

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

November 19, 2013

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 **October 30, 2013**. 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: 11/05/2013
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 10/30/2013
NAME OF PROVIDER OR SUPPLIER SPRINGFIELD HEALTH & REHAB			STREET ADDRESS, CITY, STATE, ZIP CODE 105 CHESTER RD SPRINGFIELD, VT 05158	
(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	F 000		
F 225 SS=D	<p>An unannounced on-site annual recertification survey was conducted by the Division of Licensing and Protection from 10/28/13 - 10/30/13. The following regulatory violations were cited as a result.</p> <p>483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS</p> <p>The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law, or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.</p> <p>The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.</p> <p>The results of all investigations must be reported to the administrator or his designated</p>	F 225	<p>F225</p> <p>Investigate/Report Allegations/Individuals</p> <p>The following was completed as corrective action for all residents found to be potentially affected by the alleged deficient practice. In-services reviewing the Elder Abuse Act with steps for mandatory reporting identified and the process for reporting explained will be conducted for all staff.</p> <p>Corrective action will be completed by November 20, 2013.</p> <p>A random audit will be completed monthly for the next three months by the DNS or designee of five staff to review what</p>	

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

Heather Presch

Executive Director

11/18/13

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.

MLC

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F 225	<p>Continued From page 1</p> <p>representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p> <p>This REQUIREMENT is not met as evidenced by: Based on resident and administrator interview, record and investigation report review, the facility failed to ensure that all allegations of abuse, neglect and mistreatment are thoroughly investigated and reported to the designated state agency immediately, and in accordance with Vermont Statute for 1 of 3 residents in the stage 2 sample. (Resident # 44) Findings include:</p> <p>Per 10/29/13 record review, Resident #44 is 82 years old and has diagnoses of Parkinson's disease, muscle weakness, lack of coordination, difficulty walking, a personal history of falls, degenerative joint disease and depression. His/her Alteration in ADL (activities of daily living) status related to Parkinson's disease care plan indicated the need for extensive assistance of one for personal hygiene, transfers and toileting.</p> <p>Per interview on 10/29/13 at 9:43 AM, Resident # 44 reported that approximately 2 weeks ago, he/she pressed the call light for assistance to use the bathroom. An LNA came to the room and said, "It's only been an hour since you went." Resident # 44 replied, "My bladder does not tell time." The LNA assisted the resident to the toilet, but when the LNA got him/her off the toilet, the resident reported, that he/she "put 2 hands on my left arm" ("have pain in that shoulder") and</p>	F 225	<p>constitutes abuse and what steps to take if that staff observes a resident being a victim of abuse. The results of these audits will be reported by the DNS or designee to the CQI committee. The CQI committee will evaluate the data and act on the information as indicated.</p> <p><i>F225 POC accepted 11/19/13 PMcsturn</i></p>		

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F 225	<p>Continued From page 2</p> <p>"yanked me off the toilet to a standing position." The resident added, "I was afraid I could have my shoulder broken." He/she "was very rough with me and that's abuse." Resident # 44 stated he/she reported the LNA immediately to an RN.</p> <p>Per request, on 10/29/13 at 1:13 PM, the facility administrator provided a copy of the internal investigation involving Resident # 44. The written investigation consisted of a letter of complaint dated 9/26/13 and signed by Resident # 44 and an undated time study of the resident's call light activity and LNA response time from 3:20-6:48 (no indication of date done or AM or PM) and a second set of time parameters, 4 AM-5:00 (also undated). In the 9/26/13 complaint letter, Resident # 44 identified by first name 2 LNA's who he/she reported as handling him/her "roughly" during transfers and that he/she felt "uncomfortable under their care." He/she wrote, "comments are made as to my requests for going to the bathroom. Comments-"You just went," "It hasn't been an hour yet," etc. Most generally the time lapses are exaggerated making the time less than the real time elapsed." Per 10/29/13 at 1:13 PM interview, the administrator stated the internal investigation included interviews with Resident # 44 and a family member and the 2 named LNAs; the investigation focused on transfer techniques and call light response times (confirmed per administrator as not documented as of 10/29/13 at 1:13 PM).</p> <p>Per review of the facility "Abuse Prevention Policy and Procedures" (Revised: 9/03) provided by the facility administrator on 10/30/13 at 11:01 AM, the definition of abuse means: "any conduct committed with a willful or reckless disregard that such conduct is likely to cause unnecessary</p>	F 225			

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F 225	Continued From page 3 harm, unnecessary pain or unnecessary suffering to a vulnerable adult..." "intentionally subjecting a resident/vulnerable adult to behavior which should reasonably be expected to result in intimidation, fear, humiliation, degradation, agitation, disorientation, or other forms of serious or emotional distress...." Per 10/29/13 at 1:13 PM interview, the administrator confirmed that the resident's voiced complaints of rough handling by the LNAs was reportable and confirmed that he/she did not report the incident to the State Agency or APS (Adult Protective Services).	F 225		
F 226 SS=D	(Refer also to F226) 483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on administrator interview and complaint investigation review, the facility failed to implement policies and procedures for abuse reporting for 1 of 3 residents in the stage 2 sample (Resident # 44). Findings include: On 10/29/13 at 1:13 PM, the facility administrator provided a copy of the internal investigation of a complaint of staff abuse made by Resident # 44. Per review, the written investigation consisted of	F 226	F226 Develop/Implement Abuse/Neglect Etc Policies The following was completed as corrective action for all residents found to be potentially affected by the alleged deficient practice. In-services reviewing the Elder Abuse Act with steps for mandatory reporting identified and the process for reporting will be conducted for staff. Corrective action will be completed by November 20, 2013.	

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F 226	Continued From page 4 2 documents: a letter of complaint from Resident # 44 and a call light time study. Per 10/29/13 review of the resident's letter, signed and dated 9/26/13, Resident # 44 identified by first name 2 LNA's who he/she reported as handling him/her "roughly" during transfers and that he/she felt "uncomfortable under their care." He/she wrote, "Comments are made as to my requests for going to the bathroom. Comments-"You just went," "It hasn't been an hour yet," etc. Most generally the time lapses are exaggerated making the time less than the real time elapsed." The second investigation document was an undated time study of Resident # 44's call light activity and LNA response time from 3:20-6:48 (no indication of date done or AM or PM) and a second set of time parameters, 4 AM-5:00 (also undated). Per 10/29/13 at 1:13 PM interview, the facility administrator stated the internal investigation included interviews with the resident and a family member and with the 2 named LNAs; the investigation focused on transfer techniques and call light response times (confirmed per administrator that the interviews were not documented as of 10/29/13 at 1:13 PM). Per review of the facility "Abuse Prevention Policy and Procedures" (Revised 9/03) provided by the facility administrator on 10/30/13 at 11:01 AM, the definition of abuse means: "any conduct committed with a willful or reckless disregard that such conduct is likely to cause unnecessary harm, unnecessary pain or unnecessary suffering to a vulnerable adult;..." "intentionally subjecting a resident/vulnerable adult to behavior which should reasonably be expected to result in intimidation, fear, humiliation, degradation, agitation, disorientation, or other forms of serious or emotional distress;..." Per policy, "All incidents	F 226	A random audit will be completed monthly for the next three months by the DNS or designee of five staff to review what constitutes abuse and what steps to take if that staff observes a resident being a victim of abuse. The results of these audits will be reported by the DNS or designee to the CQI committee. The CQI committee will evaluate the data and act on the information as indicated. <i>F226 POC accepted 11/19/13 Amistaren</i>		

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F 226	Continued From page 5 of witnessed or suspected abuse, neglect, mistreatment or the misappropriation of funds will be investigated immediately by the facility, and will be reported to the proper authorities." The policy further states, "When an employee reports an incident of witnessed or suspected abuse, mistreatment or neglect to the Administrator/designee, the Administrator/designee will submit the report of the incident to Adult Protective Services as soon as possible, but never later than 48 hours after the incident." Per federal regulation 483.13(c)(2) The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). Immediately is defined as reporting allegations of abuse within 24 hours to the State Agency. Per 10/29/13 at 1:13 PM interview, the administrator confirmed that the resident's voiced complaints of rough handling by the LNAs was reportable and confirmed that he/she did not report the incident to the State Agency or APS (Adult Protective Services).	F 226			
F 279 SS=D	(Refer also to F225) 483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's	F 279	F 279 Develop Comprehensive Care Plans The following was completed as corrective action for all residents found to have the potential to be affected by the		

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F 279	<p>Continued From page 6 comprehensive plan of care.</p> <p>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility failed to develop a comprehensive plan of care for 1 of 16 applicable residents in the stage 2 sample (Resident #143). Findings include: Per record review on 10/31/13 at 9:00 AM, there were no care plans to address the needs of Resident #143 related to pressure ulcers or terminal care. Resident #143 was admitted to the facility on 7/22/13. Per the initial nursing assessment dated 7/22/13, the Resident has two stage II pressure ulcers on his/her buttocks. There is a physician's order dated 8/9/13 stating that the facility may begin terminal care orders. The Minimum Data Set (MDS) dated 8/12/13 for Resident #143 identified pressure ulcers at stage 1 or greater. During interview with the Unit</p>	F 279	<p>alleged deficient practice. Unit Managers will review care plans on all residents with pressure areas and/or terminal care orders to ensure that a comprehensive care plan is in place. An in-service will be conducted for licensed staff by on developing care plans for any change in resident condition.</p> <p>Corrective action will be completed by November 20, 2013.</p> <p>A random audit will be completed monthly for the next three months by the Unit Managers or designee on all care plans for residents with identified pressure ulcers and/or terminal care orders. The results of the audits will be reported at the monthly CQI meeting and acted upon as indicated.</p>		

F279 POC accepted 11/19/13 pncotaw

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F 279	Continued From page 7 Manager (UM) on 10/30/13 at 9:15 AM, the UM stated that it is his/her expectation that care plans be developed for the pressure ulcers and terminal care. The UM confirmed that Resident # 143 had 2 stage II pressure ulcers, had terminal care orders and that there were no plans of care for pressure ulcers or terminal care.	F 279			
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on staff interviews and record review, the facility failed to ensure professional standards of quality were met related to following physician orders to obtain a timely psychiatric consult for 1 of 12 residents in the stage 2 survey sample (Resident # 105). Findings include: Per 10/29/13 medical record review, Resident # 105 had diagnoses that included Alzheimer's disease with behavioral symptoms, cognitive impairment, depressive disorder, anxiety state, symbolic dysfunction, and memory loss along with other chronic medical conditions. Per review of the May 2013 nursing progress notes, the resident is documented as being resistive to care and demonstrating aggressive behaviors. A 5/20/13 nursing incident note stated that the resident "pushed staff and punched an LNA" who was trying to provide care. A 5/22/13 nursing progress note documented that when an LNA asked for a spoon the resident was holding, he/she "was angry and tried to bite the LNA's	F 281	F281 Services Provided Meet Professional Standards The following was completed as corrective action for all residents found to have the potential to be affected by the alleged deficient practice. An in service on the process for psychiatric consultations will be conducted for licensed nursing staff to ensure that all psychiatric		

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F 281	<p>Continued From page 8</p> <p>arm" and tried to hit the LNA in the stomach.</p> <p>Per 10/30/13 medical record review, on 5/23/13 the resident's physician ordered a referral for psychiatric consult for "ideas re behaviors." Per 10/30/13 8:00 AM interview with the facility social worker (SW), the facility procedure for psychiatric referrals involves staff notifying the SW of the referral so that he/she can contact the family for consent before processing the referral. He/she reported that he/she was not notified of Resident # 105's psychiatric referral, which had been completed by a per diem nurse (per diem nurse = nurse employed for the day/as needed).</p> <p>Per 10/30/13 8:00 AM interview, the SW confirmed his/her last progress note entry dated 9/12/13 reported that Resident # 105 was "very difficult to redirect or distract and can easily become agitated." Per 10/30/13 review of nursing progress notes for the month of October 2013, there is documentation of continued aggressive and resistant behaviors on 10/3, 10/5, 10/12 10/15, 10/22 and 10/26 that including hitting, biting attempts and care resistance.</p> <p>Per 10/30/13 8:15 AM interview with the facility unit manager (UM), he/she confirmed that there is no evidence in the medical record that Resident # 105 received a psychiatric consult based on the 5/23/13 order or that the physician was notified that the consult had not been arranged as ordered.</p>	F 281	<p>consultations are processed and followed up on in a timely manner.</p> <p>Corrective action will be completed by November 20, 2013.</p> <p>A random audit will be conducted by the Unit Managers on 10 newly admitted residents each month for three months to ensure that all potential psychiatric consultations have been processed and followed up on in a timely manner. The CQI committee will evaluate the data and act on the information as indicated.</p> <p><i>F281 POC accepted 11/19/13 pmcbtarn</i></p>		