

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

May 1, 2012

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

Provider #: 475025

Dear Ms. Presch:

Enclosed is a copy of your acceptable plans of correction for the survey and complaint investigation conducted on **April 2, 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, MS
Licensing Chief

PC:ne

Enclosure



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

PRINTED: 04/13/2012
FORM APPROVED
OMB NO. 0938-0391

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| 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 04/02/2012 |
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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 280 | <p>Continued From page 1</p> <p>admitted to the facility on 6/27/11 with diagnoses that include history of falls, degenerative joint disease, atrial fibrillation, seizure disorder, dementia with agitated behaviors, Parkinson's disease and poor safety awareness. Per review of the nurses' notes dated 6/17/11, Resident #1 fell backwards hitting head causing a burst wound to the head. Per nurses' notes dated 7/4/11, the resident fell from a Geri chair hitting his head against the wall, sustaining a T1 (spinal) fracture and Medial Sesamoid bone (foot) fracture. On 9/19/11, Resident #1 was found under the bed on the floor, bleeding from the head and sustained a head laceration requiring staples and a cranial bleed.</p> <p>Review of the Fall Risk Evaluation dated 3/10/11, the resident was a high risk for falls. Per review of Resident #1's comprehensive care plan titled "At high risk for falls and injury" dated 3/22/11, and the high risk for falls and injury care plan dated 7/13/11, there was no evidence that the care plans had been updated to reflect the falls on 6/17/11, 7/4/11 and 9/19/11 or that the plan of care had been revised to identify Resident #1's need for interventions to prevent further falls and injury. Per review of the facility's "Assessing Falls and Their Causes" policy, it indicates that "appropriate interventions should be taken to prevent future falls". Per interview with the Director of Nursing Services on 4/2/12 at 1:16 PM, he/she reviewed the comprehensive care plans dated 3/22/11 and 7/13/11 and confirmed that he/she could not identify where the care plan had been updated to reflect the falls on 6/17, 7/4 and 9/19/11 and had not been revised to indicate Resident #1's need for interventions to prevent future falls and injury.</p> | F 280 | <p>On April 9 2012 Springfield Health & Rehab adopted Revera's newly revised Concurrent Review policy. During the concurrent review meeting the previous day's events are reviewed and discussed and the resident care plans are updated. Based on care plan updates, LNA Kardex will be updated as needed.</p> <p>Audits will be performed by the Staff Development Director on all falls twice weekly for a 60 day period. The results of the audits will be presented to the CQI committee for 3 months.</p> <p>An audit will be conducted by the DNS on care plans of all residents who have had a fall within the last 90 days to ensure that the care plans have been updated. The audit will be completed on or before May 2, 2012 and results will be reported at the next CQI meeting.</p> | |
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| F 280 | <p>Continued From page 2</p> <p>2. Per medical record review on 4/2/12, Resident #2 was admitted to the facility on 1/22/12 with diagnoses that include history of falls, dementia and depression. Per review of the nurses notes dated 3/14/12, Resident #2 was found in the bathroom on the floor complaining of right hip pain. Resident #2 was admitted to the hospital on 3/15/12 with a diagnosis of a fractured acetabulum. Per review of the Fall Risk Evaluation dated 3/18/12, the resident scored at a high risk for falls and a personal alarm was placed to identify staff at Resident #2's attempt to self transfer. Review of the comprehensive plan of care titled "At risk for falls/injury" dated 2/2/12 there was no evidence that the care plan had been updated to reflect the fall on 3/14/11 and there was no documentation of the utilization of a personal alarm. Review of the Licensed Nursing Assistant (LNA) Kardex used as a guide for the LNA's to provide care to the resident, it indicated that Resident #2 was a fall risk with the use of assistive devices (cane). There was no personal alarm listed on the Kardex. Per interview with the DNS on 4 /2/12 at 3:36 PM, he/she reviewed the care plan and LNA Kardex and confirmed that the care plan was not updated to reflect the falls on 3/14/12 and there were no resident specific interventions listed to prevent further falls and injury, also that the care plan had not been updated to reflect the fall on 3/14/11 or the need to utilize a personal alarm to alert staff when Resident #2 attempts to self transfer.</p> <p>3. Per medical record review on 4/2/12, Resident #3 was admitted to the facility on 4/22/11 with diagnoses that include; right sided hemiplegia, mild dementia, poor safety awareness and</p> | F 280 | | |
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| F 280 | Continued From page 3 hypotension. Per review of the nurses notes dated 2/11/12, Resident #3 was found sitting on the floor, alarm unhooked, no injuries reported. Per nurse's notes on 2/22/12, Resident #3 was found laying on floor in bathroom on his/her side, no injuries noted and new non-skid socks applied. Per review of the Fall Risk Evaluation, dated 1/4/12, Resident #3 was a moderate fall risk. Per review of the comprehensive care plan titled "At risk for falls/injury" there was no evidence that the care plan had been updated with the fall on 2/11/12 and 2/22/12 and there was no evidence that the care plan had been revised to indicate Resident #3's need for a new intervention after the 2/22/12 fall. Per review of the LNA Kardex, it indicated that Resident #3 was a fall risk, utilizes assistive devices (walker and wheelchair) and had a bed and chair alarm. Per interview with the DNS on 4/2/12 at 3:36 PM, he/she indicated that the intervention for the fall on 2/22/12 was the utilization of new slipper socks, he/she confirmed after review of the care plan and LNA Kardex that the care plan was not updated to reflect the falls on 2/11 and 2/22 and there were no resident specific interventions listed to prevent further falls and injury. The DNS also confirmed that the LNA Kardex did not reflect the need to utilize slipper socks as a safety measure for Resident #3. | F 280 | | | |
| F 323 SS=D | 483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. | F 323 | F323 Free of Accident Hazards/Supervision/Devices Resident known as #1 care plan will not be altered as the resident has since expired. | | |

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| F 323 | <p>Continued From page 4</p> <p>This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility failed to ensure that one resident (Resident #1) received adequate supervision and assistance devices to prevent accidents. The findings include:</p> <p>1. Per record review on 4/2/12, Resident #1 was admitted to the facility on 6/27/11 with diagnoses that include history of falls, degenerative joint disease, atrial fibrillation, seizure disorder, dementia with agitated behaviors, Parkinson's disease and poor safety awareness. Per review of the nurses' notes dated 7/4/11, the resident fell from a Geri chair, hitting his head against the wall, sustaining a T1 (spinal) fracture and a Medial Sesamoid bone (foot) fracture. On 9/19/11, Resident #1 was found under the bed on the floor bleeding from his/her head and sustained a head laceration requiring staples and a cranial bleed. Review of the Fall Risk Evaluation dated 3/10/11, the resident was a high risk for falls. Per review of Resident #1's comprehensive care plan titled "At high risk for falls and injury" dated 3/22/11, and the high risk for falls and injury care plan dated 7/13/11, there was no evidence that any new interventions were utilized after the falls on 7/4 and 9/19/11 to prevent resident #1 from any further re-occurrence of falls and injury. Per review of the facility's "Assessing Falls and Their Causes" policy, it indicates that "appropriate interventions should be taken to prevent future falls". Per interview</p> | F 323 | <p>All residents in the facility who have a fall have the potential to be affected by the alleged deficient practice.</p> <p>After a resident fall has occurred a Fall Investigative Story Tool will be completed by the DNS. This will then be brought to concurrent review. The resident care plan will be reviewed and updated with changes made. Based on the care plan updates, LNA Kardex will be updated as needed.</p> <p>Audits will be performed by the Staff Development Coordinator on all falls twice weekly for a 60 day period. The results of the audits will be presented to the CQI committee for a three month period.</p> | |

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| F 323 | Continued From page 5 with the Director of Nursing Services on 4/2/12 at 1:16 PM, he/she reviewed the comprehensive care plans dated 3/22 and 7/13/11 and confirmed that he/she could not identify where the care plan had been updated to reflect the falls on 7/4 and 9/19/11 and no interventions had been identified to ensure that Resident #1 was free of future falls and injury. | F 323 | An audit will be conducted on the care plans of all residents who have had a fall within the last 90 days. This audit will be conducted by the DNS on or before May 2, 2012. Results will be reported at the following CQI meeting. <i>F280 + F323 POC's accepted 4/27/12 M. Culina RN / Amcot RN</i> | |
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