

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

September 5, 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 **August 14, 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

Pamila MCotaRN

Licensing Chief

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

PRINTED: 08/28/2019 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY		
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A BUILDING COMPLETED		
	475025	B. WING.	4	G
NAME OF PROVIDED OF CHERTIES	<u>des la companya de l</u>		DELIGIODECC CITY STATE OF CORE	08/14/2019
NAME OF PROVIDER OR SUPPLIER		1745//	REET ADDRESS, CITY, STATE, ZIP CODE. 15 CHESTER RD	
SPRINGFIELD HEALTH & RE	HAB		RINGFIELD, VT 05156	
(X4) ID SUMMARY ST	ATEMENT OF DEFICIENCIES	(ID)	PROVIDER'S PLAN OF CORRECTIO	N 3 July 2
PREFIX (EACH DEFICIENCE	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX . TAG	(EACH CORRECTIVE ACTION SHOULD CROSS: REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETION
				
F.000 INITIAL COMMEN	TS.	F 000	F600	
		. , ,	Free from Abuse, Neglect, a	nd
Án unannounced	onsite investigation of two (2)		Exploitation	
facility reported inc	cidents was conducted by the		Exploitation	
	ng and Protection on		5/22/19 incident was report	ted to
identified as a res	vere regulatory deficiencies ult of this investigation.		APS, DAIL and local authorit	ies.
Findings include:			8	,
F 600 Free from Abuse a		F 600	Progress notes were review	
SS=D CFR(s): 483.12(a)	(1)	1 . !	residents who exhibit sexua	
\$483.12 Freedom	from Abuse, Neglect, and		behaviors and no further co	ncerns
Exploitation			were noted.	
The resident has the	ne right to be free from abuse,		The following was complete	d ac
neglect, misappror	neglect, misappropriation of resident property,		corrective action for all resid	
includes but is not	and exploitation as defined in this subpart. This includes but is not limited to freedom from			
corpora) punishme	nt, involuntary seclusion and		found to be potentially affe	* \$ 5 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0
any physical or che	any physical or chemical restraint not required to treat the resident's medical symptoms.		the alleged deficient practic	e,
treat the residents	medical symptoms.		A chart review was conduct	ed for
§483,12(a) The fac	cility must-		residents with known sexua	i i
PARK 407-1/45 65-1	To be The state of		behaviors and care plans we	
9403.12(a)(1) Not i	use verbal, mental, sexual, or reporal punishment, or		revised as needed.	
involuntary seclusion	อทรู			
	NT is not met as evidenced		Education will be provided t	0
by: Based on record r	ovilous and ataff intensions the		nursing staff regarding what	
Based on record review and staff interview, the facility failed to ensure the resident right to be			constitutes abuse, how to re	eport
free from sexual at	ouse for one (1) of four (4)		and who to report to. Educa	ition will
sampled residents,	Resident #1. Findings include:		be completed by 9/11/19.	
Per record review,	a nursing progress note	201	An audit will be completed	weekly
	ered Nurse, (RN) in Resident 6/22/2019 at 10:44 PM reads;		x4 and monthly x2 by the CI	and the second s
	was noted to have grabbed a		designee to monitor the	
resident in the groi	n area and chuckled that	, a 4	effectiveness of the plan.	7.
'[S/he] must have li	ked that.' Supervisor and DON		encenveness of the plan.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

ȚITE :

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 50 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above tingings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
				C	
475025		B. WING.		08/14/2019	
	PROVIDER OR SUPPLIER	iaB		STREET,ADDRESS; GITY, STATE, ZIP COD 105 CHESTER RD SPRINGFIELD, VT 05156	E
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC (DENTIFYING INFORMATION)			ID PRÉFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SI- CROSS-REFERENCED TO THE AP DEFICIENCY)	OULD BE COMPLETION
F 600	interview with the R note, the Licensed reported that Resid #1 in the groin area Per interview with the PM, Resident #2 ha lately so staff were with him/her. The L #2 had grabbed Re	8/14/2019 at 3:20 PM, per N who wrote the progress Nursing Assistant (LNA) ent #2 had grabbed Resident	F 600	The QAPI committee will the data and act on the as indicated and at the emonths to determine fur frequency of the audits. Floo for accepted 91/11 Free F609 Reporting of Alleged Vio	information and of three orther man Rd Pmc
	cry". 609 Reporting of Alleged Violations SS=D CFR(s): 483.12(c)(1)(4)			5/22/19 incident was re APS, DAIL and local auth	The state of the s
	§483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must:			The center initiated 24 h checks and no other nur progress reports were n	sing
	involving abuse, ne mistreatment, include source and misappinare reported immed hours after the alleg that cause the alleg serious bodily injury the events that cause abuse and do not rethe administrator of officials (including to adult protective senfor jurisdiction in lor	re that all alleged violations glect, exploitation or dinginjuries of unknown appriation of resident property, liately, but not later than 2 pation is made, if the events ation involve abuse or result in, or not later than 24 hours if se the allegation do not involve esult in serious bodily injury, to the facility and to other or the State Survey Agency and vices where state law provides ig-term care facilities) in		contain any allegations of Alleged abuse reports we audited with checklist mecompletions and areas needed per policy. The following was comparesidents found to be possible affected by the alleged of practice.	ill be onitored for oted leted for all otentially deficient
accordance with State law through established procedures. §483.12(c)(4) Report the results of all		•	Education provided to n regarding the requirement reporting abuse. Educate completed by 9/11/19.	nts for	

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (DENTIFICATION NUMBER)		(X2) MULTIPLE CONSTRUCTION A. BUILDING.		(X3) DATE SURVEY COMPLETED	
		475025	B. WING		C 08/14/2019
NAME OF PROVIDER OR SUPPLIER SPRINGFIELD HEALTH & REHAB			, n	TREET ADDRESS, CITY, STATE, ZIP CODE 06 CHESTER RD PRINGELELD, VT 05156	307.112415
(X4) ID PREFIX TAG				PROVIDER'S PLAN OF CORRECTIVE (EACH CORRECTIVE ACTION SHOUL CROSS REFERENCED TO THE APPROV DEFICIENCY)	D.BE COMPLETION
F 609	designated represe accordance with SI Survey Agency, wit incident, and if the appropriate correct This REQUIREME by: Based on record re facility failed to rep State Survey Agen services (APS) for residents, Residen	e administrator or his or her entative and to other officials in ate law, including to the State hin 5 working days of the alleged violation is verified ive action must be taken. NT is not met as evidenced eview and staff interview, the ort an incident of abuse to the cy and adult protective one (1) of four (4) sampled t #1. Findings include:	F 609	An audit will be completed x4 and monthly x2 by the C designee to monitor the effectiveness of the plan. The QAPI committee will evithe data and act on the info as indicated and at the end months to determine furthe frequency of the audits.	valuate ormation of three
	Resident #2"s reco PM reads; [Reside grabbed a resident that '[S/he must ha	a nursing progress note in ord dated 5/22/2019 at 10:44 at #2] "also was noted to have in the groin area and chuckled ve liked that] Supervisor and e Executive (CNE)] made	And the second s	F609 POC accepted 9/4/19 Streen	wi RN/ Mile
	with the Registerer progress note, the (LNA) reported tha Resident #1 in the the Nursing Super contact the Directo confirmed that the	20 PM, during an interview I Nurse (RN) who wrote the Licensed Nursing Assistant it Resident #2 had grabbed groin area. The RN informed visor who instructed her to or of Nursing. The RN CNE advised to monitor both ot advise to file a report to the cy of APS.			
	PM, s/he confirme Resident #1 in the	the LNA on 8/14/2019 at 5:00 d that Resident #2 had grabbed groin area and that Resident ut and started to cry".			

Per interview with the interim CNE on 8/14/2019

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CC A. BUILDING	NSTRUCTION	(X8) DATE SURVEY COMPLETED	
		475025	B. WING		C 08/14/2019
NAME OF	PROVIDER OR SUPPLIER	L	STREE	ET ADDRESS, CITY, STATE, ZIP CODE	
SPRINGFIELD HEALTH & REHAB			105 G	HESTER RD NGFIELD, VT 05156	
Annual Com-	CERMANADVOTA	TEMENT OF DEFICIENCIES	JÖ .	PROVIDER'S PLAN OF CORRECTION	ON OVEN
(X4) ID PREFIX TAG	(EAGH DEFICIENC)	Y MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	DBE COMPLETION
F 609	Continued From pa	ide 3	F 609		
1 .000		onfirmed that the incident	1 555		
	should have been	eported to the State Survey and that it had not been		4	
	Bulley and letter for	on DHADONO of O'EC DM the			
		on 8/14/2019 at 2:56 PM the d that s/he "was just hearing of			
		On 8/14/2019 at 5:55 PM, the			
		confirmed that the incident			
	should have been i			* 4	
F 610		VCorrect Alleged Violation	F 610	8 9 4	
SS=D	CFR(s): 483.12(c)(2)-(4)		FC10	
	8483 12(c) In respo	onse to allegations of abuse,	7.	F610	
	neglect, exploitation, or mistreatment, the facility			Investigate/Prevent/Correc	t Alleged
	must:		ŀ	Violations	
•	§483.12(c)(2) Have violations are thoro	e evidence that all alleged		Progress notes reviewed at	morning
		agmy mreengacea.	N. 4	meeting by CNE or Designe	e and
		ent further potential abuse,		staff interviewed to ensure	no .
	neglect, exploitation in neglect, exploitation in p	n, or mistreatment while the		allegations of abuse are pre	esent and
	investigation is in p	rogress.	1	areas noted addressed per	policy.
	§483.12(c)(4) Repo				
		e administrator or his or her	i	The following was complete	
		entative and to other officials in tate law, including to the State		residents found to be poter	ntially
		hin 5 working days of the	e I	affected by the alleged defi	cient
	incident, and if the	alleged violation is verified	8	practice.	
	appropriate correct	live action must be taken.	, F × 4		a k
		NT is not met as evidenced		Education provided to nurs	
	by: Based on record r	eview and staff interview, the	<u>.</u>	regarding what constitutes	abuse
		roughly investigate and	9	and the requirements for re	eporting
	implement appropr	late corrective action to		abuse. Education will be co	ompleted
	(4) sampled reside	ential abuse for one (1) of four nts, Resident #1. Findings		by 9/11/19.	
	include:	P out			

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STATEMENT OF DEFICIENCIES (X1) AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA. IDENTIFICATION NUMBER:	(X2) MULTIPL A, BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	€	475025	B. WING:		08/14/2019
NAME OF F	ROVIDER OR SUPPLIER	470020	in the second	TREET ADDRESS CITY, STATE, ZIP C	
SPRINGFIELD HEALTH & REHAB		1	05 CHESTER RD PRINGFIELD, VT 05156		
(X4) ID PREFIX TAG	PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE COMPLETION
F 610	Continued From pa	ige 4	F 610		e de la companya de l
the management of the state of	Resident #2"s reco PM reads; [Resider grabbed a resident that '[S/he must hav DON [Center Nurse aware," Resident # inappropriate behave loss/dementia, initia #2's plan of care di inappropriateness to was not updated to no evidence in Resident # record that the incide any corrective actic potential abuse.	a nursing progress note in ord dated 5/22/2019 at 10:44 nt #2] "also was noted to have tin the groin area and chuckled we liked that] Supervisor and e Executive (CNE)] made #2 is care planned for sexually viors related to cognitive ated on 5/20/2019. Resident id not address sexual towards other residents, and it or reflect this incident. There is sident #1 or Resident #2's dent was investigated or that on was taken to prevent further or on 8/14/2019 at 2:56 PM the irmed that there was no		An audit will be comp x4 and monthly x2 by designee to monitor effectiveness of the p The QAPI committee the data and act on t as indicated and at the months to determine frequency of the aud	the CNE or the plan. will evaluate he information ne end of three e further its.
	evidence that the ir investigated. Per interview with t at 5:47 PM, s/he convidence that the ir investigated, nor with investigated, nor with presented to present the investigated of th	the interim CNE on 8/14/2019 on firmed that there was no incident had been thoroughly vere any corrective actions event further potential abuse at Comprehensive Care Plan	F 656	F656 Develop/Implement/ Care Plan Care Plans for resider were reviewed and reneeded. Residents #1 and #2 effects from the allegoractice.	nts #1 and #2 evised as had no lasting

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are with the process of the light of the first

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A BUILDING		(X3) DATE SURVEY COMPLETED	
	14		A BOILDING.		C .
		475025	B. WING	the same and the s	08/14/2019
NAME OF PROVIDER OR SUPPLIER SPRINGFIELD HEALTH & REHAB		STREET ADDRESS, CITY, STATE, ZIP CODE 105 CHESTER RD SPRINGFIELD, VT. 05156			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	ID PREFIX TAG		D.BE COMPLETION
F 656	needs that are iden assessment. The codescribe the following (i) The services that or maintain the resiphysical, mental, arrequired under §48 (ii) Any services that under §483,24, §48 provided due to the under §483,10, included the under §483,10, include	and mental and psychosocial tified in the comprehensive comprehensive comprehensive comprehensive comprehensive comprehensive comprehensive care plan must ng - t are to be furnished to attain dent's highest practicable and psychosocial well-being as 3.24, §483.25 or §483.40; and at would otherwise be required i3.25 or §483.40 but are not resident's exercise of rights uding the right to refuse 83.10(c)(6), services of specialized es the nursing facility will of PASARR If a facility disagrees with the ARR, it must indicate its dent's medical record. with the resident and the tative(s)-poals for admission and preference and potential for accilities must document accilities must document int's desire to return to the sessed and any referrals to be and/or other appropriate pose. In the comprehensive care as in the comprehensive care as in the comprehensive care as in accordance with the orth in paragraph (c) of this in not met as evidenced eview and staff interview, the elop and implement a	F 65	The following was complete residents found to be potential affected by the alleged definition. An in house screen was confor residents with known subhaviors. Care plans were reviewed and updated as in Education provided to nurse care plan process. Education completed by 9/11/19. An audit will be completed x4 and monthly x2 by the Completed by 9/11/19. The QAPI committee will enter the data and act on the infinition indicated and at the end months to determine further frequency of the audits. FLOSE POE accepted 9/1/19.50	ntially icient inducted exual eeded. ees on the on will be weekly into or valuate ormation I of three er
		rson-centered care plan for campled residents, Resident #1	1		

PRINTED: 08/28/2019 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED OMB NO: 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY COMPLETED (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES DENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING 08/14/2019 475025 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 105 CHESTER RD SPRINGFIELD HEALTH & REHAB SPRINGFIELD, VT 05156 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION DATE SUMMARY STATEMENT OF DEFICIENCIES (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX CROSS-REFERENCED TO THE APPROPRIATE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFIGIENCY) F 656 F 656 Continued From page 6 and Resident #2. Findings include: Per review of Resident #2's record, s/he grabbed Resident #1 in the groin area. Resident #1's care plan does not reflect the incident, nor does it include any interventions to prevent further potential abuse. There is no evidence in Resident #1's record that a care plan was developed or implemented that address the potential for further sexual abuse. Per interview with the interim CNE on 8/14/2019 at 5:47 PM, s/he confirmed that there was no evidence that Resident #1's care plan was developed or implemented to prevent further potential sexual abuse. 2. Per record review, Resident #2 is care planned for sexually inappropriate behaviors related to cognitive loss/ dementia that was initiated on 5/20/2019. Resident #2's plan of care does not address sexual inappropriateness towards other residents, and it was not updated to reflect the incident. Per interview with the interim CNE on 8/14/2019 at 5;47 PM, s/he confirmed that there was no evidence that Resident #2's care plan was updated to reflect actual or potential sexual abuse toward other residents.