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

October 12, 2018

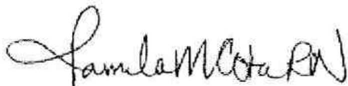
Ms. Heather Presch, Administrator
Springfield Health & Rehab
105 Chester Rd
Springfield, VT 05156-2106

Dear Ms. Presch:

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

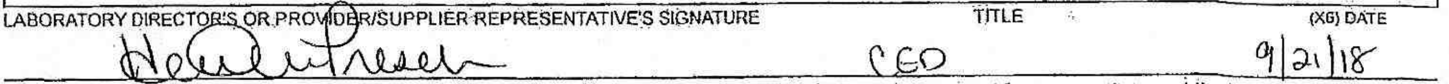
DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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 ______	R-C 09/10/2018

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 The Division of Licensing and Protection conducted an unannounced onsite follow-up investigation on 9/10/18, and the following regulatory violation was identified.	{F 000}		
{F 689} SS=B	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, staff interview and record review, the facility failed to ensure that the resident environment remains as free of accident hazards as is possible for 4 applicable residents, Residents #1, #2, #5 and #6. Findings include: During a previous investigation on 8/1/18 it was discovered that there are three (3) unalarmed doors on the ground level of the building. The facility reported that as of the date of this investigation, 9/10/19, the three (3) doors are still unalarmed. The equipment needed to be ordered and they believe that by the end of the week the equipment should be installed. Four (4) residents had previously been identified as being at risk for elopement. Residents #1, #2, #5 and #6. All four residents have cognitive impairment and poor safety awareness. Although all four residents have a Wander-Guard	{F 689}	**F689** FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES Immediate response was made on 8/10/18 for residents utilizing the secure care system. None of the residents have eloped. The care plan for each of these residents has been updated with the following information as it relates to Elopement Risk and ability to exit doors that are non-Secure Care reactive – "9/13/18: Resident is utilizing a Secure Care anklet. There are three doors on the Ground Floor of the facility that are as of this date non-Secure Care reactive. With this residents fluctuating cognitive ability they may upon trying each door, realize they can exit without setting off an alarm. They also have the physical ability to exit the doors. For this residents safety they will be monitored on 15 minute checks until all exit doors that residents have access to are Secure Care reactive."	

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



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.

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

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{F 689}	Continued From page 1 Elopement Device attached to their person, the three doors do not have the equipment needed to alert staff that a resident is attempting to leave the facility. As part of the previous investigation the facility stated that in order to protect these residents from elopement, they had instituted 15-minute safety checks for each of the four residents and care plans were updated to reflect this intervention. In review of the 15-minute check flow sheets for Resident #1, there are 10 days out of 19 possible days in which only partial data is recorded and 3 days in which the facility could not provide the flow sheet at all. For Resident #2, in reviewing their 15-minute check flow sheets, there are 7 days out of 19 possible days in which only partial data is recorded and 1 day in which the flow sheet is missing. For Resident #5, in reviewing their 15-minute check flow sheets there are 3 days out of a possible 19 days in which only partial data is recorded. For Resident #6, in reviewing their 15-minute check flow sheets there are 6 days out of 19 possible days in which only partial data is recorded and 1 day in which the flow sheet is missing. The Director or Nursing (DNS) confirmed on 9/10/19 at 12:15 PM that the 15-minute flow sheets are incomplete, that in fact, several days are missing and therefore s/he could not confirm that the checks were being done to ensure resident safety.	{F 689}	Licensed nursing staff (RN's and LPN's) will be re-educated about the current plan to provide resident safety as it relates to F689 Free of Accident Hazards/Supervision/Devices specifically around elopement prevention. This re-education will be completed by 9/30/18. The audit for F689 Free of Accident Hazards/Supervision/Devices: As it relates to the need for q15 minute checks for Elopement Prevention will continue weekly x4 and monthly x3 or until all doors that residents have access to are Secure Care reactive. The facility is actively working to get the non-Secure Care reactive doors alarmed. One the system upgrade has occurred residents at risk will be re-evaluated and their care plans updated accordingly. The QAPI committee will evaluate the data and make recommendations as needed. Date of compliance: 9/30/18 F-689 POC accepted 10/11/18 C. Lovell RN / S. Perry RN	

September 21, 2018

To: Division of Licensing and Protection

Re: Springfield Health & Rehab

Plan of Correction

Credible Allegation of Compliance

Dear Licensing Chief:

On September 10, 2018 surveyors from the Vermont Agency of Human Services, Division of Licensing and Protection completed a re-visit survey at Springfield Health & Rehab. As a result of the inspection, the surveyor alleged that the Facility was not in substantial compliance with certain Medicare and Medicaid certification requirements. Enclosed you will find the Statement of Deficiencies (HCFA – 2567) with the Facility's Plan of Correction for the deficiencies.

Please consider this letter and the Plan of Correction to be the Facility's credible allegation of compliance. Please notify me if you do not find this plan acceptable. This letter is also our request for a re-survey, if one is necessary, to verify that the Facility achieved substantial compliance with the applicable requirements as of the dates set forth in the Plan of Correction and credible allegation of compliance. Please call me if you have any questions.

Respectfully,

Heather Presch, LNHA

Center Executive Director