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

February 13, 2020

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

Dear Ms. Presch:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **January 15, 2020.** Please post this document in a prominent place in your facility.

We may follow-up to verify that substantial compliance has been achieved and maintained. If we find that your facility has failed to achieve or maintain substantial compliance, remedies may be imposed.

Sincerely,

Pamela M. Cota, RN
Licensing Chief

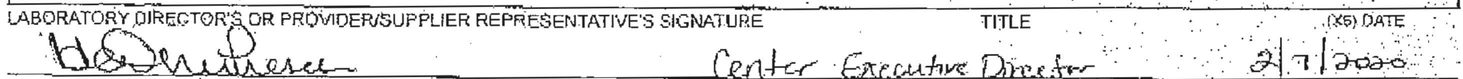
DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	475025	A. BUILDING ______ B. WING ______	01/15/2020

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 on 1/13 - 1/15/2020. There were no regulatory deficiencies regarding Emergency Preparedness as a result.	E 000		
F 000	INITIAL COMMENTS An unannounced, on-site recertification survey was conducted by the Division of Licensing and Protection between 1/13 - 1/15/2020. The following regulatory concerns were identified and the specifics are detailed below:	F 000		
F 623 SS=B	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	F 623	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



Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 623 Continued From page 1 — F 623

made by the facility at least 30 days before the resident is transferred or discharged.
(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

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F 623	Continued From page 2 disabilities, the mailing and email address and telephone number of the agency responsible for 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 staff interview and record review, the facility failed to ensure 2 of 6 applicable residents (Residents #64, 57) or their representatives received transfer notices with all of the information required by regulation. Findings	F 623	F623 Notice Requirements Before Transfer/Discharge Residents #64 and #57 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 3 include: 1. Resident # 64 was hospitalized on 12/27/19, returning to the facility on 12/30/19. The notice of transfer did not include where the resident was transferred to or why the resident's needs could not be met at the facility. Additionally, the resident was transferred to the hospital on 1/6/20 and remains there to date. There is no indication on the notice of transfer why the resident's need could not be met at the facility. 2. Resident # 57 was hospitalized on 12/13/19, returning to the facility on 12/17/19. The notice of transfer did not include where the resident was transferred to or why the resident's needs could not be met at the facility. On 01/14/20 at 03:05 PM, the Center Executive Director (CED) and Human Resources Manager confirmed that the transfer notices did not contain the information required by regulation.	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 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 CNE or designee to monitor the effectiveness of the plan. The QAPI committee will evaluate the data and make recommendations as needed. Date of Compliance: 2/14/20 F623 POC accepted 2/13/20 TDougherty RN/PMC	
F 625 SS=B	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §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	F 625	F625 Notice of Bed hold Policy Before/Upon Transfer Residents #36, 64, 57 and 43 were issued the appropriate notice post survey. They had no negative effects from the alleged deficient practice.	

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F 625	Continued From page 4 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 staff interview and record review, the facility failed to ensure 4 of 5 applicable residents and/or resident representative (Resident # 36, #64, 43 and #57), received bed hold notices with all of the information required by regulation. The findings include the following: 1. Per review of the medical record for Resident #36, who was transferred to the hospital on 11/30/19, for an evaluation. There is no evidence in the medical record that demonstrates that the resident and/or representative was provided with required information related to the bed hold policy. The incomplete form identifies the initials of the Business Office staff member and date only. Confirmation was made by the Center Executive Director on 01/14/20 at 3:10 PM that the bed hold notice was not provided to the resident and/or the representative as required. 2. Resident # 64 was hospitalized on 12/27/19, returning to the facility on 12/30/19. There is no	F 625	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 CNE or designee to monitor the effectiveness of the plan. The QAPI committee will evaluate the data and make recommendations as needed. Date of Compliance: 2/14/20 F625 POC accepted 2/13/20 TDoughty RN/PML	

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F 625	Continued From page 5 evidence in the medical record that demonstrates that the resident and/or representative was provided with required information related to the bed hold policy. The incomplete form identifies the initials of the Business Office staff member and date only. 3. Resident # 57 was hospitalized on 12/13/19, returning to the facility on 12/17/19. There is no evidence in the medical record that demonstrates that the resident and/or representative was provided with required information related to the bed hold policy. The incomplete form identifies the initials of the Business Office staff member and date only. 4. Resident # 43 was hospitalized from 12/16/19 - 12/20/19. There is no evidence in the medical record that demonstrates that the resident and/or representative was provided with required information related to the bed hold policy. The incomplete form identifies the initials of the Business Office staff member and date only. On 01/14/20 at 03:05 PM, the Center Executive Director (CED) and Human Resources Manager confirmed that the notices did not contain the information required by regulation	F 625		
F 645 SS=D	PASARR Screening for MD & ID CFR(s): 483.20(k)(1)-(3) §483.20(k) Preadmission Screening for individuals with a mental disorder and individuals with intellectual disability. §483.20(k)(1) A nursing facility must not admit, on or after January 1, 1989, any new residents with: (i) Mental disorder as defined in paragraph (k)(3)	F 645		

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F 645	Continued From page 6 (i) of this section, unless the State mental health authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission; (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services; or (ii) Intellectual disability, as defined in paragraph (k)(3)(ii) of this section, unless the State intellectual disability or developmental disability authority has determined prior to admission- (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services for intellectual disability. §483.20(k)(2) Exceptions. For purposes of this section- (i)The preadmission screening program under paragraph(k)(1) of this section need not provide for determinations in the case of the readmission to a nursing facility of an individual who, after being admitted to the nursing facility, was transferred for care in a hospital. (ii) The State may choose not to apply the preadmission screening program under paragraph (k)(1) of this section to the admission to a nursing facility of an individual- (A) Who is admitted to the facility directly from a hospital after receiving acute inpatient care at the	F 645		

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F 645	Continued From page 7 hospital, (B) Who requires nursing facility services for the condition for which the individual received care in the hospital, and (C) Whose attending physician has certified, before admission to the facility that the individual is likely to require less than 30 days of nursing facility services. §483.20(k)(3) Definition. For purposes of this section- (i) An individual is considered to have a mental disorder if the individual has a serious mental disorder defined in 483.102(b)(1). (ii) An individual is considered to have an intellectual disability if the individual has an intellectual disability as defined in §483.102(b)(3) or is a person with a related condition as described in 435.1010 of this chapter. This REQUIREMENT is not met as evidenced by: Based on record review and confirmed by staff interview the facility failed to ensure that a Preadmission Screening (PASSAR) was updated for 1 applicable resident in the sample of 20, who has a diagnosis of a mental disorder. Resident #14 had a length of stay that exceeded the 30-day exemption. This is a repeat citation from 03/14/18. The findings include the following: Per review of the medical record for Resident #14, who was admitted from the acute hospital on 01/22/19 with diagnosis to include, but not limited to Bipolar Disease and mood disorder. The PASARR form was completed in full by the Registered Nurse (RN) from the acute setting at the time of the discharge. Review of the Part A-Exemption was also completed at that time,	F 645	F645 PASARR Screening for MD & ID A PASARR screen and resident review was completed for resident #14. Resident #14 had no negative effects from the alleged deficient practice. The following was completed as corrective action for residents found to be potentially affected by the alleged deficient practice. A chart review was conducted on current residents to ensure PASARR screens were conducted accurately. Any findings were updated during the review. Education will be provided to Admissions staff and Social Services Staff regarding the requirements and process for PASARR screening and rescreening. When new staff members are hired into these positions they will be trained on the PASARR process.	

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F 645	Continued From page 8 identifying that Resident #14 was being admitted to the nursing facility and is likely to require less than 30 days in the nursing facility. The physician certified the resident will require less than 30 days of nursing facility services. The PASARR form identifies if the nursing facility stay is 30 days or longer, a new PASARR screen and resident review must be performed within 30 calendar days of admission. Resident #14 had scheduled surgery on 10/15/19 and returned on 10/18/19 some 9 months after the initial admission. There is no evidence identifying that an updated PASARR screening was completed at any time since the initial admission or at the return after surgery. The resident remains in the facility to date (01/14/20). Confirmation was made by the Social Service Director on 01/14/20 at approximately 4 PM, that the screening should have been updated.	F 645	An audit will be completed weekly x4 and monthly x3 by the CNE or designee to monitor the effectiveness of the plan. The QAPI committee will evaluate the data and make recommendations as needed. Date of Compliance: 2/14/20 F645 POC accepted 2/13/20 TDougherty RN/PM	
F 867 SS=B	QAPI/QAA Improvement Activities CFR(s): 483.75(g)(2)(ii) §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; This REQUIREMENT is not met as evidenced by: Based upon interview and record review, the facility failed to ensure its' Quality Assessment and Performance Improvement committee [QAPI] developed and implemented appropriate plans of action to correct identified quality deficiencies. Findings include:	F 867	F867 QAPI/QAA Improvement Activities Process identified during survey was corrected. Deficiencies and the associated POC for the past two year period were reviewed for ongoing compliance and addressed as necessary. No residents were negatively impacted by the alleged deficient practice.	

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F 867	Continued From page 9 An annual re-certification survey was conducted at the facility on 1/13 - 1/15/2020. The survey included a review of concerns identified during the previous year's survey, completed on 2/28/19. The previous year's survey included concerns regarding resident transfer notices. A review of the facility's Plan of Correction for the concerns regarding transfer notices from the previous year's survey lists "The QAPI committee will evaluate the data and make recommendations as necessary. Date of compliance: 3/29/19". During the present survey on 1/13 - 1/15/2020, concerns were again identified regarding a failure to ensure residents or their representatives received transfer notices with all the information required by regulation. A review of the facility's Quality Assessment and Performance Improvement Plan includes "The QAPI program is evaluated annually to determine its effectiveness in improving quality of care and quality of life, operational sustainability, employee and customer satisfaction". The Quality Assessment and Performance Improvement Plan is marked as reviewed and updated on 11/19/19. The dates for the concerns regarding transfer notices identified during the current survey are 11/30/19, 12/13/19, 12/16/19, & 12/27/19. An interview was conducted with the facility's Center Executive Director (CED) on 1/15/2020 at 1:07 PM. The CED confirmed s/he was aware of the concerns identified by the survey team during the current survey, and that the concerns were regarding transfer notices with all the information required by regulation. The CED confirmed that the concerns were similar or identical to compliance concerns cited on the facility's	F 867	Education was provided to the QAPI committee regarding QAPI/QAA process and ongoing monitoring. A monthly review will be conducted on QAPI projects to ensure ongoing compliance. An audit of the reviews will be kept by the CED or designee and will be reviewed weekly x4 and monthly x3 and quarterly x3 to monitor the effectiveness of the plan. The QAPI committee will evaluate the data and make recommendations as needed. Date of Compliance: 2/14/20. F867 POC accepted 2/13/20 TDougherty RN/PMC	

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F 867	Continued From page 10 previous recertification survey completed on 2/28/19, and that QAPI measures needed to be implemented to address the concerns. The CED stated that s/he was 'frustrated' about the repeat of concerns cited previously regarding the facility's compliance.	F 867		
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 environments. Resident closet doors were found in poor repair, in need of cleaning and resident safety mats were identified with fraying edges and in need of cleaning. This is a repeat citation form recertification survey of 02/28/19. The detailed findings are as follows: Per facility tour (1st and 2nd floors), on 1/15/20 at approximately 09:57 AM in the presence of the Center Executive Director, the Maintenance Director, the Housekeeping Supervisor and the Regional Supervisor for the Health-Care Service Group the following was identified: Room #120 window was identified to have a crack along the lower edge of the frame. The cracked edge is found to have cold air seeping through the crack and along the window edge. The resident has complained of being cold, but	F 921	**F921** Safe/Functional/Sanitary/ Comfortable Environment Concerns identified on the facility tour were corrected. An audit was conducted assessing window frames, fall mats and closets and identifying those requiring repair, replacement or cleaning and an order was placed for replacement fall mats. 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 fall mats replaced the unsatisfactory fall mats on 1/17/20. Closet cleaning and window frame repair began on 1/15/20, with all closets and window frames being addressed on or before 2/14/20.	

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	475025	A. BUILDING ______ B. WING ______	01/15/2020

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 11 the temperature of the room registered (with the facility's infra-red thermometer), at 70-71 degrees Fahrenheit; Semi-private bedroom closet doors (of the metal type), were found to be off the sliding tracks and have an accumulation of visible dirt, dust, and lint resting in the tracks on the base of the doors. They are as follows: Second floor rooms # 123, 120, 112, 109, 106 and 104. Third floor rooms #209, 223, 226, and 215. Room #202 had a fabric drape utilized as a closet door that was found with dried brown liquid visible from the resident's bedroom; Floor safety mats on the 3rd floor evidenced with fraying along the edges, some of the vinyl covering evidenced as being cracked and dirty with dried matter and dust. They are utilized for the following residents: Residents #13, #36, #56 and #58. Confirmation was made during the tour that the above identified concerns were present and need attention. Per review of policies for both Genesis and Healthcare Service Group identify that spot cleaning and surface sanitizing will be completed daily and privacy curtains will be cleaned when visibly dirty by laundering or cleaning. Floor dusting/mopping will be completed at least daily to include resident rooms and tracks at various areas.	F 921	Audits 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: 2/14/20. F921 POC accepted 2/13/20 TDougherty RN/PMC	