

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

February 11, 2016

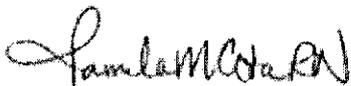
Ms. Heather Presch, Administrator
Springfield Health & Rehab
105 Chester Rd
Springfield, VT 05156-2106

Dear Ms. Presch:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **January 6, 2016**. 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: 01/14/2016
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 01/06/2016
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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 000	INITIAL COMMENTS	F 000		
F 280 SS=D	<p>483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP</p> <p>The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.</p> <p>A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.</p> <p>This REQUIREMENT is not met as evidenced by: Based on staff interview and medical record review, the facility failed to revise the care plan regarding the need for increased care for 1 of 20 residents reviewed, Resident #16. Findings include:</p>	F 280	<p>F280 Right to Participate Planning Care - Revise CP</p> <p>The care plan for resident #16 was revised immediately. Resident #16 did not have any negative effects for the alleged deficient practice.</p> <p>The following was completed as corrective action for all residents found to be potentially affected by the alleged deficient practice.</p> <p>Education will be provided to nursing staff regarding the requirements for care plan revision. Education will be completed by 2/6/16. An audit will be completed weekly by the DNS or designee to monitor the effectiveness of the plan.</p> <p>The QAPI committee will evaluate the data and act on the information as indicated and at the end of three months to determine further frequency of the audits.</p>	

F280 POC accepted 2/4/16 G. Coleman R. P. Mc
(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE
Hedone Presch Executive Director 1/29/16

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 280	Continued From page 1 Per record review, Resident #16 was admitted to the facility with diagnoses that include osteoarthritis and contracture, and required extensive assist with care. Per interview with a Licensed Nursing Assistant (LNA) on 1/6/15 at 1:33 PM, the resident had a decline in his/her abilities and doesn't do as much as s/he used to be able to do. The LNA further stated that the resident is totally dependent on staff for bathing and grooming and the only thing that s/he can do is feed him/herself with encouragement and assistance. Per interview with the Unit Manager (UM) at 1:50 PM s/he stated that s/he makes the revisions to the care plans and they are reviewed by the Registered Nurse quarterly. The UM confirmed that there was a decline in the resident's functional ability in early October 2015 and the current care plan dated 11/10/15 does not reflect the decline. S/he stated that resident is care planned for extensive assist of one staff member but actually requires total assist from staff. The UM further stated that the care plan should have been updated at that time the decline.	F 280			
F 312 SS-D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and medical record review, the facility failed to provide	F 312	F312 ADL Care Provided For Dependent Residents The hands/nails of resident #16 were cleaned/trimmed immediately. Resident #16 had no negative effects from the alleged deficient practice. The following was completed as corrective action for all residents found to be potentially affected by the alleged deficient practice.		

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F 312	<p>Continued From page 2</p> <p>appropriate personal hygiene care to 1 of 20 residents reviewed, Resident #16. Findings include:</p> <p>Per observation of Resident #16 during Stage One of the survey on 1/4/16 at 2:52 PM, s/he presented with dirty and untrimmed fingernails and there was brown dried matter on his/her left middle finger, that was contracted in toward the palm of her hand.</p> <p>Record review on 1/6/15 at 1:50 PM presents that Resident #16 has a care plan for self-care performance deficit related to weakness and decreased range of motion to upper extremities. Per the care plan the resident requires extensive assist of one staff member for personal hygiene. Per interview with the Unit Manager (UM) at this time, s/he stated that the resident had a decline in October and is now totally dependent on the staff for personal hygiene. The UM stated that the care plan reflects that the resident is extensive assist of one staff for personal hygiene but s/he is actually totally dependent on staff for care. The UM further stated that there was no way that the resident could care for his/her own fingernails or washing of his/her hands.</p> <p>Per interview with the day shift primary Licensed Nursing Assistant (LNA) for Resident #16 on 1/6/15 at 2:10 PM, Resident #16 requires total care and that the resident is not able to wash her own hands or cut her own nails. The LNA confirmed at this time that the first, middle and ring finger of Resident #16's left hand had brown matter on them and his/her finger nails on the same fingers were dirty and needed to be trimmed and that they would be taken care of immediately. The LNA further stated that s/he</p>	F 312	<p>Education will be provided to nursing staff regarding the requirements for ADL care for dependent residents, to include proper hand hygiene and nail care. Education will be completed by 2/6/16. An audit will be completed weekly by the DNS or designee to monitor the effectiveness of the plan.</p> <p>The QAPI committee will evaluate the data and act on the information as indicated and at the end of three months to determine further frequency of the audits.</p> <p><i>F312 POC accepted 2/4/16 Coleman RN/PML</i></p>

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F 312	Continued From page 3 had not been on duty the day before but s/he always makes sure the resident is washed thoroughly when s/he is bathed before getting up. (Resident was sitting up in gerichair at time of interview.) The LNA then stated that s/he had not noticed the fingers earlier and reported to this surveyor a few minutes later that s/he had cleaned the fingers and trimmed the nails.	F 312		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which	F 441	F441 Infection Control, Prevent Spread, Linens Residents #28, 76, and 108 had no negative effects from the alleged deficient practices. The following was completed as corrective action for all residents found to be potentially affected by the alleged deficient practice. Education will be provided to nursing staff regarding Infection Control Practices. Education will be completed by 2/6/16. An audit will be completed weekly by the DNS or designee to monitor the effectiveness of the plan. The QAPI committee will evaluate the data and act on the information as indicated and at the end of three months to determine further frequency of the audits.	

F441 POC accepted 2/1/16 G Coleman RN/PMC

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F 441	<p>Continued From page 4</p> <p>hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and staff interview the facility failed to provide a sanitary environment to help prevent the development and transmission of disease and infection for 3 residents, Residents #28, 76 and 108. Findings include:</p> <p>1. Per observation during the initial facility tour, a pillow was on the floor between the two beds in Resident #108's room and at 10:40 AM, the Licensed Practical Nurse (LPN) picked the pillow up from the floor, adjusted the pillowcase and then placed it on the bed, under another pillow that was already on the bed for Resident #108. The LPN confirmed at this time that s/he had picked the pillow up from the floor and did not change the pillowcase. S/he further stated that the pillow was placed under the other pillow that Resident #108 was laying on so that the resident's head was not laying on the pillow that was on the floor. S/he further confirmed that even if Resident #108 was not actually laying on the pillow that was on the floor, that it was still a breach of infection control.</p> <p>2. Per observation on 1/5/16 at 12:07 PM, during the lunch meal, LNA #1 spilled a cup of thickened apple juice for Resident #76 on the table and on</p>	F 441			

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F 441	<p>Continued From page 5</p> <p>his/her fingers, the LNA then wiped the excess that was on his/her fingers across the top of the cup. The LNA continue resumed feeding Resident #76, and then gave a drink from the cup that s/he wiped his/her fingers across to Resident #76. At 12:10 PM the LNA stated that s/he probably had wiped her fingers across the rim of the cup, but didn't realize that s/he had done it "because sometimes things happen and you don't think about it", and s/he agreed that it had been a breach of infection control.</p> <p>3. Per observation on 1/5/16 at 12:07 PM, during the lunch meal, LNA #2 asked Resident #28 if they would like more to drink and then took the cup, which had a sipper top on it. LNA #2 unscrewed the top with ungloved hands while touching the mouthpiece of the sipper top and then placed the top on the counter. S/he filled the cup, replaced the cover and gave it to the resident who then began to drink from it. The LNA confirmed at 12:10 PM that it was a breach of infection control and s/he had not even thought about it.</p>	F 441		
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