR) for their psychoactive medication or have sufficient documentation to support continued use of the medications in question. A non-pharmacological check sheet will be placed in the MAR for interventions tried prior to PRN medication use before October 12, 2012.

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F 329 Continued From page 5

medication since 4/7/11. Additionally, there is no evidence that staff are monitoring for signs and symptoms of depression. The Unit Manager confirmed on 9/12/12 at 11:45 A.M. that there is no evidence of a GDR attempt for Fluoxetine or monitoring for signs and symptoms of depression.

2. Per record review on 9/12/12, there is no diagnosis in Resident #4's clinical record to support use of Seroquel, an antipsychotic medication. Additionally, there is no evidence staff is monitoring behaviors to support use of Seroquel.
Per interview with the Director of Nursing Services (DNS) on 9/12/12 at 2:33 PM, the DNS confirmed that there was not adequate monitoring related to use of the Seroquel.

3. Per record review on 9/12/12, there is no diagnosis in Resident #108's clinical record to support the use of an antipsychotic medication, Seroquel, which the resident has been taking since at least 2010. Additionally, per review of the monthly pharmacist recommendations dated on 7/20/12 after a medication review called the MRR or 'medication regimen review', the pharmacist documented that "Routine Seroquel 25 mg at 5 am daily. Nursing review behaviors with MD: trigger for anti-psychotic administration review. Supporting DX (diagnosis)... consider alternative therapy: discontinue with assessment period". In addition, there were hand-written notes next to the words: "Secondary Physician, Unassigned"; "No nsg [nursing] notes for behaviors? GDR [Gradual dose reduction] then D/C [discontinue]." Also: "Admit note says have to work on psych med's."

F 329

All residents have the potential to be affected by this alleged deficient practice. No residents experienced ill effect from the alleged deficient practice.

All residents who receive psychoactive medications shall be reviewed for appropriate diagnosis, appropriate monitoring of the side effects of psychoactive medications, sufficient physician documentation to support continuation of psychoactive medications or a GDR and all residents receiving PRN psychoactive medications shall have a non-pharmacological intervention check sheet in their MAR before October 12, 2012.

Robert Kewley RPH will provide an in service for all licensed nurses on psychoactive medications, covering indication for use, documentation requirements and potential side effects.

A monthly audit will be conducted by the Nurse Managers or designee on

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F 329 Continued From page 6

There was no evidence that the pharmacist's recommendations documented on the MRR with the date of 7/20/12 were followed up on with the resident's physician. Per interview with the DNS (Director of Nursing Services) on 9/12/12 at 2:40 P.M., s/he confirmed that there was no physician diagnosis for the use of Serquel besides dementia and that there had been no follow-up with the resident's physician regarding the 7/20/12 MRR pharmacist recommendations.

4. Per record review, Resident #155 was admitted to the facility on 8/27/12 with diagnoses that include senile dementia and cognitive communication deficit. Per review of the medical record, on 8/30/12 at 9:46 PM Resident #155 continues to show signs and symptoms of sundowning, grows very agitated and confused and has no safety awareness. Haldol given at beginning of shift with some effect. Per documentation in the medical record on 8/30/12 at 10:37 PM, Resident #155 was very confused, agitated, standing up unassisted and crawling from bed to bed, unable to make any sense on needs and wants, and Ativan was given with effects pending.

Per review of the medical record, the progress notes indicate that Resident #155 also displayed behaviors on 9/1/12, 9/5/12, 9/8, and 9/11/12 and was medicated with Haldol or Ativan. There was no evidence in the progress notes on 8/30, 9/1, 9/5, 9/8 or 9/11 that any non-pharmacological interventions were attempted prior to the administration of Haldol or Ativan for behaviors. Per review of the "behavior intervention monthly documentation" from 8/27/12 to 9/11/12, no

F 329 ten randomly selected resident charts. The charts will be reviewed for psychoactive drugs, appropriate dose reductions or documentation from the physician supporting the need for the medication, appropriate documentation on non-pharmacological interventions for PRN use, appropriate monitoring of side effects and appropriateness of diagnosis. The audit will be conducted for a period of three months with results to be reviewed at the monthly QAPI meeting.

*F329 POC accepted 10/15/12
McLellan RLL PMU*

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F 329 Continued From page 7
interventions, outcomes or side effects were documented for 8/30, 9/1, 9/5, and 9/8. Review of the progress notes from 8/27/12 to 9/11/12 indicate that Resident #155 displayed behaviors 34 times. Per review of the behavior intervention monthly flow record from 8/27 to 9/11, 32 of 34 times that the progress notes indicate Resident #155 displayed behaviors there is no documentation on the behavior intervention monthly flow records indicating any behavior interventions, outcomes, and side effects.

Per review of the interim care plan under psychotropic drug use, staff is to monitor target behaviors per psychotropic flowsheet and monitor for side effects per the psychotropic flowsheet. Per interview with the Unit Manager (UM) on 9/12/12 at 8:59 AM, he/she confirmed after review of the progress notes that Resident #155 displayed behaviors on 9/1/12, 9/5/12, 9/8, and 9/11/12 and was medicated with Haldol or Ativan. The UM confirmed that there was no evidence in the progress notes on 8/30, 9/1, 9/5, 9/8 or 9/11 that any non-pharmacological interventions were attempted prior to the administration of Haldol or Ativan for behaviors. Per interview with the UM on 9/12/12 at 8:59 AM, he/she reviewed the behavior intervention monthly flow sheets for August and September and confirmed that the behavior intervention monthly flow record from 8/27 to 9/11 only reflected documentation for 9/10 and 9/11/12. Per interview with the UM on 9/12/12 at 8:59 AM, he/she confirmed that the interim care plan under psychotropic drug use, staff is to monitor target behaviors per psychotropic flowsheet and monitor for side effects per the psychotropic flowsheet.

F 329

F428 Drug Regimen Review, Report Irregular, Act On

F 42B 483.60(c) DRUG REGIMEN REVIEW, REPORT

F 42B

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F 428 Continued From page 8
SS=D IRREGULAR, ACT ON

The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist.

The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon.

This REQUIREMENT is not met as evidenced by:

Based on record reviews and staff interviews, the pharmacist failed to report an irregularity and the facility failed to ensure that the pharmacist's recommendations regarding any medication irregularities were reported to the attending physician so that they might be acted upon for 2 of 11 sampled residents in the Stage 2 sample. (Residents # 24 & #108) Findings include:

1. Per record review 9/12/12 at 10:25 A.M., there is no evidence that a Gradual Dose Reduction (GDR) for Fluoxetine (an antidepressant) 20 milligrams by mouth daily was recommended by the consulting pharmacist. Resident #24 has been taking this medication since at least 4/7/11. There is no evidence that staff are monitoring for signs and symptoms of depression. The Unit Manager confirmed on 9/12/12 at 11:45 A.M. that there is no evidence of a GDR attempt for Fluoxetine, monitoring for signs and symptoms of depression or of a recommendation by the consulting pharmacist for a GDR.

F 428 Resident #24 and #108 have been reviewed for appropriate diagnosis, as well as either a GDR for medication in question or documentation by the resident's physician supporting the need for current medication regimen.

All residents receiving psychoactive medications have the potential to be affected by this alleged deficient practice. No residents had ill effects related to the alleged deficient practice.

All charts for residents who receive psychoactive medications shall be reviewed for appropriate diagnosis, appropriate monitoring of side effects of psychoactive medications and sufficient physician documentation to support either the continuation of psychoactive medication use or a GDR and all MAR's for residents receiving PRN psychoactive medications shall

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F 428 Continued From page 9

2. Per record review on 9/12/12, there is no diagnosis in Resident #108's clinical record to support the use of an antipsychotic medication, Seroquel which the resident has been taking since at least 2010. Additionally, per review of the monthly pharmacist recommendations dated on 7/20/12 by the pharmacist after a medication review called the MRR or 'medication regimen review', the pharmacist documented that "Routine Seroquel 25 mg at 5 am daily. Nursing review behaviors with MD; trigger for anti-psychotic administration review. Supporting DX [diagnosis]... consider alternative therapy; discontinue with assessment period". In addition, there were hand-written notes next to the words: "Secondary Physician, Unassigned"; "No msg (nursing) notes for behaviors? GDR [Gradual dose reduction] then D/C [discontinue]." Also: "Admit note says have to work on psych med's."

There was no evidence that the pharmacist's recommendations documented on the MRR with the date of 7/20/12 were followed up on with the resident's physician. Per interview with the DNS (Director of Nursing Services) on 9/12/12 at 2:40 P.M., s/he confirmed that there was no physician diagnosis for the use of Seroquel besides dementia and that there had been no follow-up with the resident's physician regarding the 7/20/12 MRR pharmacist recommendations.

F 428

contain a non-pharmacological intervention check sheet before October 12, 2012.

An audit will be conducted by the Nurse Managers or designee on a monthly basis on ten randomly selected resident charts with orders for psychoactive medications. The charts will be reviewed to ensure there is an appropriate diagnosis and appropriate physician documentation supporting the current psychoactive medication regimen or that a GDR has been tried. This audit will be conducted for a period of three months with results to be reviewed at the monthly QAPI meeting.

F428 PIC accepted 10/15/12
McCowan RN / PIC