

Division of Licensing and Protection
103 South Main Street
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

January 5, 2015

Ms. Heather Presch, Administrator
Springfield Health & Rehab
105 Chester Rd
Springfield, VT 05156-2106

Dear Ms. Presch:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **December 10, 2014**. 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

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

PRINTED: 12/19/2014
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 12/10/2014
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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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(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
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F 000	INITIAL COMMENTS	F 000		
F 241 SS=D	<p>483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and interviews the facility failed to promote services for 3 out of 17 residents in a manner, during meal experiences, that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. (Residents #3, #54 and #130) Findings include:</p> <p>1. During observation of the Noon meal on the first floor unit, 3 Residents were not assisted with their meals in a timely manner as follows:</p> <p>On 12/08/14 at 11:30 AM, 6 residents were seated and being served drinks. At approximately 12:11 PM, several residents stated the noon meal is usually served between 11:45 -12:00 o'clock but it must be running late, and acknowledged that they were hungry. The LNA [licensed nursing assistant] was taking meal orders and said "I'm trying to get their request so they don't have to wait so long, some have been down here almost an hour already". The food</p>	F 241	<p>F241</p> <p>Dignity and Respect of Individuality</p> <p>The following was completed as corrective action for all residents found to be potentially affected by the alleged deficient practice. Nursing Assistants and Dietary staff will be in-serviced regarding Resident's Rights, scheduled meal times and proper serving techniques in the dining rooms to ensure that all residents at one table are served timely to preserve dignity, respect and choice in the dining experience.</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Robert Neudorfer</i>	TITLE Executive Director	(X6) DATE 12/29/14
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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.

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F 241	Continued From page 1 cart arrived at 12:15 PM. Resident #3 and #130 requested an alternative, a grilled cheese sandwich at that time. Both residents made request several times for their alternatives, while their table mates ate their meals. The sandwiches were served approximately half hour later at 12:43 PM. Resident #54 requested an alternative at 12:20 PM, and greater than 15 minutes later, the LNA at 12:37 PM stated to the kitchen staff "[Resident #54] is getting anxious, can we get [his/her] plate now". The Unit Manager at 3:30 PM stated that s/he had called down to the kitchen because residents were not being served timely and confirmed the resident's personal choices and preferences were not recognized during the dining experience.	F 241	Corrective action will be completed on or before 1/09/15. Random audits of the dining service will be conducted on a weekly basis for a three month period by the Dietary Director or designee to ensure timely meal delivery to the floors and timely preparation and delivery of alternate meals. The SDC or designee will conduct weekly audits for a three month period to ensure that all residents at each table are served together. The QAPI committee will review the data and act on the information as indicated.	
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 upon staff interview and record review the facility failed to provide services that meet professional standards of quality regarding skin assessments, weights, and vital signs for one resident [Resident #157] of 24 residents in the sample group. Findings include:	F 281	F241 POC accepted 12/31/14 Dougherty Ral PML F281 Services Provided to Meet Professional Standards 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 281	<p>Continued From page 2</p> <p>1.) Per record review the Admission Evaluation Note for Resident #157 dated 11/26/14 documents the resident has "Multiple skin issues including vascular wounds, pressure areas and skin tears." Physician Orders for 11/26/14 include "Braden Scale upon admission, then in 6 days, then weekly for 3 weeks". [The Braden Scale for Predicting Pressure Ulcer Risk is a tool used to assess a patient's risk of developing a pressure ulcer]. Per review of the Agency for Healthcare Research and Quality's toolkit- 'What Are the Best Practices in Pressure Ulcer Prevention that We Want to Use?', the toolkit records "skin assessment is not a one-time event limited to admission. It needs to be repeated on a regular basis to determine whether any changes in skin condition have occurred." Additionally, it reports the Braden Scale serves "as a standardized way to review some factors that may put a person at risk for developing a pressure ulcer." (http://www.ahrq.gov/professionals/systems/long-term-care/resources/pressure-ulcers/pressureulcer toolkit/putool3.html)</p> <p>Per record review, along with multiple skin issues, Resident #157's diagnoses include congestive heart failure [CHF] and atrial fibrillation [quivering or irregular heartbeat]. Physician Orders for Resident #157 include "vital signs- every evening shift" and "Daily weight at 6:00 AM". Per review of the healthcare resource Advance for Nurses report 'CHF and Weight Monitoring'; "If a patient is diagnosed with CHF, daily weight monitoring is crucial." (http://nursing.advanceweb.com/sharedresource/s/advanceforurses/resources/downloadableresources/nurseweightfeb18.pdf)</p> <p>Per record review and confirmed by Resident</p>	F 281	<p>alleged deficient practice. Unit Managers will review charts on all residents to ensure that Admissions Assessments were completed appropriately. An in-service will be conducted for licensed staff on order entry procedures, assessments and follow through with scheduling.</p> <p>Corrective action will be completed on or before 1/09/15.</p> <p>A random audit will be completed on 10 newly admitted residents each month for three months to ensure orders for Braden Scale, weights, vital signs and skin assessments have been entered and scheduled properly. The QAPI committee will evaluate the data and act on the information as indicated.</p> <p><i>F281 POC accepted 12/31/14 TDougherty RNF/RL</i></p>	
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F 281	Continued From page 3 #157's Unit Manager [UM] on 12/09/14 at 1:20 PM, the UM confirmed that a Braden Scale Skin Assessment was not done 6 days after admission per physician orders, daily weights regarding Resident #157's CHF were not done on 2 dates [12/3 & 12/4/14], and no vital signs [blood pressure, temperature, heart rate, etc.] were taken on 12/3/14.	F 281	F282 Services By Qualified persons/per Care Plan	
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN 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 interviews and record review the facility failure to implement care plans for 2 of 21 applicable residents in the sample. (Residents #158 & #108) Findings include: 1. Per record review on 12/09/14, facility staff failed to monitor pain every shift for Resident #158 who was admitted on 12/01/14 under Hospice services. The admission care plan directed staff to monitor and record pain characteristics every shift and PRN [as needed]. Staff were to record the quality (e.g. sharp, burning); severity (1 to 10 scale); anatomical location; onset; duration (e.g., continuous, intermittent); aggravating factors and relieving factors. Per review of the nursing progress notes, MAR [medication administration record] and TAR [treatment administration record] no daily shift monitoring was found. Since	F 282	The following was completed as corrective action for all residents found to have the potential to be affected by the alleged deficient practice. The Unit Managers will review charts on all residents to ensure that pain and skin assessments are scheduled in the Emar. An in-service will be conducted for licensed staff on pain management, skin assessments and corresponding documentation. Corrective action will be completed on or before 1/09/15.	

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F 282	<p>Continued From page 4</p> <p>admission, Tylenol was recorded three times as given. The Unit Manager confirmed that staff failed to consistently document that monitoring of pain every shift, as care planned, had taken place.</p> <p>2. Based on observation, record review and interviews facility staff failed to monitor and assess Resident #108's skin as care planned. Per observation on 12/08/2014 at 2:37 PM some bruising was noted on the left arm near the elbow. Per interview on 12/09/14 at 1:11 PM the resident stated "I have thin skin" and acknowledged frequent bruising. Per review of the MDS (minimum data set) assessment dated 11/04/14 presents that the resident at that time had no pressure ulcers and the assessment tool (Braden) to determine potential skin integrity and/or pressure ulcers was noted as a score of 22 or low risk.</p> <p>Per orders dated 06/16/14 and 11/27/14 directs staff to do skin assessments every bath day [Thursday]. Per review of the nursing notes and/or assessments for the last 2 months -10/02/14 through 12/04/14, skin was assessed only 3 out of 11 bath days. (On 10/23/14, 11/20/14, and 11/27/14). Per interview, the Unit Manager on 12/09/14 at 2:55 PM stated "I actually don't see where staff are noting the skin assessment and we need a better process...we are working on it". S/he confirmed at that time staff failed to monitor/assess the skin weekly.</p>	F 282	<p>A random audit will be completed on 10 newly admitted residents each month for three months to ensure compliance with monitoring and recording pain and skin assessments. The QAPI committee will evaluate the data and act on the information as indicated.</p> <p><i>FAB & POC accepted 12/31/14 TDougherty RN / PML</i></p>	