VERMONT

AGENCY OF HUMAN SERVICES

DEPARTMENT OF DISABILITIES, AGING AND INDEPENDENT LIVING

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	475025	A. BUILDING _____ B. WING _____	C 02/28/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRINGFIELD HEALTH & REHAB	105 CHESTER RD SPRINGFIELD, VT 05156

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments A review of the facility's Emergency Preparedness Program was conducted in conjunction with the annual re-certification survey between 2/25 and 2/28/19. There were no regulatory deficiencies as a result.	E 000		
F 000	INITIAL COMMENTS An unannounced on-site annual re-certification survey was completed, in conjunction with a complaint investigation, by the Division of Licensing and Protection between 2/25 and 2/28/2019. There were regulatory deficiencies regarding bed hold notification and transfer notifications involving the complaint. There were also regulatory deficiencies surrounding the re-certification survey.	F 000		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the	F 580	Springfield Health and Rehab Center provides this plan of correction without admitting or denying the validity or existence of the alleged deficiencies. The plan of correction is prepared and executed solely because it is required by federal and state law.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Heather Prusch	Center Executive Director	3/21/19

ny deficiency 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 llowing 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.

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F 580	Continued From page 1 resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to notify the resident's representative of a change in condition that resulted in a transfer to the hospital for 1 applicable resident, Resident #20. Findings include: Per record review, on 7/15/18 Resident #20 was noted to be "off" his/her "baseline". His/her right	F 580	**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 deficient practice.	

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F 580	Continued From page 2 arm was very weak. When asked to smile, s/he "could barely lift right side of [his/her] face". The nurse received an order from the on-call physician to send Resident #20 to the hospital. Per review of a nursing progress note from 7/16/18, it read, Evening nurse received a call from Resident #20's guardian who inquired why s/he was not informed of the transfer to the hospital. Per interview on 2/28/19 at 8:43 AM with the Unit Manager, s/he confirmed that the resident's representative was not appropriately notified of Resident #20's transfer to the hospital.	F 580	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 3/22/19 B. Bartell, RN / S. Perry RN	
F 623 SS=E	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged.	F 623		

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F 623	Continued From page 3 (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for	F 623		

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F 623	Continued From page 4 the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to notify the resident and/or resident's representative in writing of a transfer/discharge and send a copy to the Ombudsman (public official appointed to investigate complaints people make against government and/or public organizations), for seven (7) of seven (7)	F 623	F623 Notice Requirements Before Transfer/Discharge Residents # 8, 11, 64, 219, 65, 20 and 31 were presented with appropriate notice post survey. None of the residents had negative effects from the alleged deficient practice.	

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F 623	Continued From page 5 residents in the sample, Resident #20, 65, 8, 64, 11, 219 and 31. Findings include: 1.) Resident #8 was transferred to the hospital 12/4/18 for an evaluation for zoster neuralgia 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 transfer 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 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 at 10:14 PM. 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 transfer/discharge notice was sent in writing to the resident and/or the resident's ~~s~~representative. Confirmation was made by the Office Manager on 2/26/19 at approximately 4:15 PM that the	F 623	Residents transferred to the hospital have the potential to be affected by the alleged deficient practice. 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 Business Office and licensed Nursing staff regarding the requirements and process for transfer notification. An audit will be completed weekly x4 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. Date of Compliance: 3/29/19 F-623 POC accepted 3/22/19 B. Bartell, RN / S. Leung, RN	

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F 623	Continued From page 6 transfer/discharge written notice was never provided (as required), at time of transfer/discharge or as soon as possible for either of the two transfers. Confirmation was also made at this time that the facility did not follow the Genesis policy related to voluntary transfer/discharge. The contents of the notice did not contain all required elements per Federal CMS (Centers for Medicare Services) requirements listed in this regulation. Since the notice was not provided the information was not available to the resident and/or representative. 4. Per record review, Resident #219 was transferred to the acute hospital on 2/1/19 and was admitted for treatment. The resident returned to the facility on 2/9/19. The Office Manager provided the surveyor with incomplete documentation identifying that the resident was transferred to the acute hospital on 2/1/19. The notice of discharge/transfer was not completely filled out and was mailed to the resident on 2/4/19. The resident signed the notification of transfer/discharge on 2/21/19, after returning to the facility. Confirmation was made by the Office Manager on 2/26/19 and 2/27/19 at approximately 1:30 PM, that the transfer and discharge written notice was not provided as required at time of transfer/discharge or as soon as possible, the documents mailed were not completely filled out and did not meet all requirements. Confirmation was also made that the facility did not follow the Genesis policy related to voluntary transfer/discharge. The contents of the notice do not contain all required elements per Federal (CMS)	F 623		

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F 623	Continued From page 7 requirements listed in this regulation. Since the notice was not provided the information was not available to the resident and/or representative. 5. Per record review and staff interview, Resident #65 was transferred to the hospital on 1/28/19 due to a change of health status. During interview on 2/26/19 at 1:19 PM, the facility's Business Manager confirmed that no transfer notice with required display of rights and contacts was issued to either Resident #65 or the legal representative. Further, the ombudsman was not notified of the transfer. 6.) Per record review Resident #20 was transferred to the hospital on 7/15/18, 7/28/18, 12/31/18, and 1/22/19. There was no evidence that a transfer notice was given to the resident and/or resident's representative and Ombudsman for each of these transfers to the hospital. Per interview on 2/28/19 at approximately 10:00 AM with the Business Office Manager, s/he confirmed that there were no notices given to the resident and/or resident's representative and the Ombudsman for each of these transfers to the hospital. 7.) Per record review Resident #31 was transferred to the hospital on 12/26/18, 1/26/19, 2/6/19, the resident and/or resident's representative was given the transfer notices; however, the notices did not contain the reason for the transfer, the email address of the entity who receives appeal requests, information on how to obtain the appeal form and assistance in completing the form, and submitting the appeal hearing request; and the email address of the Ombudsman.	F 623		
F 625 SS=E	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2)	F 625	F625 Notice of Bedhold Policy Before/Upon Transfer	

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F 625	Continued From page 8 §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to notify the resident and/or resident's representative in writing of the bed hold policies for seven (6) of seven (7) residents in the applicable sample, Resident# 20, 65, 8, 64, 11, and 219. Findings include: 1.) Resident #8 was transferred to the hospital	F 625	Residents # 8, 11, 64, 219, 65, and 20 were issued the appropriate notice post survey. They had no negative effects from the alleged deficient practice. Residents transferred to the hospital have the potential to be affected by the alleged deficient practice. 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 Business Office and licensed Nursing staff regarding the requirements and process for issuing bed hold notices per regulation and on Genesis Policy for bed hold notification. An audit will be completed weekly x4 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. Date of Compliance: 3/29/19	

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F 625	Continued From page 9	F 625	F 625 POC accepted 3/22/19 B. Bartell, RN/ S. Perry RN	

12/4/18 for an evaluation for zoster neuralgia 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 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 hold authorization was never provided as required, at time of transfer/discharge or as soon as possible for either of the two transfers. Confirmation was also

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F 625	Continued From page 10	F 625		

made that the facility did not follow Genesis policy related to bed hold notification.

4. Per record review Resident #219 was transferred to the acute hospital on 2/1/19 and was admitted for treatment. The resident returned to the facility on 2/9/19. The Office Manager provided the surveyor with incomplete documentation identifying that the resident was transferred to the acute hospital on 2/1/19. The notice of bed hold authorization was mailed to the resident on 2/4/19. The resident signed the bed hold authorization on 2/21/19 after returning to the facility.
Confirmation was made by the Office Manager on 2/26/18 and 2/27/19 at approximately 1:30 PM, that the
bed hold authorization written notice was not provided as required at time of transfer/discharge or as soon as possible, that the documents were incomplete and did not meet all requirements. Confirmation was also made that the facility did not follow Genesis policy related to bed hold notification.

5. Per record review and staff interview, Resident #65 was hospitalized on 1/28/19 due to a change of health status. During interview on 2/26/19 at 1:19 PM, the facility's Business Manager confirmed that no bed hold notice with required display of rights and contacts was issued to either Resident #65 or the legal representative.
6. Per record review Resident #20 was transferred to the hospital on 7/15/18, 7/28/18, 12/31/18, and 1/22/19. There was no evidence that a bed hold notice was given to the resident and/or resident's representative for each of these transfers to the hospital. Per interview on 2/28/19 at approximately 10:00 AM with the Business

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F 625	Continued From page 11 Office Manager, s/he confirmed that there were no bed hold notices given to the resident and/or resident's representative for each of these transfers to the hospital for Resident #20.	F 625		
F 656 SS=E	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for	F 656		

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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 by: Based on staff interview and record review, the facility failed to develop a plan of care for 1 of 21 residents, Resident #31 regarding respiratory status and psychotropic medication use; failed to implement the plan of care for 1 of 21 residents, Resident #60 ; and failed to revise a plan of care for 1 of 21 residents Resident #31. Findings include: 1.) Resident #60 presents with a newly facility acquired pressure ulceration on his/her right heel, and review of the care plan dated 2/6/19 states that the resident is to have a pillow under his/her right calf. Also, due to actual skin break down, an update on 2/15/19 indicates that the resident is to have the right leg elevated. Per observation on 2/26/19, Resident #60 was in bed and there was no evidence of a pillow being under the right leg nor of the right leg being elevated, which was confirmed by the Licensed Nursing Assistant (LNA) at the time of discovery at 9:00 AM. The resident was observed with the pillow under 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	F 656	**F656** Develop/Implement Comprehensive Care Plan Care plan for resident #31 was updated regarding respiratory status and psychotropic medication use and anticoagulant monitoring. Care plan for resident #60 was updated regarding a pressure ulcer. Residents #60 and #31 had no negative effects from the alleged deficient practices. Residents with care plan interventions related to pressure ulcers, psychotropic medication and anticoagulant medication have the potential to be affected by 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 656	Continued From page 13 sometimes has a pillow under the leg and sometimes it isn't in place. At 4:26 PM the resident was observed in the bed and the pillow was still not under the right leg, nor was the right leg elevated. Confirmation was made by the Unit Manager at 4:26 PM that the care plan has not been consistently followed. 3. a) Per review of a discharge summary from 1/29/19 for Resident #31, on 1/26/19 s/he was admitted to the hospital with shortness of breath and a nonproductive cough; and later diagnosed with pneumonia. Upon review Resident #31's plan of care there was no evidence that a care plan for altered respiratory status/complications had been developed. Per interview on 2/27/19 at 8:45 AM with the Unit Manager, s/he confirmed that a care plan had not been developed for altered respiratory status/complications and should have been. b) Per review of Resident #31's Medication Administration Record (MAR), Resident #31 was prescribed Temazepam (medication used to depress the central nervous system and can treat insomnia) 15 mg (milligrams) by mouth at bedtime. Per review of Resident #31's care plan there was no care plan developed for psychotropic medication use. Per interview on 2/27/18 at 10:07 AM with the Nurse Practice Educator, s/he confirmed there was no care plan developed for Resident #31 regarding psychotropic medication use and there should have been. c) Upon further review of Resident #31's care plan for compromised peripheral circulation, it read, "Administer and monitor anticoagulant	F 656	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. F656 POC accepted 3/22/19 B. Bartell, RN / S. Perry RN	

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F 656	Continued From page 14 therapy as ordered (initiated 10/6/18). Assess for adverse effects of anticoagulant therapy and report adverse effect to physician (initiated 10/6/18)". Per review of the MAR and physician's orders there was no evidence that Resident #31 had been prescribed an anticoagulant medication. Per interview on 2/27/19 at 8:45 AM with the Unit Manager, s/he confirmed that the resident had not been prescribed an anticoagulant medication and that these interventions should have been removed from the care plan.	F 656		
F 725 SS=E	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides.	F 725		

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F 725	Continued From page 15 §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on observation, resident and family interviews, staff interviews and record review, the facility failed to ensure there was sufficient nursing staff to provide nursing and related services assuring resident safety and maintaining the highest practicable physical, mental and psychosocial well-being of each resident, consideration for the number of residents who reside in the home, the resident assessments, individual care plans, acuity and diagnosis of the population in accordance with the facility assessment. Findings include: 1. While making observations on the afternoon of 2/26/19 on the second floor unit, the surveyor interviewed a licensed staff person at 4:10 PM. This unit is home to mostly long term residents, many having dementia. The staff person complained that residents do not have enough to do, and further stated that available staff are too busy with duties to provide adequate supervision. At the time, the surveyor observed nine residents clustered in the area of the nurses' station. In the adjacent dining room, 9 other residents were unsupervised; two residents were rummaging in the dining supplies. Two additional residents entered the dining room and could not find seating; chairs had been moved out to the nurses' station area for the residents congregated there. 2. On the afternoon of 2/26/19, the legal representative of a resident [who requested	F 725	**F725** Sufficient Nursing Staff An audit was conducted for residents on the second floor observing hygiene, safety, supervision and engagement and call bells. Concerns identified were addressed upon identification. Residents did not suffer adverse events based on the alleged deficient practice. Residents on the second floor have the potential to be affected by the alleged deficient practice.	

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F 725	Continued From page 16 confidentiality] complained that there are multiple wanderers on the unit and not enough staff or activities to engage them. S/he described recently visiting when a resident walked into the room and took one of the resident's personal items and hid it in a drawer. The resident's fingernails were found long and soiled. 3.) Per observation of residents on second floor on 2/26/19, between 9:38 AM and 9:50 AM, there were a dozen residents seated either in wheelchairs or straight back chairs at the nurses station. There were no staff present, but staff did come to the medication carts or walked past in the hall. People getting off the elevator were having difficulty maneuvering past the residents and one stated that they didn't "want to trip over anyone." During this time other residents were observed attempting to ambulate past the residents with difficulty. On 2/26/18 at 3:30 PM, during an interview with the Unit Manager (UM) on the second floor, there were 11 residents seated at the nurse station and while a nurse attempted to get the music playing on a CD player, Resident #59 was behind him/her attempting to stand and another staff member passed by and assisted the resident. The UM stated that the residents are high risk and the behavioral elements of the residents require that they be observed for safety. S/he further stated that there are just not enough staff to watch all of the residents and to protect them from resident to resident altercations, falls or wandering, so they need to congregate at the nurses station. S/he further stated that when the Licensed Nursing Assistants (LNA) are getting residents out of bed or down for naps, they can't watch the residents and get their tasks done too. It takes too long to get trays passed or picked up and s/he stated that the LNAs are only able to provide the basic	F 725	Education will be provided to scheduler and nursing staff on sufficient nurse staffing. Education will be provided to Activities staff on assisting with resident engagement. Audits 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-725 POC accepted 3/22/19 B. Bartell, RN / S. Reny, RN	

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F 725	Continued From page 17	F 725		

care of bathing and incontinent care and "sometimes there aren't enough staff or hours in the day to get the job done.".

4.) During interview with Resident #8, s/he complained that residents wander into his/her room and on one occasion s/he was awakened during the night when noises came from the bathroom and there was another resident of the opposite sex using the bathroom. It bothered the resident that no staff came to check on the situation and s/he was told that the resident often wanders and they don't have enough staff to watch everyone.

During an interview on 02/26/19 at 3:58 PM with the Activities Director, s/he stated that there isn't very much for the residents with dementia, that s/he doesn't have dedicated staff to address the needs of the residents with dementia and there are concerns that the residents can't remain engaged and therefore wander.

5.) On 02/25/19 at 9:58 AM, fifteen (15) residents were observed sitting at the nurses station on the second floor in wheelchairs and straight back chairs. Per interview with a Licensed Nursing Assistant (LNA) residents are placed there after breakfast is finished while the dining area is cleaned. S/he reported that they were waiting for the music program and that it takes approximately one-half (1/2) hour for the room to be cleaned. The residents at the nurse's station received very little supervision or staff attention during the 1/2 hour they were awaiting for the dining area to be cleaned.

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F 725	Continued From page 18	F 725		

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 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.

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.

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.

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F 725	Continued From page 19 9.) During the resident council meeting on 2/27/29 at 9:45 AM residents discussed concerns and frustration regarding long wait times for assistance. One resident reported that it usually takes at least 20 minutes and has at times waited for up to an hour to be assisted back to bed. S/he has had to "sit in a mess" causing her to develop "diaper rash". The residents shared that they feel the facility is admitting more difficult/violent residents and they don't have enough staff to watch them. Residents wander in and out of other resident's rooms without being redirected. They have been told that the facility staffs per the State requirements. Per review of the last five (5) months of Resident Council minute notes, long wait times for assistance has been an on-going issue since 11/30/18 meeting.	F 725		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented	F 758	**F758** Free from Unnecessary Psychotropic Meds/PRN Use A diagnosis was obtained for resident #34 to support the use of an antidepressant and address in writing that a GDR is not in her best interest at this time. The medication for resident #31 was d/c'd. The residents had no negative effects from the alleged deficient practices.	

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F 758	Continued From page 20 in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility failed to ensure that a Gradual dose reduction (GDR) was addressed for 1 of 5 residents in the applicable sample, Resident #34 and failed to ensure that 2 of 5 residents, Resident #31 and 34 were free from unnecessary psychotropic drug use. Findings include: 1. Per record review Resident #34 has physician	F 758	Residents prescribed psychotropic medications are at risk for being affected by the alleged deficient practice. No adverse outcomes were noted related to the alleged deficient practice. A chart audit for residents on psychotropic medications was conducted and concerns addressed as needed. Education will be provided to the pharmacist and licensed nurses on finding, reporting and following up on irregularities related to psychotropic medications. Education will be provided to doctors on the regulations related to psychotropic medications. Education will be given for staff authorized to transcribe and administer licensed practitioner orders to ensure that licensed practitioner orders are addressed as written, supporting diagnosis are in place and d/c orders are in place as required.	

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F 758	Continued From page 21 orders for the administration of two (2) psychotropic medications, both medications are classified as antidepressants. Per pharmacist consultation report dated 10/16/18, identifies that Resident #34 is due for a GDR, as s/he is receiving Amitriptyline and Venlafaxine. The attending physician responded on 11/8/18 that s/he will re-evaluate on follow up visit. Physician visits (progress notes) dated 12/10/18, 1/24/19 and 2/27/19, do not identify that the medications were reviewed nor is there any documented rationale for continued use. Per discussion with the Unit Manager on 2/26/19 approximately 4 PM, s/he confirms that there is no evidence found in the medical record that identifies that the attending physician addressed the use of the psychotropic medication or the rationale for continued use. Per facility policy, titled Psychotropic Medication Use identifies that the physician/prescriber should document the clinical rationale for why any attempted dose reduction would be likely to impair the resident's function or increase distressed behavior. 2.) Per review of Resident #31's MAR, a physician's order dated 2/8/19 read, "Olanzapine (antipsychotic medication) tablet 5 mg (milligrams), give 0.5 tablet by mouth every 12 hours as needed for anxiety". There was no evidence that the as needed order for the Olanzapine was limited to 14 days as per regulation. Per interview on 2/26/19 at 4:05 PM with the Unit Manager, s/he confirmed that the medication should have been discontinued after 14 days and was not.	F 758	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-758 POC accepted 3/27/19 B. Bartell RN / S. Remy RN	

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F 921	Continued From page 22	F 921		
F 921 SS=E	Safe/Functional/Sanitary/Comfortable Environ CFR(s): 483.90(i) §483.90(i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation and confirmed by staff interview, the facility failed to ensure that 2 of 2 nursing units have a safe, sanitary and comfortable environment. Over-bed tables were identified to be in disrepair and baseboard heaters observed with accumulated dust and grime. The detailed findings are as follows: Per facility tour (1st and 2nd floors), on 2/27/19 at approximately 1:40 PM in the presence of the Maintenance Director, the Housekeeping Supervisor and the Regional Supervisor for the Health-Care Service Group the following was identified: 1. Numerous over-bed tables were identified with loose fitting laminate around the edges of the tables, vinyl covering torn/loose and sloughing off and some of the tables have missing particle board, leaving gaps and gouges on the surfaces, putting residents at risk for skin tears/scratches or injury and infection. The Maintenance Director confirms during the tour, that the facility has conducted an audit identifying 25 over-bed tables as 'junk tables', 60 over-bed tables are in good condition and 11 resident care areas are missing over-bed tables. The audit is dated as 1/31/19. Per discussion with the Licensed Nursing Home Administrator (LNHA) on 2/27/19 at approximately 2:30 PM there has been a	F 921	**F921** Safe/Functional/Sanitary/ Comfortable Environment An audit was conducted on 1/31/19 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 remove accumulated dust between grates. No residents were affected by the alleged deficient practice. Education will be provided to housekeeping and maintenance staff regarding what constitutes a safe/functional/sanitary/ comfortable environment. New tables replaced the unsatisfactory tables on 3/18/19. Register cleaning began on 2/28/19, with all resident room and hallway registers being completely cleaned on or before 3/29/18. Quarterly register cleaning will be added to the TELS preventative maintenance program.	

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SPRINGFIELD HEALTH & REHAB	105 CHESTER RD SPRINGFIELD, VT 05156

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 921	Continued From page 23 discussion to purchase needed equipment and bedroom chairs. However, to date nothing has been ordered. 2. Base board heating units were found to have open grates (on the top of the units), with visible accumulated dust and grime. On examination of the coiled heating element at the base of the units on the second floor, various items (food/pills/dust/hair/paper sugar packets) were physically removed. This was brought to the attention of the LNHA and the Unit Manager. The Housekeeping Supervisor, and the Regional Supervisor of Health Care Services Group, confirm at 3:20 on 2/27/19 that the base board units need cleaning. The LNHA voices this will be a collaborative effort between housekeeping and the maintenance department. Per observation on 2/27/19 from 3:30 PM-4:30 PM, the surveyor identified the following condition of the base board heaters: 1st floor: Dining room units are heavily caked with dust and grime; 5 units located in resident rooms are heavily caked with dust and grime (Rooms # 125, 113, 112, 108, 107, and 102), 12 units in resident rooms need attention and 7 units in resident rooms are identified are in satisfactory condition; 2nd floor: Dining room units are heavily caked with dust and grime, 13 units located in resident rooms are heavily caked with dust and grime (Rooms # 213, 211, 210, 205, 204, 226, 225 Quiet Room, 223, 220, 219, 217, 216, and 215), 7 units are moderately caked with dust and grime Rooms # 212, 208, 203, 202, 222, 221 and 218 and 4 units are in satisfactory condition. Hall Units on the 2nd floor on both West and East side are moderately caked with dust and grime	F 921	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 F921 POC accepted 3/22/19 B. Bartell, RN / S. Bengy RN	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	475025	A. BUILDING _____ B. WING _____	C 02/28/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRINGFIELD HEALTH & REHAB	105 CHESTER RD SPRINGFIELD, VT 05156

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F 921	Continued From page 24	F 921		
	and need attention.			
F9999	FINAL OBSERVATIONS	F9999		
	The following violations of Vermont Licensing and Operating Rules for Nursing Homes, dated June 1, 2018 were identified in relation to staffing levels.		**F9999** Nursing Services	
	7.13 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.	
	d. Staffing Levels. The facility shall maintain staffing levels adequate to meet resident needs.		Daily schedule and Key factor report will be reviewed regularly to ensure compliance with state staffing requirements.	
	1. At a minimum, nursing homes must provide:		An audit will be completed weekly x4 and monthly x3 by the CED or designee to monitor the effectiveness of the plan.	
	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		The QAPI committee will evaluate the data and make recommendations as needed.	
	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.		Date of Compliance: 3/29/19	
	This REQUIREMENT is NOT MET as evidenced by:		F9999 POC accepted 3/22/19 B. Bartell RN / S. Perry RN	
	Based on staff interviews and record review the facility failed to provide staffing levels adequate to meet resident needs. The findings include the following:			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	475025	A. BUILDING _____ B. WING _____	C 02/28/2019

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SPRINGFIELD HEALTH & REHAB	105 CHESTER RD SPRINGFIELD, VT 05156

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F9999	Continued From page 25 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.	F9999		

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER # 475025	MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	DATE SURVEY COMPLETE: 2/28/2019

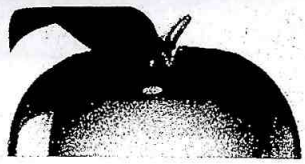
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRINGFIELD HEALTH & REHAB	105 CHESTER RD SPRINGFIELD, VT

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
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. F641 Accuracy of Assessments 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. F641 POC accepted 3/22/19 B. Bartell RN/SLM RN

ny iency 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 o 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 deficiencies pose no actual harm to the residents

Genesis HealthCare℠



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.

Respectfully,

Heather Presch, CED, LNHA

Heather Presch, LNHA

Center Executive Director