

## DEPARTMENT OF DISABILITIES, AGING AND INDEPENDENT LIVING

Division of Licensing and Protection

HC 2 South, 280 State Drive
Waterbury, VT 05671-2060
<a href="http://www.dail.vermont.gov">http://www.dail.vermont.gov</a>
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

March 22, 2019

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 **February 28**, **2019**. 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

mlaMCotafor)

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	2 350	E CONSTRUCTION	(X3) DA	D. 0938-0 TE SURVEY
}	c	475025	B. WING		0:	C 2/28/2019
AME OF	PROVIDER OR SUPPLIER		S S	TREET ADDRESS, CITY, STATE, ZIP COL	)E	3-90.10
PRING	FIELD HEALTH & RE	HAB	- 10	05 CHESTER RD PRINGFIELD, VT 05156	*-04.7	
X4) ID REFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID. PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH: CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	TOULD BE	(X5) COMPLE DATE
≣ 000	Initial Comments		E 000			
1	conjunction with the	ram was conducted in annual re-certification survey 2/28/19. There were no				
000	INITIAL COMMENT	And the state of t	F 000	į		<b>a</b>
	survey was completed complaint investigated Licensing and Protes 2/28/2019. There was a survey of the survey of th	n-site annual re-certification ted, in conjunction with a tion, by the Division of ection between 2/25 and vere regulatory deficiencies notification and transfer			2 24 e 2 2	L D
) 580	notifications involving also regulatory defice re-certification surver Notify of Changes (I	ng the complaint. There were beliencies surrounding the believ.  njury/Decline/Room, etc.)	F 580			
	consult with the resiconsistent with his orepresentative(s) who has a accident involves the consistent injury and ohysician intervention (B) A significant characterioration in healtstatus in either life-the clinical complication (C) A need to alter the need to discontinuite to adverte to a continuite	fication of Changes. mediately inform the resident; dent's physician; and notify, or her authority, the resident nen there is- living the resident which has the potential for requiring on; nge in the resident's physical, icial status (that is, a th, mental, or psychosocial inreatening conditions or is); eatment significantly (that is, e an existing form of verse consequences, or to orm of treatment); or		Springfield Health and Rehat provides this plan of correct without admitting or denying validity or existence of the deficiencies. The plan of co- is prepared and executed so because it is required by feat state law.	tion ng the alleged orrection olely	

ny liency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that her safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days lowing 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 ogram participation.

PRINTED: 03/14/2019

DEPARTMENT OF HEALTH			PRINTED: 03/14/20 FORM APPROVE
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		COMB NO: 0938-030  LTIPLE CONSTRUCTION  (X3) DATE SURVEY  COMPLETED
	475025	B. WING	C 02/28/2019
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE
SPRINGFIELD HEALTH & REH	АВ		105 CHESTER RD SPRINGFIELD, VT 05156
PREFIX (EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)	ID PREFIX TAG	
§483.15(c)(1)(ii). (ii) When making no (14)(i) of this section all pertinent informat is available and prov physician. (iii) The facility must resident and the resi when there is- (A) A change in room as specified in §483. (B) A change in resid State law or regulation (e)(10) of this section (iv) The facility must	cility as specified in  tification under paragraph (g) to the facility must ensure that tion specified in §483.15(c)(2) rided upon request to the also promptly notify the dent representative, if any, or roommate assignment 10(e)(6); or lent rights under Federal or ons as specified in paragraph to the face of the face of the paragraph to the face of the	F 58	580
supersentative(s).  §483.10(g)(15)  Admission to a composite di §483.5) must discloss its physical configurat locations that compris part, and must specif room changes between under §483.15(c)(9).  This REQUIREMENT by:  Based on interview a failed to notify the reschange in condition the thospital for 1 apples.	osite distinct part. A facility istinct part (as defined in e in its admission agreement tion, including the various se the composite distinct y the policies that apply to en its different locations is not met as evidenced and record review the facility ident's representative of a nat resulted in a transfer to licable resident, Resident		F580 Notify of Changes (Injury/Room/Decline, etc.)  Resident Representative for Resident #20 was notified of transfer on 7/16/18.  Resident #20 did not have any negative effects from the alleged
noted to be "off" his/h	er "baseline". His/her right		deficient practice.

	and the second test to the secon	AND HUMAN SERVICES  & MEDICAID SERVICES		PRINTED: 03/14/201 FORM APPROVEI OMB NO. 0938-038
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION (X3) DATE SURVEY COMPLETED
		475025	B.: WING_	02/28/2019
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE  105 CHESTER RD
SPRING	FIELD HEALTH & REH	AB		SPRINGFIELD, VT 05156
(X4) ID PREFIX TAG	(EACH DEFICIENCY	FEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL CONTROL OF THE STATE O	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (X5) (EAGH)CORRECTIVE ACTION SHOULD BE CROSS REFERENCED TO THE APPROPRIATE DEFICIENCY)  (X5)  COMPLETION DATE
F 580	arm was very weak.	When asked to smile, s/he	F 58	30
F 623 SS=E	"could barely lift right nurse received an ophysician to send Reper review of a nurse 7/16/18, it read, Ever from Resident #20's s/he was not informate hospital. Per interviewith the Unit Managaresident's represent notified of Resident: Notice Requirement CFR(s): 483.15(c)(3) Notice Before a facility transpessed of the reasons for the language and managaresident, the facility representative of the Long-Term Care Om (ii) Record the reason discharge in the residence of the reasons for the reasons for the language and managaresident of the Long-Term Care Om (iii) Record the reasons discharge in the residence with paragare	t side of [his/her] face". The reder from the on-call esident #20 to the hospital, ing progress note from ning nurse received a call guardian who inquired why ed of the transfer to the ew on 2/28/19 at 8:43 AM er, s/he confirmed that the ative was not appropriately #20's transfer to the hospital. Is Before Transfer/Discharge (b)-(6)(8)  It before transfer. It is before transfer or discharge and mustand the resident's the transfer or discharge and move in writing and in a er they understand. The copy of the notice to a confice of the State budsman.  Ins for the transfer or dent's medical record in agraph (c)(2) of this section; tice the items described in his section.	F 62	Residents who are transferred to the hospital have the potential to be affected by the alleged deficient practice.  The following was completed as corrective action for residents found to be potentially affected by the alleged deficient practice.  Education will be provided to nurses on the requirement for notification of changes in condition.  An audit will be completed weekly x4 and monthly x3 by the DNS or designee to monitor the effectiveness of the plan.  The QAPI committee will evaluate the data and make recommendations as needed.  Date of Compliance: 3/29/19  F-580 POC accepted 3/23/19 B. Bartoll, EU JS. Reugen
*	(i) Except as specified (c)(8) of this section, discharge required u	d in paragraphs (c)(4)(ii) and the notice of transfer or nder this section must be at least 30 days before the	*	
	resident is dansieffe	u or uscharged.		

	entry between	AND HUMAN SERVICES  & MEDICAID SERVICES				FORM	D: 03/14/2019 MAPPROVED D: 0938-0391
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING	LE CONSTRUCTION	====	(X3) DA	TE SURVEY MPLETED
		475025	B: WING		<u> </u>	02	C //28/2019
NAME OF	PROVIDER OR SUPPLIER		- 13	TREET ADDRESS, CIT	Y, STATE, ZIP CODE		20/2013
SPRING	FIELD HEALTH & REF	IAB		05 CHESTER RD SPRINGFIELD, VT	05156		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRI	'S PLAN OF CORRECT SHOP SHOP SHOP SHOP SHOP SHOP SHOP SHOP	ULD BE	(X5) COMPLETION DATE
F 623	Continued From page	ge 3	F 623	I 194			
	(ii) Notice must be n	nade as soon as practicable					*
	before transfer or di	scharge when- lividuals in the facility would					
	be endangered und	er paragraph (c)(1)(i)(C) of					
	this section;	lividuals in the facility would		<i>P</i>			
	be endangered, und	er paragraph (c)(1)(i)(D) of	l.				
	this section;	ealth improves sufficiently to			¥ ~~	8 * 6	
	allow a more immed	iate transfer or discharge,		E 1000		(2 )	
	under paragraph (c)	(1)(i)(B) of this section;	a a				
- Transit	required by the resid	ansfer or discharge is lent's urgent medical needs,		ž į		* ,	
ŀ	under paragraph (c)	(1)(i)(A) of this section; or				1907	£ .
	days.	ot resided in the facility for 30		-	<u> </u>		1
	notice specified in pa	nts of the notice. The written aragraph (c)(3) of this section		B 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1		а — «	
	must include the folk (i) The reason for tra	OWing: ansfer or discharge:	(E)			20	
	(ii) The effective date	of transfer or discharge;					
	(iii) The location to w transferred or discha					185	
		e resident's appeal rights,		I	4	ti la	
		address (mailing and email), er of the entity which	į.		**************************************	5	
		et of the entity which sts; and information on how	ŧ				
	to obtain an appeal f	orm and assistance in					
ľ	hearing request;	and submitting the appeal	ž				1
	(v) The name, addre	ss (mailing and email) and	=	i .	*		#:
	telephone number of Long-Term Care Om	the Office of the State budsman:		ø 4		a	
1	(vi) For nursing facility	ty residents with intellectual	8		ς δ		
	and developmental disabilities, the mailing	lisabilities or related ng and email address and				× 2	
1	telephone number of	the agency responsible for	4				
i					,		

		AND HUMAN SERVICES  & MEDICAID SERVICES			RINTED: 03/14/2019 FORM APPROVED MB:NO: 0938-0391
STATEMEN AND PLAN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A: BUILDING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	e	475025	B. WING		C 02/28/2019
NAME OF	PROVIDER OR SUPPLIER		!	REET ADDRESS, CITY, STATE, ZIP CODE	
SPRING	FIELD HEALTH & REH	IAB		CHESTER RD PRINGFIELD, VT 05156	1
(X4) ID PREFIX TAG	(EACH DEFICIENCY	FEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH) CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIES DEFICIENCY)	COMPLETION
F 623	Continued From page	de 4	F 623		
00 000000000000000000000000000000000000	the protection and a developmental disal	dvocacy of individuals with pilities established under Part			
	and Bill of Rights Ac	ntal Disabilities Assistance t of 2000 (Pub. L. 106-402, . 15001 et seg.); and			
e i	(vii) For nursing faci disorder or related d	lity residents with a mental isabilities, the mailing and			
	agency responsible advocacy of individu	elephone number of the for the protection and als with a mental disorder			
	established under the for Mentally III Individual	e Protection and Advocacy duals Act.			
	effecting the transfer must update the rec	ges to the notice. the notice changes prior to or discharge, the facility plents of the notice as soon the updated information	-		
	In the case of facility	in advance of facility closure closure, the individual who is	,		
	written notification proto the State Survey A	the facility must provide rior to the impending closure Agency, the Office of the		* . * .	Ann
	the facility, and the rewell as the plan for the	re Ombudsman, residents of esident representatives, as ne transfer and adequate		F623 Notice Requirements Before	e
	483.70(I).	dents, as required at §  T is not met as evidenced		Transfer/Discharge  Residents # 8, 11, 64, 219, 65, 20	
1	by: Based on interview	and record review, the facility		and 31 were presented with appropriate notice post survey.	
	representative in writ and send a copy to t	sident and/or resident's ting of a transfer/discharge he Ombudsman (public nvestigate complaints people	30 · · · · · · · · · · · · · · · · · · ·	None of the residents had negat effects from the alleged deficien	1.5.
	make against govern			practice.	

24		AND HUMAN SERVICES  & MEDICAID SERVICES			FORM.	03/14/2019 APPROVED 0938-0391-
STATEMEN AND PLAN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COM	SURVEY PLETED
		475025	B. WING		02/2	28/2019
NAME OF	PROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STATE, ZIP CODE		2/40.10
SPRING	FIELD HEALTH & REF	IAB	1	05 CHESTER RD PRINGFIELD, VT 05156		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	-	
PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS REFERENCED TO THE APPROPE DEFICIENCY)	RE :	(X5) COMPLETION DATE
F 623	Continued Frame no	E	F 000		- 1	
F 023		<b>-</b>	F 623	Residents transferred to the hos	pital	
	residents in the sam 11, 219 and 31. Fin	ple, Resident #20, 65, 8, 64,		have the potential to be affected	by.	
	11, 219 and 31. Till	dings include.		the alleged deficient practice.		
		s transferred to the hospital ation for zoster neuralgia flare		The following was completed as	- 8	
	up, again on 12/13/1	18 secondary to an acute	4	corrective action for all resident	s	
1		on with cystitis and again on		found to be potentially affected	by	
		an eye infection. Each of the		the alleged deficient practice.	į	ĺ
		e hospital emergency uation and treatment. Per		a a		1
}		business office manager on		Education will be provided to	-	
	2/26/19 at 12:40 PM	, the resident did not receive		Business Office and licensed Nur	sing	
	notification of transfe		9	staff regarding the requirements	and	
	0) 5 4 4 44			process for transfer notification.	[	1
		es transferred to the hospital itted until his return to the				v 41
:/		returned to the emergency		An audit will be completed week	dy	
		and was admitted for altered		x4 and monthly x3 the DNS or		
Į.	mental status and se	eizure activity. The resident	:	designee to monitor the		
		y on 12/4/18. Per record		effectiveness of the plan.		
		evidence that notification of				
		d per requirements and ade through an interview with		The QAPI committee will evalua	te	ľ
		nanager on 2/27/19 at 2:04		the data and make		
		had not been provided per		recommendations as needed.	. 1	
	regulations.			Date of Compliance: 3/29/19		
	3. Per record review				- 1	
	transferred to the En	nergency Room for 9 at 4:47 PM for medical	,	F-423 POC accepted 3/2 B. Bartell, RU/S. Lewy	1916	
		ned to the facility at 10:14		t-uasiocatapies	011	
		as returned to the hospital on		B. Bartell, W/S. Lewy	w	
-	1/18/19 and was adr	nitted for treatment. The			į	
		n to the facility until 2/5/19.				<u>,</u> [.
		edical record for Resident		<sup>ক</sup> ুন প্ৰক্ৰা	(9)	
	#64, there is no evid transfer/discharge no	otice mat a		4 "L	n n	
		he resident's representative.			The Kons	
-	Confirmation was ma	ade by the Office Manager on			v .	
	2/26/19 at approxima	ately 4:15 PM that the			<del></del>	
DAM CAME OF	37(02-99) Previous Versions (	Obsolete Event ID: GONX1	1 Fai	cility ID: 475025	tion chack	Page 6 of 26

	FR 1	AND HUMAN SERVICES  & MEDICAID SERVICES								PRIN F OME	ORM	APPF	NOS	FD
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING							(X3) DATE SURVEY COMPLETED C				
	a	475025	Br.WING.						N N	11		28/20	110	
NAME OF	PROVIDER OR SUPPLIER				TREETA	DDRESS	CITY, ST	TATE, ZIF	CODE		UZI	20120	13	-
SPRING	FIELD HEALTH & REF	iab		1	05 CHES	STER RE	) -				- <u></u>		r'.	100
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREF TAG		CF	PROVI (EACH CO ROSS RE	FERENCE	VE ACTI	ON SEQ HE APPR	ULD BE	re	- COMP	(X5) PLET:IC PATE	N
F 623	1	<del></del>	F	6 <b>2</b> 3			#1 #1						v. enem	
	transfer/discharge v	vritten notice was never		15	-				8		d			ļ.
		or as soon as possible for	×	1							÷			ł
		nsfers. Confirmation was also				-					;	3.7	3 <b>=</b> 0	
	made at this time th	at the facility did not follow the			i.			8						- 1
i	Genesis policy relate	ed to voluntary	į		l					1)	3	ľ		1
	transfer/discharge.				l		(4))					1.		
i		notice did not contain all	S						*		¥.	1		1
ì	required elements p Medicare	er Federal CMS (Centers for			į.					•				
		ents listed in this regulation.						×				ı		
		s not provided the information			ŀ	1.00			(4)/ O	. 3			3839	1
	was not available to							•						1
:	representative.													
		*					9	Ý,				į.		
	4. Per record review	v, Resident #219 was	į.						6		y			
	transferred to the ac	tute hospital on 2/1/19 and	į		1									#
		atment. The resident							9		Ì	ľ	20 W	
		ly on 2/9/19. The Office			İ						İ			Ĭ
16	decumentation ident	ne surveyor with incomplete							•		1		85	1
		fying that the resident was ute hospital on 2/1/19. The			1			3	(2)		. 4			1
6)		ransfer was not completely							. 8		4			ľ
		ailed to the resident on				¥								į.
- 1		t signed the notification of	ļ i	5	1	\$1		2			1		3	1
1		n 2/21/19, after returning to	İ				-			*	1			
	the facility.		•		i.						3.50	1		
ł		ade by the Office Manager on						e.						ľ
		at approximately 1:30 PM, discharge written notice was						99 P				ĺ		
	not provided as requ	ired at time of	10 12											1
Î	transfer/discharge or	r as soon as possible, the			į							i		1
	documents mailed w	vere not completely filled out			I		(# C#0			*1		i i		1
	and did not meet all	requirements Confirmation	8		×	80						2		
Ì	was also made that	the facility did not follow the			8	-					=	1		1
į	Genesis policy relate	ed to voluntary	•			(*)			<b>3</b> 7					
	transfer/discharge.	-			E				8	8 88	-	i		
ļ		notice do not contain all	*		i					*				
	required elements pe	ei Leneigi (CiM2)											·	. 1

		AND HUMAN SERVICES  & MEDICAID SERVICES						FOR	D: 03/14 MAPPRO D: 0938	DIVER
STATEME	NT OF DEFICIENCIES N OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A, BUILD		CONSTRUCTION			(X3) DA	TE SURVE MPLETED	EV
Land Comment		475025	B: WING	l			÷	0.0	C	_
NAME O	F PROVIDER OR SUPPLIER		V:-=		EET ADDRESS, CITY	, STATE, ZIF	CODE	<u> </u>	/28/201	9
SPRIN	GFIELD HEALTH & REH	IAB		8	CHESTER RD RINGFIELD, VT(	)5156	ā.		£	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL BC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDERS (EACH) CORRE CROSS REFERE	CTIVE ACTIO	ON SHOULD LEAPPROP	BE	COMPL DAT	ETION
F 623	Continued From pag	ge 7	F	523		-				
	requirements listed notice was not proving available to the residence of the series of	in this regulation. Since the ded the information was not dent and/or representative. and staff interview, Resident to the hospital on 1/28/19 health status. During interview M, the facility's Business that no transfer notice with ghts and contacts was issued 65 or the legal representative. man was not notified of the A Resident #20 was spital on 7/15/18, 7/28/18, 9. There was no evidence was given to the resident resentative and Ombudsman asfers to the hospital. Per at approximately 10:00 AM fice Manager, s/he confirmed otices given to the resident		02.3						ACTIVATE TO A STREET OF THE ST
F 625 SS=E	hospital.  7.) Per record review transferred to the hos 2/6/19, the resident a representative was ginowever, the notices for the transfer, the e who receives appeal how to obtain the apprompleting the form, hearing request; and Ombudsman.	Resident #31 was spital on 12/26/18, 1/26/19, and/or resident's iven the transfer notices; did not contain the reason mail address of the entity requests, information on local form and assistance in and submitting the appeal the email address of the olicy Before/Upon Trnsfr	_ F6	325	F625 Notice o Before/Upon		Policy			

		AND HUMAN SERVICES  & MEDICAID SERVICES				FORM	03/14/2019 APPROVED 0938-0391
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A: BUILD		CONSTRUCTION	(X3) DAT	E SURVEY IPLETED
		475025	B:-WING			02/	28/2019
NAME OF	PROVIDER OR SUPPLIER	Will street water 11 th and the		1	REET ADDRESS, CITY, STATE, ZIP CODE		
SPRING	FIELD HEALTH & REH	AB			5 CHESTER RD PRINGFIELD, VT 05156		5 <del>-7</del>
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL BC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROVIDENCY)	D BE	(X5) COMPLETION DATE
F 625	Continued From pag	ge 8	F6	625			
	§483.15(d)(1) Notice nursing facility trans the resident goes or nursing facility must the resident or residespecifies— (i) The duration of the any, during which the return and resume refacility; (ii) The reserve bed plan, under § 447.40 (iii) The nursing facility bed-hold periods, who paragraph (e)(1) of the resident to return; and (iv) The information of this section.  §483.15(d)(2) Bed-hold the time of transfer of the hospitalization or the facility must provide resident representation specifies the duration described in paragra This REQUIREMENT by:  Based on interview a failed to notify the resident representative in write for seven (6) of seve	old notice upon transfer. At a resident for rapeutic leave, a nursing to the resident and the ve written notice which of the bed-hold policy ph (d)(1) of this section.  I is not met as evidenced and record review, the facility sident and/or resident's ting of the bed hold policies n (7) residents in the desident# 20, 65, 8, 64, 11,		The second secon	Residents # 8, 11, 64, 219, 65, a 20 were issued the appropriate notice post survey. They had magative effects from the allege deficient practice.  Residents transferred to the hothave the potential to be affected the alleged deficient practice.  The following was completed as corrective action for all resident found to be potentially affected the alleged deficient practice.  Education will be provided to Business Office and licensed Nustaff regarding the requirement process for issuing bed hold not per regulation and on Genesis For bed hold notification.  An audit will be completed week and monthly x3 the DNS or designee to monitor the effectiveness of the plan.  The QAPI committee will evaluate the data and make recommendations as needed.	spital ed by s ts d by rsing ts and tices Policy	
	1.) Resident #8 wa	s transferred to the hospital			Date of Compliance: 3/29/19		

STATEMENT OF DEFOCEACIES AUXIPPROVIDENCING DENTIFICATION NUMBER:  475025  SPRINGFIELD HEALTH & REHAB  SIMILARY STATEMENT OF DEFOCEACIES PROVIDENCY STATE AUXIPPROVIDENCY STATE A			AND HUMAN SERVICES  & MEDICALD SERVICES	•			FORM.	03/14/201 APPROVEI 0938-039
PRINGFIELD HEALTH & REHAB  SPRINGFIELD HEALTH & REHAB  PROPER PROVIDER OR SUPPLIER  SUMMARY STATEMENT OF DEPOCRACIES PRESENT ROSSINGERIES (EACH DEFICIENCY MUST BE PRECEDED BY FILL REGULATORY OR USE DEMTIFYING INFORMATION)  F 625  Continued From page 9  12/4/18 for an evaluation for zoster neuralgia flare up, again on 12/3/18 secondary to an acute Uringny Tract Infection with cystitis and again on 2/4/19 secondary to an eye infection. Each of the transfers were to the hospital emergency department for evaluation and treatment. Per confirmation by the business office manager on 2/26/19 at 12-40 PM, the resident did not receive notification of bed hold per requirements.  2.) Resident #11 was transferred to the hospital on 11/5/18 and admitted until his return to the facility 11/9/19. He returned to the facility on 12/4/18, Per record review, there was no evidence that notification of transfer was provided per requirements and confirmation was made through an interview with the business office manager on 2/27/19 at 2.04 PM, that bed hold notification had not been provided per requirements and confirmation was made through an interview with the business office manager on 2/27/19 at 2.04 PM, that bed hold notification had not been provided per requirements and confirmation was made through an interview with the business office manager on 2/27/19 at 2.04 PM, the resident was returned to the facility at 10:14 PM (2214). The resident was returned to the facility at 10:14 PM (2214). The resident was returned to the hospital on 11/8/19 and was admitted for treatment. The resident did not return to the facility until 2/5/19. Per review of the medical record for Resident #64, there is no evidence that a bed hold notice was given in writing to the resident and/or the resident's representative. Confirmation was made by the Office Manager on 2/26/19 at approximately 4.15 PM that the transfer and the begingler and the begingler and the beging and the beging or as soon as possible for						<u>.</u>	(X3) DATE COM	SURVEY PLETED
SPRINGFIELD HEALTH & REHAB  SPRINGFIELD HEALTH & REHAB  SPRINGFIELD HEALTH & REHAB  SUMMARY STATEMENT OF DEPCISIONISS  FREET ADDRESS, CITY, STATE, 2IP CODE  SPRINGFIELD, VT 05156  SPR	`., 		475025	B. WING		<u> </u>		
SPRINGFIELD HEALTH & REHAB    SPRINGFIELD, VT 06156   CACH DEFICIENCY MUST BE PRECEDED BY FULL PROPUPER'S PLANOF CORRECTION MUST BE PRECEDED BY FULL PROPUPER'S PLANOF CORRECTION SUGGISTION PROPUPER'S PLANOF CORRECTION SUGGISTION PROPUPER'S PLANOF CORRECTION SUGGISTION PROPUPER'S PLANOF CORRECTION SUGGISTION PROPUPER'S PLANOF CORRECTION SUGGISTION PROPUPER'S PLANOF CORRECTION SUGGISTION PROPUPER'S PLANOF CORRECTION PROPUPER'S PLANOF CORRECTION SUGGISTION PROPUPER'S PLANOF CORRECTION PROPUPER'S PARCETION PROPUPER'S PLANOF CORRECTION PROPUPER'S PARCETION PROPUPER'S PARCETION PROPUPER'S PARCETION PROPUPER'S PARCETION PROP	NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, ST.	ATE, ZIP CODE	- V.L.	LUIZUIS
F 625 Continued From page 9 12/4/18 for an evaluation for zoster neutralgia flare up, again on 12/13/18 secondary to an acute Urinary Tract Infection with cystitis and again on 2/4/19 secondary to an eye infection. Each of the transfers were to the hospital emergency department for evaluation and treatment. Per confirmation by the business office manager on 2/26/19 at 12:40 PM, the resident did not receive notification of bed hold per requirements.  2.) Resident #11 was transferred to the hospital on 11/5/18 and admitted until his return to the facility 11/9/19. He returned to the emergency department 11/15/18 and was admitted for altered mental status and seizure activity. The resident returned to the facility on 12/4/18, Per record review, there was no evidence that notification of transfer was provided per requirements and confirmation was made through an interview with the business office manager on 2/27/19 at 2:04 PM, that bed hold notification had not been provided per regulations.  3. Per record review Resident #64 was transferred to the Emergency Room for evaluation on 1/17/19 at 4/47 PM for medical evaluation and returned to the facility and 10/26/19. Per review of the medical record for Resident #64, there is no evidence that a bed hold notice was given in writing to the resident and/or the resident's representative. Confirmation was made by the Office Manager on 2/26/19 at approximately 4/15 PM that the transfer discharge or as soon as possible for	SPRING	FIELD HEALTH & REH	IAB	- II		56	* × ×	í
12/4/18 for an evaluation for zoster neuralgia flare up, agalin on 12/13/18 secondary to an acute Urinary Tract Infection with cystitis and again on 2/4/19 secondary to an eye infection. Each of the transfers were to the hospital emergency department for evaluation and treatment. Per confirmation by the business office manager on 2/26/19 at 12:40 PM, the resident did not receive notification of bed hold per requirements.  2.) Resident #11 was transferred to the hospital on 11/5/18 and admitted until his return to the facility 11/9/19. He returned to the emergency department 11/15/18 and was admitted for altered mental status and seizure activity. The resident returned to the facility on 12/4/18. Per record review, there was no evidence than tofitication of transfer was provided per requirements and confirmation was made through an interview with the business office manager on 2/27/19 at 2:04 PM, that bed hold notification had not been provided per requilations.  3. Per record review Resident #64 was transferred to the Emergency Room for evaluation and returned to the facility at 10:14 PM (22:14). The resident was returned to the hospital on 1/18/19 and was admitted for treatment. The resident did not return to the facility until 2/5/19. Per review of the medical record for Resident #64, there is no evidence that a bed hold notice was given in writing to the resident and/or the resident's representative.  Confirmation was made by the Office Manager on 2/26/19 at approximately 4:15 PM that the transfer and the bed hold authorization was never provided as required, at time of transfer/discharge or as soon as possible for	PREFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE CROSS REFERENCE	EACTION SHOULD D TO THE APPROP	THE	COMPLETION
transferred to the Emergency Room for evaluation on 1/17/19 at 4:47 PM for medical evaluation and returned to the facility at 10:14 PM (2214). The resident was returned to the hospital on 1/18/19 and was admitted for treatment. The resident did not return to the facility until 2/5/19. Per review of the medical record for Resident #64, there is no evidence that a bed hold notice was given in writing to the resident and/or the resident's representative.  Confirmation was made by the Office Manager on 2/26/19 at approximately 4:15 PM that the transfer and the bed held authorization was never provided as required, at time of transfer/discharge or as soon as possible for		12/4/18 for an evaluary, again on 12/13/1 Urinary Tract Infection 2/4/19 secondary to transfers were to the department for evaluation by the 12/26/19 at 12:40 PM notification of bed had not 11/5/18 and admit facility 11/9/19. He returned to the facility review, there was not transfer was provided confirmation was matter business office in PM, that bed hold no provided per regulation.	ation for zoster neuralgia flare 18 secondary to an acute on with cystitis and again on an eye infection. Each of the chospital emergency lation and treatment. Per pusiness office manager on the resident did not receive old per requirements.  Is transferred to the hospital ted until his return to the eturned to the emergency and was admitted for altered eizure activity. The resident yon 12/4/18. Per record evidence that notification of did per requirements and det through an interview with manager on 2/27/19 at 2:04 tification had not been ons.	F 625	F_625 PO	c acception. Bartill, a	15.C	myri
either of the two transfers. Confirmation was also		3. Per record review transferred to the Emeraluation on 1/17/19 evaluation and return (2214). The resident on 1/18/19 and was a resident did not return Per review of the method, there is no evidewas given in writing the resident's representation was made and the bed provided as required transfer/discharge or	Resident #64 was nergency Room for 9 at 4:47 PM for medical ned to the facility at 10:14 PM to was returned to the hospital admitted for treatment. The n to the facility until 2/5/19. dical record for Resident ence that a bed hold notice to the resident and/or the stive. The office Manager on the facility 4:15 PM that the hold authorization was never, at time of					8

		AND HUMAN SERVICES							FORM	): 03/14/20 MAPPROV ): 0938-03	/FD
STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILDI		CONSTRUCT	ION			(X3) DAT	TE SURVEY MPLETED	
\		475025	B. WING				<u> </u>		02	C /28/2019	[
NAME OF	PROVIDER OR SUPPLIER		1		EET ADDRES		STATE, ZIF	CODE			i.
SPRING	FIELD HEALTH & REH	AB		100	RINGFIELD		156		1		
(X4) ID PREFIX TAG	. (EACH DEFICIENCY	EMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)	ID PREFIX TAG	<b>,</b> ,	(FACH	CORREC	PLAN OF C TIVE ACTION CED TO THE FICIENCY	ON SHOUL LEAPPROI	DBF	(X5) COMPLETI DATE	ON
F 625	Continued From page	ne 10	F 6	25		,	;				
	1	did not follow Genesis policy		1	<b>a</b> 6						
	transferred to the ac was admitted for tre	v Resident #219 was ute hospital on 2/1/19 and atment. The resident y on 2/9/19, The Office					2 18				ì
10-40 mag/s	Manager provided the documentation identification identification in the accordance of the document of the docu	ie surveyor with incomplete ifying that the resident was ute hospital on 2/1/19. The athorization was mailed to the life resident signed the bed in 2/21/19 after returning to			30 31 21	8 10 10 10	* .	8			i i
	the facility. Confirmation was ma	ade by the Office Manager on at approximately 1:30 PM,		The state of the s	e e			,	20 200	ation and the state of the stat	
	provided as required or as soon as possib incomplete and did r	on written notice was not at time of transfer/discharge le, that the documents were ot meet all requirements. so made that the facility did			9	a"	-	¥	=		••
		olicy related to bed hold			a = 8		19				
	#65 was hospitalized of health status. Duri 1:19 PM, the facility's				( <b>5</b> )			140 8 8	8	A COLUMN TO A COLU	
	display of rights and Resident #65 or the 6. Per record review	d hold notice with required contacts was issued to either egal representative. Resident #20 was spital on 7/15/18, 7/28/18,		; ;		,		Z Z		-	
	12/31/18, and 1/22/1 that a bed hold notice and/or resident's rep transfers to the hosp	9. There was no evidence e was given to the resident resentative for each of these ital. Per interview on 2/28/19					3Ž	* 1 × 1 × 1		-	
<u> </u>	at approximately 10:	00 AM with the Business			3 <b></b>					<u> </u>	_

		AND HUMAN SERVICES						_FORM	03/14/2019 APPROVED 0938-0391
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A::BUILDING		CTION	<del>- :</del> :	· .	СОМ	E SURVEY PLETED
\		475025	B. WING			02/28/2019			
NAME OF	PROVIDER OR SUPPLIER		s	TREET ADD	RESS, CITY,	STATE, ZIF	CODE		
SPRING	FIELD HEALTH & REF	IAB	1.	05 CHESTE PRINGFIE		5156		<u></u> .	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(FAC	SHOORRE( S-REFEREN	TIVE ACTIO	ORRECTION ON SHOULD HE APPROPE ()	BE	(X5). COMPLETION DATE
L 60E	Cartings of Farms		- 40-		-		(4)	į	
F 625			F 625	] }					
	no bed hold notices	e confirmed that there were given to the resident and/or ative for each of these						: -: -:	
		oital for Resident #20.	1 12 1 12						
F 656 SS=E	■ Value of the contract o	Comprehensive Care Plan )	F 656	).					
Transcription of the state of t	implement a compre care plan for each re	acility must develop and chensive person-centered esident, consistent with the				a	X	4	ding.
, )) := \$\delta \delta	§483.10(c)(3), that is	orth at §483.10(c)(2) and noticely and noticely are measurable rames to meet a resident's			*				
	medical, nursing, an needs that are ident	d mental and psychosocial ified in the comprehensive mprehensive care plan must	T. T. T. T. T. T. T. T. T. T. T. T. T. T			380·			
	describe the following (i) The services that	g - are to be furnished to attain					e E		ī
	physical, mental, and	ent's highest practicable d psychosocial well-being as .24, §483.25 or §483.40; and							
-10	(ii) Any services that	would otherwise be required 3.25 or §483.40 but are not							un en
.	provided due to the under §483.10, inclu	esident's exercise of rights ding the right to refuse				•	ħ0		
i		services or specialized		ž . E		2			,
ļ	provide as a result of		1	¥ * ×			s.		
	findings of the PASA	a facility disagrees with the RR, it must indicate its ent's medical record.					g.		-
ļ:		th the resident and the	· ·	×		×,	8 8		
	(A) The resident's go desired outcomes.	pals for admission and	į ·				¥	8. 8	
ļ.	(B) The resident's pr	eference and potential for							
			- Fa	cility ID: 4750	25		If continuati		

## PRINTED: 03/14/2019 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICARD SERVICES STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING 475025 B. WING . 02/28/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 105 CHESTER RD SPRINGFIELD HEALTH & REHAB SPRINGFIELD, VT 05156 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X4) ID ID (X5) COMPLETION (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) F 656 F 656 Continued From page 12 future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced F656 Develop/Implement by: Comprehensive Care Plan Based on staff interview and record review, the facility failed to develop a plan of care for 1 of 21 Care plan for resident #31 was residents, Resident #31 regarding respiratory status and psychotropic medication use; failed to updated regarding respiratory status implement the plan of care for 1 of 21 residents, and psychotropic medication use Resident #60; and failed to revise a plan of care and anticoagulant monitoring. Care for 1 of 21 residents Resident #31. Findings plan for resident #60 was updated include: regarding a pressure ulcer. 1.) Resident #60 presents with a newly facility acquired pressure ulceration on his/her right heel, Residents #60 and #31 had no and review of the care plan dated 2/6/19 states negative effects from the alleged that the resident is to have a pillow under his/her deficient practices. right calf. Also, due to actual skin break down, an update on 2/15/19 indicates that the resident is to Residents with care plan have the right leg elevated. Per observation on 2/26/19, Resident #60 was in bed and there was interventions related to pressure no evidence of a pillow being under the right leg ulcers, psychotropic medication and nor of the right leg being elevated, which was anticoagulant medication have the confirmed by the Licensed Nursing Assistant potential to be affected by the (LNA) at the time of discovery at 9:00 AM. The resident was observed with the pillow under alleged deficient practice. his/her calf and the right leg was elevated when

s/he was out of bed in the wheelchair at 2:00 PM.

but at 3:53 PM, the resident was again observed

in bed and the pillow was not in place and the leg

was not elevated. Per interview with the LNA that

provides care for Resident #60, the resident

The following was completed as

the alleged deficient practice.

corrective action for all residents

found to be potentially affected by

CENTE	RS FOR MEDICARE	AND HUMAN SERVICES & MEDICAID SERVICES		PRINTED: 03/14/20 FORM APPROVI 	ED
STATEMEN AND PLAN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 12	MULTIPLE CONSTRUCTION (X3) DATE SURVEY COMPLETED	
	. =	475025	B: WING		i
NAME OF	PROVIDER OR SUPPLIER		<u> </u>	STREET ADDRESS; CITY, STATE, ZIP CODE	==:
SPRING	FIELD HEALTH & REH	AB	17	105 CHESTER RD	
			· 	SPRINGFIELD, VT 05156	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	EMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)	ID PREFI TAG	EFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETION	W
t as by point but p 2 E d	sometimes it isn't in resident was observed was still not under the leg elevated. Confirm Manager at 4:26 PM been consistently followed been consistently fo	low under the leg and place. At 4:26 PM the ed in the bed and the pillow is right leg, nor was the right mation was made by the Unit that the care plan has not lowed.  discharge summary from #31, on 1/26/19 s/he was ital with shortness of breath cough; and later diagnosed on review Resident #31's is no evidence that a care ratory status/complications. Per interview on 2/27/19 at the Manager, s/he confirmed not been developed for atus/complications and dent #31's Medication def (MAR), Resident #31 was am (medication used to ervous system and can treat ligrams) by mouth at of Resident #31's care plan and developed for ion use. Per interview on with the Nurse Practice med there was no care plan	F6	An audit was completed on care plans to ensure interventions are being followed as written. Reports were run for residents with Pressure ulcers, respiratory issues and psychotropic medications to ensure interventions are in place.  Education will be provided to nursing staff and on the care plan process and Genesis Policy for Care Plan development and implementation.  An audit will be completed weekly x4 and monthly x3 by the DNS or designee to monitor the effectiveness of the plan.  The QAPI committee will evaluate the data and make recommendations as needed.  Date of Compliance: 3/29/19.  FUSC POC accepted 3/2-3/19.  S. Bartell, W/S. Rewy w	
h c p	ave been. ) Upon further reviev lan for compromised	v of Resident #31's care I peripheral circulation, it I monitor anticoagulant			

		AND HUMAN SERVICES  & MEDICATO SERVICES						. FURI	): 03/14/2019 APPROVED ): 0938-039
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING					(X3) DA	TE SURVEY MPLETED C
		475025	B. WING	. <u></u>				02	/28/2019
NAME OF	PROVIDER OR SUPPLIER				EET ADDRESS, O	CITY, STATE,	ZIP CODE	- <del> </del>	
SPRING	FIELD HEALTH & REH	IAB	·	11	CHESTER RD RINGFIELD, V	T 05156	-		the same street
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVID (EACH, GOI CROSS REFI	ER'S PLAN O RRECTIVE AG ERENCED TO DEFICIEN	TION SHOW THE APPR	ILD BE	(X5) COMPLETION DATE
F 656	Continued From page	ge 14	F 6	556				1000	
		(initiated 10/6/18). Assess for		1					
	adverse effects of a	nticoagulant therapy and		į					
	report adverse effec	t to physician (initiated		1		22			
	orders there was no	w of the MAR and physician's evidence that Resident #31		į.			e 9		
2	had been prescribed	d an anticoagulant		9					
		erview on 2/27/19 at 8:45 AM				×			
	resident had not bee	er, s/he confirmed that the		10				1 3	j T
	anticoagulant medic	ation and that these		1		х			
	interventions should	have been removed from the		l		¥.	2	930	
E 705	care plan.				9				
F /25 SS=E	Sufficient Nursing St CFR(s): 483,35(a)(1		F	725					
33-E	Or 11(3). 400,00(a)(1	/(4)							
	§483.35(a) Sufficien							16	i,
		e sufficient nursing staff with		į.		ū.		5.40	
		petencies and skills sets to related services to assure		ļ		*		*	
	resident safety and a	attain or maintain the highest		ľ	li i		ž v		1.
1	practicable physical,	mental, and psychosocial		ļ		. 91			
		esident, as determined by ts and individual plans of care		į.	*			21	
j	and considering the	number, acuity and		1			4		
	diagnoses of the fac	ility's resident population in		i			*/ */		
	accordance with the at §483.70(e).	facility assessment required		i	<u>.</u>				
	at 3400.70(c).			00 (g)		2			
		cility must provide services	i						].
		s of each of the following n a 24-hour basis to provide				er.			Ì
		sidents in accordance with						£	1/64
ıl	resident care plans:					8			48 8 S
1	(i) Except when waiv	ed under paragraph (e) of							
1	this section, licensed (ii) Other nursing per	sonnel, including but not	8						g s
	limited to nurse aide				_	~		_	i
1						ž.		70	E C (P)
A CNAS-256	7(02-99) Previous Versions C	Dbsolete Event ID: G0NX1	1	Facili	ty ID: 475025	<u></u>	If contin	Mation obsert	Page 15 of 26

DEPARTMENT OF HEALTH AND HUMAN SERVICES  CENTERS FOR MEDICARE & MEDICAID SERVICES								
	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
		475025	B: WING		3 1	28/2019		
NAME O	PROVIDER OR SUPPLIER		11	TREET ADDRESS, CITY, STATE, ZIP CODE		1 1		
SPRING	SFIELD HEALTH & REF	IAB	1!	05 CHESTER RD PRINGFIELD, VT 05156	E =			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG ,	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	(X5) COMPLETION DATE		
F 725	paragraph (e) of this designate a licensed nurse on each tour of This REQUIREMEN by:  Based on observation interviews, staff interfacility failed to ensure nursing staff to proviservices assuring rethe highest practical psychosocial well-be consideration for the reside in the home, to individual care plans population in accordance assessment. Finding 1. While making obs	ot when waived under a section, the facility must a nurse to serve as a charge of duty. This not met as evidenced on, resident and family views and record review, the rethere was sufficient de nursing and related sident safety and maintaining ole physical, mental and ing of each resident, number of residents who he resident assessments, acuity and diagnosis of the ance with the facility gs include:	F 725	F725 Sufficient Nursing Staff				
The state of the s	interviewed a license. This unit is home to a many having dement complained that resided, and further stated busy with duties to part the time, the surve clustered in the area adjacent dining room unsupervised; two rethe dining supplies. The entered the dining rooseating; chairs had be nurses' station area for there.	dents do not have enough to a that available staff are too rovide adequate supervision. Eyor observed nine residents of the nurses' station. In the , 9 other residents were sidents were rummaging in two additional residents om and could not find een moved out to the or the residents congregated	The second secon	An audit was conducted for residents on the second floor observing hygiene, safety, supervision and engagement a call bells. Concerns identified addressed upon identification Residents did not suffer adver events based on the alleged deficient practice.  Residents on the second floor the potential to be affected by alleged deficient practice.	and i were se			

		AND HUMAN SERVICES		FOR	D: 03/14/2019 MAPPROVED O. 0938-0391
STATEMEN AND PLAN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLI A. BUILDING	E CONSTRUCTION (X3) D.	ATE SURVEY OMPLETED
		475025	BWING		C 2/28/2019
NAME OF	PROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STATE, ZIP CODE	
SPRING	FIELD HEALTH & REI	lab,	1)	05 CHESTER RD PRINGFIELD, VT 05156	e l
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID.	PROVIDER'S PLAN OF CORRECTION	(X5), COMPLETION
PREFIX TAG		MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	DATE
	<u> </u>			DEFICIENCY)	
	1		~ ~	·	
F 725	Continued From page	ge 16	F 725		
15	confidentiality] com	plained that there are multiple			
	wanderers on the un	nit and not enough staff or	1	Education will be provided to	1
	activities to engage	them. S/he described recently	2	scheduler and nursing staff on	
	visiting when a resid	lent walked into the room and		<del>-</del>	
	took one of the resid	dent's personal items and hid	1	sufficient nurse staffing. Education	
		esident's fingernails were		will be provided to Activities staff on	
i	found long and soile		!	assisting with resident engagement.	
į	3.) Per observation	of residents on second floor		8	į.
	on 2/26/19, between	9:38 AM and 9:50 AM, there	Í	Audits will be completed weekly x4	
	were a dozen reside			and monthly x3 by the DNS or	
-		ght back chairs at the nurses		designee to monitor the	
		no staff present, but staff did			1 1
		tion carts or walked past in ting off the elevator were		effectiveness of the plan.	
,		neuvering past the residents	: -	The QAPI committee will evaluate	ı,
)		they didn't "want to trip over			
		s time other residents were		the data and make .	
1		to ambulate past the		recommendations as needed.	
	residents with difficu	lty. On 2/26/18 at 3:30 PM,			
A		with the Unit Manager (UM)	* .	Date of Compliance: 3/29/19.	
	on the second floor,	there were 11 residents	* :	2.2	
i,		station and while a nurse		F-725 PUS accepted 3/00	', d
		music playing on a CD		B. Bartell, W/s. Reuge W	
		was behind him/her		D. Bartell, 15 15. taugito	
:		and another staff member			
		ted the resident. The UM ents are high risk and the		t a seed a se	j l
		of the residents require that		. 4	1
1		safety. S/he further stated		z a se s	}
		t enough staff to watch all of			1
		protect them from resident to			Ì
		, falls or wandering, so they		· 2 2 3 2	
		at the nurses station. S/he		·	i
- 1	further stated that wi	hen the Licensed Nursing			
-	Assistants (LNA) are	getting residents out of bed		* *************************************	. i 1
		ey can't watch the residents			
		one too. It takes too long to	269-	ye s	i
		picked up and s/he stated		· · · · · · · · · · · · · · · · · · ·	1
	that the LINAS are or	ly able to provide the basic			<u></u> i

		AND HUMAN SERVICES  & MEDICAID SERVICES						FORM	03/14/2019 APPROVED 0938-0391	
STATEMEN AND PLAN	T OF DEFICIENCIES _ OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			DISTRUCTION	:		(X3) DATE SURVEY COMPLETED C		
\/ ·_=		475025	BaWING	· ====_=					2 <u>8/2019</u>	
NAME OF	PROVIDER OR SUPPLIER		i i			TTY, STATE, ZII	CODE			
SPRING	FIELD HEALTH & REI	IAB		19	HESTER RD NGFIELD, V					
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		(EACH COF	ER'S PLAN OF C RECTIVE ACTI ERENCED TO T DEFICIENCY	ON SHOULD HEAPPROPI	BE	(X5) COMPLETION DATE	
F 725	Continued From page	ge 17	F 7	725				**		
	care of bathing and	incontinent care and ren't enough staff or hours in			· ag					
	complained that res room and on one or during the night whe	with Resident #8, s/he idents wander into his/her casion s/he was awakened an noises came from the was another resident of the	g:					**************************************	ř	
,	resident that no staff situation and s/he w	he bathroom. It bothered the f came to check on the as told that the resident often on't have enough staff to				· j				
	the Activities Directo very much for the re s/he doesn't have de needs of the residen	on 02/26/19 at 3:58 PM with or, s/he stated that there isn't sidents with dementia, that edicated staff to address the its with dementia and there e residents can't remain ore wander.	Action to the contract of the					2		
	,			*	B r	¥		: :		
	were observed sitting second floor in whee chairs. Per interview	58 AM, fifteen (15) residents g at the nurses station on the elchairs and straight back with a Licensed Nursing dents are placed there after			. ·				22.2	
1	breakfast is finished cleaned. S/he report the music program a approximately one-h	while the dining area is ed that they were waiting for and that it takes alf (1/2) hour for the room to	e. ·	(©) II ,		*	e <sub>spa</sub> A			
	received very little su	dents at the nurse's station upervision or staff attention hey were awaiting for the aned.				and any of the second s	If continual			

	RTMENT OF HEALTH AND HUMAN SERVICES ERS FOR MEDICARE & MEDICAID SERVICES					FORM	: 03/14/201 APPROVE . 0938-039	n
STATEMEN AND PLAN	IT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA OF CORRECTION IDENTIFICATION NUMBER:	(X2) MU A. BUILI		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
	475025	B, WINC	) 				C <b>28/2019</b>	
NAME OF	PROVIDER OR SUPPLIER		1	TREET ADDRESS, CITY, STATE, ZIP CODE				
SPRING	FIELD HEALTH & REHAB			05 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)	IĎ PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS REFERENCED TO THE APPRO DEFICIENCY)	JLD E	E.	(X5) COMPLETION DATE	,
F 725	Continued From page 18	F	725		ji			71
	6.) Per interview on 2/25/19 at 2:13 PM, Resident #119's spouse stated that there are not enough staff to properly care for the residents. S/he reported that his/her spouse is resistive to care					380	**************************************	
	and requires 3 (three) staff members at times to assist with incontinence care. The spouse further stated that staff must wait for others to be available to help and it sometimes takes a long time. The resident has now developed a rash area on the groin and buttocks. Per interview on 02/26/19 at 3:35 PM the Licensed Practical Nurse (LPN) confirmed that the resident is resistive to care, requires 3 assist at times, and has developed excoriation in the groin and buttocks areas due to incontinence.	4				E C		
a). Calm may left when	7.) On 2/25/19 at 4:30 PM a resident was observed sitting at the nurses station with several other residents. S/he stood up and began walking down the hall leaving their walker behind near the chair. The resident ambulated from the nurse station to the entrance of the hallway (approximately 25 feet) before the LPN got the walker for him/her and reminded them that they need to use it when walking.		William William					
	8.) On 02/26/19 at 04:22 PM Eight (8) residents were observed sitting at the nurses station on the second floor. One resident was sitting in a wheelchair facing the wall of the nurse's station. Another resident was attempting to stand from a wheelchair and was being assisted to do so by another resident. There were no staff present to intervene. During interview with the LPN in the afternoon on 2/26/19, s/he confirmed that there is not enough staff to meet the needs of the residents.		and the second s					

		AND HUMAN SERVICES  & MEDICAID SERVICES			PRINTED: 03 FORMAP OMB NO: 09	PROVED
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE SU COMPLE	
		475025	B. WING		02/28/	/2019
NAME OF	PROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, STATE, ZIP CODE	· 19=:	
SPRING	FIELD HEALTH & REI	IAB		05 CHESTER RD SPRINGFIELD, VT 05156		5 E 6
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE CO	(X5) OMPLETION DATE
E 705	Cantiana d Farana	40		,		
F 725	•		F 725			
		ent council meeting on residents discussed concerns		1	t	
-		rding long wait times for	<			
	assistance. One res	sident reported that it usually				
		nutes and has at times waited	120			<b>K</b> )
		be assisted back to bed. S/he mess" causing her to develop	U o			
	"diaper rash". The r	esidents shared that they feel			* -	5 E
0.	the facility is admitti	ng more difficult/violent			ï	
	residents and they	don't have enough staff to ents wander in and out of other				
		thout being redirected. They	6 8			A
	have been told that	the facility staffs per the State				
3.40		eview of the last five (5)				
( )		Council minute notes, long tance has been an on-going			ĺ	1
	issue since 11/30/1			, as a		
F 758		sychotropic Meds/PRN Use	F 758		= 12	i i
SS=D	CFR(s): 483.45(c)(3	3)(e)(1)-(5)			»	
	§483.45(e) Psychot	ropic Drugs				
		chotropic drug is any drug that		F758 Free from Unnecessary	* 1	
		es associated with mental	,	Psychotropic Meds/PRN Use		
		avior. These drugs include, o, drugs in the following			* 1	
	categories:	s, arage in are renowing		A diagnosis was obtained for		
:	(i) Anti-psychotic;			resident #34 to support the u	se of	
1	(ii) Anti-depressant; (iii) Anti-anxiety; and			an antidepressant and address	ss in	
1	(iv) Hypnotic			writing that a GDR is not in he	er best	
			*) = 0	interest at this time. The me	dication	
	Based on a compre resident, the facility	hensive assessment of a must ensure that	## ##	for resident #31 was d/c'd.		
	6483 45/p)/1) Posic	lents who have not used		The residents had no negative	4 4	
		are not given these drugs		effects from the alleged defic	ient .	
* *	unless the medicati	on is necessary to treat a s-diagnosed and documented		practices.	8	
					· <del>-</del>	

		AND HUMAN SERVICES  & MEDICAID SERVICES			RINTED: 03/14/2019 FORM APPROVED MB NO. 0938-0391
STATEMENT	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A, BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		475025	B. WING		02/28/2019
NAME OF	PROVIDER OR SUPPLIER	Land Control of the C	24 185	TREET ADDRESS, CITY, STATE, ZIP CODE	
SPRING	FIELD HEALTH & REH	IAB		05 CHESTER RD PRINGFIELD, VT 05156	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIES (DEFICIENCY)	BE COMPLETION
	ļ		<del></del>		
E 750	. O	00			
r /56	Continued From pa		F 758		
	in the clinical record	4;			
	\$483 45(a)(2) Resid	dents who use psychotropic	1 1	Residents prescribed psychotro	
		al dose reductions, and		medications are at risk for being	g
İ		tions, unless clinically		affected by the alleged deficien	t
		an effort to discontinue these		practice. No adverse outcomes	
ti	drugs;		-	were noted related to the alleg	3
*1	5 155 151 VO 5			deficient practice.	
	§483.45(e)(3) Resid			, denderit practice.	
		pursuant to a PRN order ion is necessary to treat a		A chart audit for residents on	
		condition that is documented		psychotropic medications was	2
	in the clinical record			conducted and concerns address	ssed
	§483.45(e)(4) PRN	orders for psychotropic drugs		as needed.	
( ) - [	are limited to 14 day	ys. Except as provided in	İ	Education will be provided to the	
Tr. 128"		attending physician or	. "	Education will be provided to the	27
		ner believes that it is		pharmacist and licensed nurses	
		PRN order to be extended		finding, reporting and following	up
		or she should document their dent's medical record and	i.	on irregularities related to	*
	indicate the duration			psychotropic medications.	*
		7 10, B10 7 1 1 1 0 1 0 0 1 1			
		orders for anti-psychotic		Education will be provided to	as 2
		14 days and cannot be		doctors on the regulations relat	ed to
		attending physician or	1	psychotropic medications.	2 .
		ner evaluates the resident for			
	the appropriateness	IT is not medication.	ļ	Education will be given for staf	f
2	by:	ii is not met as evidenced		authorized to transcribe and	3
		rview and record review, the	1	administer licensed practitioner	
	facility failed to ensu	ure that a Gradual dose		orders to ensure that licensed	3.
		as addressed for 1 of 5		practitioner orders are addresse	ed as
		licable sample, Resident #34		written, supporting diagnosis ar	
1		that 2 of 5 residents, 4 were free from unnecessary			1
3		se. Findings include:	ж.	place and d/c orders are in plac	e as
:	psycholiopic arag a	se. I mangs melade.		required.	
:	1. Per record review	w Resident #34 has physician			

		AND HUMAN SERVICES				FORM	03/14/2019 APPROVED
		& MEDICAID SERVICES.	<del></del>			MB NO	0938-0391
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DAT CON	E SURVEY
			7. 6014	JING	But the second s		C
		475025	B; WING	3 <u></u>		1	28/2019
NAME OF	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
SPRING	FIELD HEALTH & REI	HAB		1	105 CHESTER RD SPRINGFIELD, VT 05156		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	· In		PROVIDER'S PLAN OF CORRECTION	<del></del>	<del>,</del>
PREFIX TAG	(EACH DEFICIENCY	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 758	Continued From pa	ne 21	· -	750			
	orders for the admir		F	758	An addit will be completed wee		
ı	psychotropic medic	ations, both medications are			x4 and monthly x3 by the DNS of	r	
(8	classified as antide	pressants. Per pharmacist	\$1		designee to monitor the		
		dated 10/16/18, identifies that e for a GDR, as s/he is			effectiveness of the plan.		
		ne and Venlafaxine. The			The QAPI committee will evalua	ite	
	attending physician responded on 11/8/18 that			æ	the data and make		*
	visits (progress note	on follow up visit. Physician es) dated 12/10/18, 1/24/19			recommendations as needed.	*	
	and 2/27/19, do not	identify that the medications				*	i i
1	were reviewed nor is there any documented rationale for continued use.				Date of Compliance: 3/29/19		
-	rationale for continu	ed use.				1 .	
	Per discussion with	the Unit Manager on 2/26/19			F-758 POCacupted 3 B, Bartin Ru/s. Leny	) pall	1
	approximately 4 PM	, s/he confirms that there is			B. Bartell RU/s. Levy	-RO	
·/  -	identifies that the att	n the medical record that tending physician addressed					
	the use of the psych	otropic medication or the	• •			38	
į	rationale for continue	ed use.	1			Ì	
. ]	Per facility policy, titl	led Psychotropic Medication		*	-		
+	Use identifies that the	ne physician/prescriber should			*		
		al rationale for why any action would be likely to			: :	*	
1	impair the resident's	function or increase					a
	distressed behavior.				8		
	2.) Per review of Re	esident #31's MAR, a	i.				
	physician's order dat	ted 2/8/19 read, "Olanzapine					
[ ]	(antipsychotic medic	ation) tablet 5 mg			* **		
	(milligrams), give 0.5 hours as needed for	tablet by mouth every 12 anxiety". There was no			e sa e e e e e		
; (	evidence that the as	needed order for the	<u>.</u>			. ,	×.
1	Olanzapine was limit	ted to 14 days as per					
: ,	egulation. Per inter with the Unit Manage	view on 2/26/19 at 4:05 PM er, s/he confirmed that the			* * * * * * * * * * * * * * * * * * *		9 11
1	medication should ha	ave been discontinued after			24 w n n n n n n n n n n n n n n n n n n	¥	
12	14 days and was not				# A	î.	

PRINTED: 03/14/2019

		AND HUMAN SERVICES			RINTED: 03/14/2019 FORM APPROVED MB NO: 0938-0391		
STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A: BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
\	<u> </u>	475025	BWING		02/28/2019		
NAME OF	PROVIDER OR SUPPLIER		1 8	STREET ADDRESS, CITY, STATE, ZIP CODE			
SPRING	FIELD HEALTH & REH	IAB	i	05 CHESTER RD SPRINGFIELD, VT 05156	. (2)		
(X4) ID PREFIX TAG	EACH DEFICIENCY	FEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD: CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE COMPLETION		
F 921 F 921 SS=E	Safe/Functional/San CFR(s): 483.90(i)	itary/Comfortable Environ	F 921 - F 921				
	The facility must pro sanitary, and comfor residents, staff and the This REQUIREMEN by: Based on observation interview, the facility nursing units have a	T is not met as evidenced on and confirmed by staff failed to ensure that 2 of 2 safe, sanitary and		An audit was conducted on 1/31, assessing over bed tables and identifying those requiring replacement and an order was placed on 2/28/19. Register were vacuumed across the top to remo	e		
	identified to be in dis heaters observed wit	nent. Over-bed tables were repair and baseboard h accumulated dust and findings are as follows:	7	accumulated dust between grate  No residents were affected by the alleged deficient practice.	1		
	approximately 1:40 P Maintenance Director Supervisor and the R	and 2nd floors), on 2/27/19 at M'in the presence of the r, the Housekeeping egional Supervisor for the Group the following was		Education will be provided to housekeeping and maintenance s regarding what constitutes a safe/functional/sanitary/ comfortable environment.	itaff		
	loose fitting laminate tables, vinyl covering and some of the table board, leaving gaps a putting residents at ripor injury and infection confirms during the toconducted an audit id as 'junk tables', 60 over ondition and 11 residuer-bed tables. The Per discussion with the	ed tables were identified with around the edges of the torn/loose and sloughing off es have missing particle and gouges on the surfaces, sk for skin tears/scratches. The Maintenance Director our, that the facility has lentifying 25 over-bed tables er-bed tables are in good dent care areas are missing audit is dated as 1/31/19. The Licensed Nursing Home		New tables replaced the unsatisfactory tables on 3/18/19. Register cleaning began on 2/28/with all resident room and hallwaregisters being completely cleane on or before 3/29/18. Quarterly register cleaning will be added to TELS preventative maintenance program.	19, ly ed		
, F	Administrator (LNHA) approximately 2:30 P	on 2/27/19 at		, <u> </u>			

		AND HUMAN SERVICES  & MEDICAID SERVICES			PRINTED: 03/14/2019 FORM APPROVED OMB NO 0938-0391
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED C
		475025	B WING	TAKE.	02/28/2019
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	. 02/20/2013
SPRING	FIELD HEALTH & REF	IAB		105 CHESTER RD SPRINGFIELD, VT 05156	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TÉMÉNT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT  (FACH CORRECTIVE ACTION SHOT  CROSS: REFERENCED TO THE APPR  DEFICIENCY)	LD BE COMPLETION
	bedroom chairs. Ho been ordered.  2. Base board heat open grates (on the accumulated dust at the coiled heating el on the second floor, (food/pills/dust/hair/physically removed. attention of the LNH. Housekeeping Supe Supervisor of Health confirm at 3:20 on 20 units need cleaning. a collaborative effort the maintenance depression on 2	ing units were found to have top of the units), with visible and grime. On examination of ement at the base of the units various items paper sugar packets) were This was brought to the A and the Unit Manager. The rvisor, and the Regional Care Services Group, 127/19 that the base board The LNHA voices this will be between housekeeping and partment.	F 92	An audit will be completed we x4 and monthly x3 by the DNS designee to monitor the effectiveness of the plan.  The QAPI committee will evaluate data and make recommendations as needed.  Date of Compliance: 3/29/19  F921 POC accepted  B. Barkii, w/s. few	or
	PM, the surveyor ide of the base board he last floor: Dining roof with dust and grime; rooms are heavily ca (Rooms # 125, 113, units in resident rooms are condition; 2nd floor: Dining roof with dust and grime, rooms are heavily ca (Rooms # 213, 211, 20 and 4 units are in sall Units on the 2nd	ntified the following condition laters: In units are heavily caked 5 units located in resident liked with dust and grime 112, 108, 107, and 102), 12 ins need attention and 7 units identified are in satisfactory on units are heavily caked 13 units located in resident liked with dust and grime 210, 205, 204, 226, 225 io; 219, 217, 216, and 215), 7 caked with dust and grime 203, 202, 222, 221 and 218			
	7(02-99) Previous Versions O	<del></del>	<u> </u>	Facility ID: 475025 If contin	Ualing sheet Page 24 - 500

DATE SURPLY CONSTRUCTION  A 175025  NAME OF PROVIDER ON SUPPLER  SPRINGFIELD HEALTH & REHAB  SPRINGFIELD HEALTH & REHAB  SPRINGFIELD VT 05156  SPRINGFIELD	DEPAI CENTI	RTMENT OF HEALTH	AND HUMAN SERVICES  & MEDICAID SERVICES			RINTED: 03/ FORM APP //B.NO. 093	ROVED	
SPRINGFIELD HEALTH & REHAB  SPRINGFIELD HEALTH & REHAB  SPRINGFIELD HEALTH & REHAB  SPRINGFIELD HEALTH & REHAB  SPRINGFIELD HEALTH & REHAB  SPRINGFIELD HEALTH & REHAB  SPRINGFIELD HEALTH & REHAB  SPRINGFIELD HEALTH & REHAB  SPRINGFIELD HEALTH & REHAB  SPRINGFIELD HEALTH & REHAB  SPRINGFIELD HEALTH & REHAB  SPRINGFIELD HEALTH & REHAB  SPRINGFIELD HEALTH & REHAB  SPRINGFIELD HEALTH & REHAB  SPRINGFIELD HEALTH & REHAB  SPRINGFIELD HEALTH & REHAB  SPRINGFIELD HEALTH & REHAB  PROVIDER OF PROPERTY OF SPRINGFIELD HEALTH ON SHOULD BE (AND HEALTH OF THE AMPROPRIATE DEFICIENCY)  FOR STRINGFIELD HEALTH & REHAB  FROM THE SPRINGFIELD HEALTH OR SHOULD BE (AND HEALTH OF THE AMPROPRIATE DEFICIENCY)  FOR STRINGFIELD HEALTH & REHAB  SPRINGFIELD HEALTH & REHAB  FROM THE SPRINGFIELD HEALTH OR SHOULD BE (AND HEALTH OF THE AMPROPRIATE DEFICIENCY)  FROM THE SPRINGFIELD HEALTH OR SHOULD BE (AND HEALTH OF THE AMPROPRIATE DEFICIENCY)  FROM THE SPRINGFIELD HEALTH OR SHOULD BE (AND HE	STATEME	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA		CONSTRUCTION	(X3) DATE SURVEY		
SPRINGFIELD HEALTH & REHAB  SPRINGFIELD, VT 08158  SPRINGFIELD, VT 08158  SPRINGFIELD, VT 08158  SPRINGFIELD, VT 08158  SPRINGFIELD, VT 08158  SPRINGFIELD, VT 08158  FPROVIDER'S PLAN OF CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  FROM DEFICIENCY ON LSC DENTIFYING INFORMATION)  F 921  Continued From page 24 and need attention. FINAL OBSERVATIONS  The following violations of Vermont Licensing and Operating Rules for Nursing Homes, dated June 1, 2018 were identified in relation to staffing levels.  7.13 Nursing Services  d. Staffing Levels. The facility shall maintain staffing levels adequate to meet resident needs.  1. At a minimum, nursing homes must provider:  i. no fewer than three (3) hours of direct care per-resident per day, on a weekly average, including nursing care, but not including administration or supervision of staff, and  ii. of the three hours of direct care, no fewer than two (2) hours per resident per day must be assigned to provide standard LNA (Licensed Nursing Assistant) care (such as personal care, assistance with ambulation, feeding, etc.) performed by the LNAs or equivalent staff and not including meal preparation, physical therapy or the activities program.  This REQUIREMENT is NOT MET as evidenced by:  DEFICIENCY  PROVIDER'S PLAN OF CORRECTION (PROPRIATE DEFICIENCY)  PROVIDER'S PROVIDER'S LAN OF CORRECTION (PC) (CACH CORRECTIVE ACKNOS) PROVIDER'S LAN OF CORRECTION (PC) (CACH CORRECTIVE ACKNOS)  PROVIDER'S PROVIDER'S LAN OF CORRECTION (PC) (CACH CORRECTIVE ACKNOS)  PROVIDER'S PROVIDER'S LAN OF CORRECTION (PC) (CACH CORRECTIVE ALAN OF CORRECTION (PC) (CACH CORRECTIVE ACKNOS)  F 921  F 921  F 921  F 925  F 929  F 929  Nursing Services  Education will be provided to the scheduler on VT licensing and operating rules regarding staffing levels of no fewer than two hours per resident per day and of the three, no fewer than two hours per resident per day and of the three, no fewer than two hours per resident per day must be assigned to provide standard LNA (Licensed Nurs			475025	B. WING		02/28/2	040	
SPRINGFIELD, VT 05156	NAME OF	PROVIDER OR SUPPLIER		ST	REET ADDRESS, CITY, STATE, ZIP CODE	0212012	019	
F 921 Continued From page 24 and need attention. FINAL OBSERVATIONS The following violations of Vermont Licensing and Operating Rules for Nursing Homes, dated June 1, 2018 were identified in relation to staffing levels.  7.13 Nursing Services  d. Staffing Levels. The facility shall maintain staffing levels adequate to meet resident needs.  1. At a minimum, nursing homes must provide:  i. no fewer than three (3) hours of direct care per-resident per day, on a weekly average, including nursing care, personal care and restorative nursing care, but not including administration or supervision of staff; and  ii. of the three hours of direct care, no fewer than two (2) hours per resident per day must be assigned to provide standard LNA (Licensed Nursing Assistant) care (such as personal care, assistance with ambulation, feeding, etc.) performed by the LNAs or equivalent staff and not including meal preparation, physical therapy or the activities program.  This REQUIREMENT is NOT MET as evidenced by:  Continued From page 24 F 921 F 929 F 9999 Nursing Services Education will be provided to the scheduler on VT licensing and operating rules regarding staffing levels of no fewer than three hours of direct care per resident per day and of the three, no fewer than two hours per resident per day and of the three, no fewer than two hours per resident per day must be assigned to provide standard LNA (Licensed Nursing Assistant) care (such as personal care, assistance with ambulation, feeding, etc.) performed by the LNAs or equivalent staff and not including meal preparation, physical therapy or the activities program.  This REQUIREMENT is NOT MET as evidenced by:	SPRING						4	
F9999  The following violations of Vermont Licensing and Operating Rules for Nursing Homes, dated June 1, 2018 were identified in relation to staffing levels.  7.13 Nursing Services  d. Staffing Levels. The facility shall maintain staffing levels adequate to meet resident needs.  1. At a minimum, nursing homes must provide:  i. no fewer than three (3) hours of direct care per-resident per day, on a weekly average, including nursing care, personal care and restorative nursing care, but not including administration or supervision of staff: and  ii. of the three hours of direct care, no fewer than two (2) hours per resident per day must be assigned to provide standard LNA (Licensed Nursing Assistant) care (such as personal care, assistance with ambulation, feeding, etc.) performed by the LNAs or equivalent staff and not including meal preparation, physical therapy or the activities program.  This REQUIREMENT is NOT MET as evidenced by:  F9999 Nursing Services  Education will be provided to the scheduler on VT licensing and operating rules regarding staffing levels of no fewer than three hours of direct care per resident per day and of the three, no fewer than two hours per resident per day must be assigned to provide standard LNA care.  Daily schedule and Key factor report will be reviewed regularly to ensure compliance with state staffing requirements.  An audit will be completed weekly x4 and monthly x3 by the CED or designee to monitor the effectiveness of the plan.  The QAPI committee will evaluate the data and make recommendations as needed.	PREFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI	IE CON	(X5) IPLETION DATE	
F9999  FINAL OBSERVATIONS  The following violations of Vermont Licensing and Operating Rules for Nursing Homes, dated June 1, 2018 were identified in relation to staffing levels.  7.13 Nursing Services  d. Staffing Levels. The facility shall maintain staffing levels adequate to meet resident needs.  1. At a minimum, nursing homes must provide:  i. no fewer than three (3) hours of direct care per-resident per day, on a weekly average, including nursing care, but not including administration or supervision of staff: and  ii. of the three hours of direct care, no fewer than two (2) hours per resident per day must be assigned to provide standard LNA (Licensed Nursing Assistant) care (such as personal care, assistance with ambulation, feeding, etc.) performed by the LNAs or equivalent staff and not including meal preparation, physical therapy or the activities program.  F9999 Nursing Services  Education will be provided to the scheduler on VT licensing and operating rules regarding staffing levels of no fewer than three hours of direct care per resident per day and of the three, no fewer than two hours per resident per day must be assigned to provide standard LNA (care.  Daily schedule and Key factor report will be reviewed regularly to ensure compliance with state staffing requirements.  An audit will be completed weekly x4 and monthly x3 by the CED or designee to monitor the effectiveness of the plan.  This REQUIREMENT is NOT MET as evidenced by:	F 921	·10°	ge 24	F 921				
and Operating Rules for Nursing Homes, dated June 1, 2018 were identified in relation to staffing levels.  7.13 Nursing Services  d. Staffing Levels. The facility shall maintain staffing levels adequate to meet resident needs:  1. At a minimum, nursing homes must provide:  i. no fewer than three (3) hours of direct care per-resident per day, on a weekly average, including nursing care, personal care and restorative nursing care, but not including administration or supervision of staff; and  ii. of the three hours of direct care, no fewer than two (2) hours per resident per day must be assigned to provide standard LNA (Licensed Nursing Assistant) care (such as personal care, assistance with ambulation, feeding, etc.) performed by the LNAs or equivalent staff and not including meal preparation, physical therapy or the activities program.  Education will be provided to the scheduler on VT licensing and operating rules regarding staffing levels of no fewer than three hours of direct care per resident per day and of the three, no fewer than two hours per resident per day must be assigned to provide standard LNA care.  Daily schedule and Key factor report will be reviewed regularly to ensure compliance with state staffing requirements.  An audit will be completed weekly x4 and monthly x3 by the CED or designee to monitor the effectiveness of the plan.  The QAPI committee will evaluate the data and make recommendations as needed.	F9999		DNS	F9999			1	
including nursing care, personal care and restorative nursing care, but not including administration or supervision of staff; and  ii. of the three hours of direct care, no fewer than two (2) hours per resident per day must be assigned to provide standard LNA (Licensed Nursing Assistant) care (such as personal care, assistance with ambulation, feeding, etc.) performed by the LNAs or equivalent staff and not including meal preparation, physical therapy or the activities program.  This REQUIREMENT is NOT MET as evidenced by:  will be reviewed regularly to ensure compliance with state staffing requirements.  An audit will be completed weekly x4 and monthly x3 by the CED or designee to monitor the effectiveness of the plan.  The QAPI committee will evaluate the data and make recommendations as needed.  Date of Compliance: 3/29/19		and Operating Rules June 1, 2018 were lo levels.  7.13 Nursing Service d. Staffing Levels. T staffing levels adequate  1. At a minimum, provide: i. no fewer than few	for Nursing Homes, dated lentified in relation to staffing see the facility shall maintain ate to meet resident needs.  The facility shall maintain ate to meet resident needs.  The facility shall maintain ate to meet resident needs.		Education will be provided to the scheduler on VT licensing and operating rules regarding staffing levels of no fewer than three hour of direct care per resident per day and of the three, no fewer than twhours per resident per day must be assigned to provide standard LNA care.	/O e		
facility failed to provide staffing levels adequate to F999 Poc accepted 3/00/19 — meet resident needs. The findings include the following:  B. Bartellau S. Cerry w		per-resident per day, including nursing-care restorative nursing care administration or supplies. Of the three hothan two (2) hours peressigned to provide some subjections of the LNA necluding meal preparate activities program. This REQUIREMENT by:  Based on staff interviewell in the section of the providence of the providence of the section of the providence of the section of the providence of the section of the providence of the section of the providence o	on a weekly average, e, personal care and are, but not including ervision of staff; and are of direct care, no fewer resident per day must be tandard LNA (Licensed re (such as personal care, lation, feeding, etc.) as or equivalent staff and not ation, physical therapy or is NOT MET as evidenced ews and record review the e staffing levels adequate to		will be reviewed regularly to ensure compliance with state staffing requirements.  An audit will be completed weekly x4 and monthly x3 by the CED or designee to monitor the effectiveness of the plan.  The QAPI committee will evaluate the data and make recommendations as needed.	e	The second secon	

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES	PRINTED: 03/14/2019 FORM APPROVED © N/B: NO. 0938, 0391
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  C
475025	B. WING
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRINGFIELD HEALTH & REHAB	105 CHESTER RD SPRINGFIELD, VT 05156
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORRECTION (XS) PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETION TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)
F9999 Continued From page 25	F9999
During an interview on 02/27/19 at 03:05 PM the Director of Nursing Services (DNS) reported that the facility used to staff four (4) LNAs on Floor Two and a fifth LNA was added within the last 3-4 months and over the past six (6) months s/he has been escalating their presence on the floor. The DNS reported that without looking at the schedule s/he would guess that there are at least five (5) LNAs on Floor Two between five and seven days per week. During an interview on 2/28/29 at 8:45 AM the Nursing Scheduler reported that Medication Techs (ACMV) and students (ANCN) are counted in the State requirements for staffing as direct care staff. S/he confirmed that the ACMV is entered as direct care even when scheduled to administer medications instead of providing patient care for the shift. Per review of the facility staffing sheets during the time period of 2/1/19-2/27/19 there were eleven (11) day and evening shifts with only 4 LNAs on the unit. Review of facility schedules and placements showed seven days in the same period, where direct care staff did not meet the State requirements. The average weekly direct care staffing during the week of 2/14/19 - 2/20/19 was 1.926 which is under the required average of 2.0.	

STATEMENT	OR MEDICARE & MEDICAID SERVICES OF ISOLATED DEFICIENCIES WHICH CAUSE	PROVIDER #	MULTIPLE CONSTRUCTION	"A" FOR	
NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SUFSAND NES  NAME OF PROVIDER OR SUPPLIER  SPRINGFIELD HEALTH & REHAB		Approximately Approximately 200	A, BUILDING:	COMPLETE:	
		475025	B. WING.	2/28/2019	
		105 CHESTER	STREET ADDRESS, CITY, STATE, ZIP CODE  105 CHESTER RD  SPRINGFIELD, VT		
ID PREFIX TAG	SUMMARY STATEMENT OF DEFICI	ENCIES			
F 641	Accuracy of Assessments CFR(s): 483.20(g)  §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to ensure the Minimum Data Set (MDS) accurately reflected the resident's status for 1 applicable resident (Resident #31). Findings include:  Per review of section J-1400 (Prognosis) of the MDS from 2/16/19, it was documented that Resident #31 had a life expectancy of less than 6 months. Upon review of a discharge summary from 2/8/19, there was no evidence in the physician's documentation that the resident had a life expectancy of less than six months. Per interview on 2/27/19 at 7:58 AM with the MDS coordinator, s/he confirmed that the assessment was inaccurate.				
	* ** ** ** **		16		
	F641 Accuracy of Assessr	ments	* <sub>2</sub>		
	MDS for resident #31 was modified immediately. A report was run to identify other potential inaccuracies with section J-1400. Modifications were submitted for issues identified.				
	Education provided for licensed nursing staff regarding need for documentation to support check off on section J-1400.				
	FLY1 POCacapte	d 3/22/19			

ny jency 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 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 or 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

The above isolated deliciencies pose no actual harm to the residents





March 21, 2019

To: Division of Licensing and Protection

Re: Springfield Health and Rehab

Plan of Correction

Credible Allegation of Compliance

## Dear Licensing Chief:

On February 28, 2019 surveyors from the Vermont Agency of Human Services, Division of Licensing and Protection completed an annual survey at Springfield Health and Rehab. As a result of the inspection, the surveyors alleged that the Facility was not in substantial compliance with certain Medicare and Medicaid certification requirements. Attached you will find the Statement of Deficiencies (HCFA-2567) with the Facility's Plan of Correction for the alleged 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 contact me if you have any questions.

nesch CED, LNHA

Respectfully,

Heather Presch, LNHA

Center Executive Director