VERMONT

AGENCY OF HUMAN SERVICES

DEPARTMENT OF DISABILITIES, AGING AND INDEPENDENT LIVING

Division of Licensing and Protection
HC 2 South, 280 State Drive
Waterbury, VT 05671-2060
http://www.dail.vermont.gov
Survey and Certification Voice/TTY (802) 241-0480
Survey and Certification Fax (802) 241-0343
Survey and Certification Reporting Line: (888) 700-5330
To Report Adult Abuse: (800) 564-1612

August 14, 2018

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 **August 1, 2018.** 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	475025	A. BUILDING _____ B. WING _____	C 08/01/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRINGFIELD HEALTH & REHAB	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 An unannounced on site investigation of three (3) self- reports, was conducted by the Division of Licensing and Protection on 7/31/18 through 8/1/18. The findings include the following:	F 000		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observation, record review and	F 657	**F657** CARE PLAN TIMING AND REVISION Immediate response was made to ensure the resident affected by the alleged deficient practice was protected. This was accomplished by updating resident #2's care plan to reflect his elopement risk and his ability to leave through doors that are non-Secure Care reactive. Identification of other residents at risk was completed by reviewing the residents that are utilizing the Secure Care system. Once identified their care plans were immediately updated to reflect their ability to leave the building through non-Secure Care reactive doors. The facility is actively working to get non-Secure Care doors alarmed. Once the system upgrade has occurred residents at risk will be reevaluated and their care plans updated accordingly.	

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

Center Executive Director 8/10/18

ny deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that ther safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days ollowing 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 ays following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued rogram participation.

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

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F 657	Continued From page 1 confirmed by staff interview the interdisciplinary team failed to revise the care plan for 1 of 3 applicable sampled residents (Resident #2). The findings include the following: Per medical record review for Resident #2, who was admitted on 5/21/18 with diagnosis to include, but not limited to, Dementia, major Depressive Disorder, Alzheimer's Disease and Korsakoff's Syndrome. Nurses notes evidence the following: May 2018: Resident was exit seeking and required medication for agitation on 6 occasions; June 2018: Resident was exit seeking and required medication for agitation on 15 occasions. S/He demonstrated aggressive behavior, had a fall, was located exiting the elevator and on one (1) occasion the Licensed Nurse Aide (LNA) shut the alarm downstairs at the main entrance. The resident was unable to be located. H/She was eventually found outside, coming around the corner of the building smelling of cigarette smoke; July 2018: Resident was exit seeking from an unsecured door located on the ground level. (There are 3 unsecured doors located on the ground level, at each end of the building.) H/She was demonstrating aggressive behavior when approached. On two (2) occasions the resident was attempting to exit the front door, to retrieve a newspaper at approximately 5:30 AM. On two (2) instances, assistance was required by the police and/or the facility Administrator to return the resident to the facility. Per review of Resident #2's interdisciplinary care plan for the problem of elopement, it identifies	F 657	Education will be provided to licensed staff on updating care plans. An audit will be completed by the DNS or designee weekly x4 and monthly x3 to ensure the effectiveness of the plan. The QAPI committee will evaluate the data and make recommendations as needed. Date of Compliance: 8/21/18 F657 POC accepted 8/13/18 MBertrand RN/PMM	

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F 657	Continued From page 2 staff to monitor circumstances of attempted elopement, utilize and monitor security bracelet per protocol, approach the resident in a calm manner/unhurried when exhibiting exit-seeking and to listen to the resident. There is no evidence in the care plan that identifies that the resident is aware of the unsecured doors and that s/he has the ability to exit through those unsecured doors on the ground level. Confirmation was made by the Interim Unit Manager on 8/1/18 at approximately 11:55 AM, that the care plan has not been revised indicating that Resident #2 knows how to leave the facility by way of the unsecured doors and that the resident has left the building since admission despite the Wander-Guard Elopement Device.	F 657		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observations, record review and confirmed by staff interviews, the facility failed to meet professional standards of care for medication administration and documentation/transcription of orders for medications for 1 applicable resident in the sample of 3, (Resident #3). The findings include the following: Per record review for Resident #3, with diagnoses to include, but not limited to, Schizophrenia,	F 658	**F658** SERVICES PROVIDED MEET PROFESSIONAL STANDARDS Immediate response was made to ensure the resident affected by the alleged deficient practice was protected. This was accomplished by alerting resident #3's physician and family that an error had occurred. The physician gave orders on how to proceed with her medications.	

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F 658	Continued From page 3 Anxiety Disorder, Psychosis and Dementia. Facsimile sent to the physician dated 6/16/18, identified that the resident has been increasingly combative, tried to hurt another resident. The resident was further seen by a Psychologist on 6/21/18 who suggested the following medication adjustments: decrease Duloxetine, (a medication used to treat depression and pain), to 30 milligram (mg.) daily and decrease Mirtazapine, (a medication used to treat depression), to 15 mg po at bedtime (hs). The suggestion was approved by the attending physician dated 6/22/18. The adjustment was made to the Duloxetine, but the Mirtazapine was never transcribed. The resident has continued to received Mirtazapine 22.5 mg by mouth at hs for 39 days after the order was approved by the attending physician. This was confirmed by the Unit Manager on 8/1/18 at approximately 10:20 AM. Ref.: Lippincott Manual of Nursing Practice (9th ed.). Wolters Kluwer Health/Lippincott Wiliams & Wilkins. pg. 17.	F 658	To identify any other residents at risk a resident chart audit was completed. This was to identify and correct any orders that may have had inconsistencies. To prevent recurrence of potential future deficient practice, staff that are legally authorized to transcribe and administer licensed practitioner's orders were given education to ensure compliance that all licensed practitioner orders are addressed as written. An audit will be completed weekly x4, monthly x3 by the DNS or designee. The QAPI committee will evaluate the data and make recommendations as needed. Date of Compliance: 8/21/18	
F 689 SS=E	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, record review and	F 689	F658 POC accepted 8/13/18 MBatchelderRN/PNL **F689** FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES Immediate response was made to ensure the residents affected by the alleged deficient practice were protected.	

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F 689	Continued From page 4 confirmed by staff interview the facility failed to ensure that 1 of 4 applicable residents in the sample, was adequately supervised to prevent accidents/elopement from the facility (Resident #2). The facility has also failed to ensure the safety of 6 of 6 residents, who are at risk for elopement, (Residents #1, #2, #5, #6, #7 and #8). The findings include the following: 1. Per medical record review for Resident #2, who was admitted on 5/21/18 with diagnoses to include, but not limited to, Dementia, major Depressive Disorder, Alzheimer's Disease and Korsakoff's Syndrome. Nurses notes evidence the following: May 2018: Resident was exit seeking and required medication for agitation on 6 occasions; 5/25/18: Wander-Guard Elopement Device attached to Resident #2's ankle; June 2018: Resident was exit seeking and required medication for agitation on 15 occasions. S/He demonstrated aggressive behavior, had a fall, was located exiting the elevator and on one (1) occasion the Licensed Nurse Aide (LNA) shut the alarm downstairs at the main entrance. The resident was unable to be located. H/She was eventually found outside, coming around the corner of the building smelling of cigarette smoke; July 2018: Resident was exit seeking from an unsecured door located on the ground level. (There are 3 unsecured doors located on the ground level, at each end of the building.) H/She was demonstrating aggressive behavior when approached. On two (2) occasions the resident was attempting to exit the front door, to retrieve a newspaper. On two (2) instances, assistance	F 689	This was accomplished by updating the care plans for the 6 residents who were utilizing the Secure Care system to reflect their elopement risk and the ability to leave through the doors that are non-Secure Care reactive. Education will be provided to licensed staff on q15 minute checks and documentation. Residents with secure care systems in place were put on q15 minute checks until all exit doors accessible by residents are made Secure Care reactive. The facility is actively working to get non-Secure Care doors alarmed. Once the system upgrade has occurred residents at risk will be reevaluated and their care plans updated accordingly. An audit will be completed by the DNS or designee weekly x4 and monthly x3 to monitor the effectiveness of the plan. The QAPI committee will evaluate the data and make recommendations as needed. Date of compliance: 8/21/18	

F689 POC accepted 8/13/18 MBertrand RN/PMU

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F 689	Continued From page 5	F 689		

was required by the police and/or the facility Administrator to return the resident to the facility.

The Interim Unit Manger confirms on 8/1/18 at approximately 11:55 AM, that Resident #2 was assessed to be an elopement risk on 4/25/18, that resident knows how to leave the facility by way of the ground level doors at the end of each hall (they are not alarmed), and that the resident has left the building since admission despite the Wander-Guard Elopement Device.

2. Per discussion with the Interim Unit Manager/Staff Development Coordinator, on 8/1/18 at approximately 11 AM, confirmation is made that there are six (6) residents in the facility who are at risk for elopement. They each have a Wander-Guard Elopement Device attached to their person and/or personal belongings. The device is used to ensure that each of those residents do not attempt to elope from the facility. Each of the six (6) residents identified, have a care plan that directs the staff to monitor the security bracelet as per protocol.

The facility Administrator confirms on 8/1/18 at approximately 3 PM, that a request has been submitted for a capital expense approval to extend the security system to the three (3) unalarmed doors on the ground level. To date, there has not been a response. Therefore, the three (3) doors on the ground level do not alert the staff that a resident who is at risk for elopement could exit from one of those unsecured doors.