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

January 3, 2022

Mr. Christopher Phillips, Administrator
Springfield Health & Rehab
105 Chester Rd
Springfield, VT 05156-2106

Dear Mr. Phillips:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **December 2, 2021**. Please post this document in a prominent place in your facility.

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

Sincerely,

Pamela M. Cota, RN
Licensing Chief

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

PRINTED: 12/15/2021
FORM APPROVED
OMB NO. 0938-0391

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 12/02/2021

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 000	INITIAL COMMENTS The Division of Licensing and Protection conducted two complaint investigations in conjunction with two facility reported incident investigations on 12/1 - 12/2/2021. There were regulatory violations identified as a result of these investigations.	F 000	The filing of this plan of correction does not constitute an admission of the allegations set forth in the allegations set forth in the statements of deficiencies. Springfield Rivers Health and Rehab has prepared and executed a plan of correction as evidence of the facilities continued compliance with the applicable federal and state laws.	12/27/21
F 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observations, resident and staff interviews, and record review, the facility failed to provide adequate supervision to prevent a resident to resident physical altercation for two of six residents (Resident #1 & Resident #2) in the applicable sample. Findings include: Per record review, Resident #1 has diagnoses that include dementia with behavior disturbance and post traumatic stress disorder (PTSD). S/he has a history of verbal and physical altercations with staff and other residents. A care plan focus that was initiated on 1/25/2021 states "Wandering related to cognitive impairment, inability to locate own room." The care plan goal states that s/he will wander only within specified boundaries through next review. Interventions reflect that staff should provide [the resident] assistance in	F 689	The facility is requesting an IDR for F689. F689 Resident #1 continues to reside in the facility and have his needs met. Resident #2 no longer resides at the facility. All residents with behaviors are at risk for this alleged deficient practice. A house wide audit of all residents with behaviors was conducted to ensure their care plans were accurate for the level of supervision required. All nursing staff were educated on the Abuse Prohibition Policy OPS 300. The DNS or designee will conduct random weekly audits X 4 and then monthly X 2. The results of these audits will be brought to the facility QAPI team for review. Tag 689 POC Accepted on 1/2/22 by S. Freeman / D Lindenmuth RN	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [signature] DNS, on behalf of
TITLE: Administrator
(X6) DATE: 12/22/21

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 689	Continued From page 1 locating room. Resident #1's care plan focus initiated on 2/19/2021 reflects that Resident #1 is at risk for/demonstrates physical/combative behaviors at times related to Dementia, with a history of harm to others. On 7/5/2021 Resident #1 was involved in a resident to resident altercation that occurred in the dining room and was observed by staff. This altercation resulted in Resident #1 hitting another resident with her/his walker and then being the recipient of three strikes to the head by the other resident. Resident #1's care plan was updated on 7/5/2021 to reflect that If [resident] appears to be agitated or threatening others with walker, escort [resident] to safe private area (resident room) until de-escalation, as tolerated. Resident #1's ADL (Activities of daily living) care plan revised on 7/6/2021 to reflect that s/he requires supervision with ambulating with walker. On 7/12/2021 at 12:30 PM Resident #1 wandered into Resident #2's room unsupervised. An Incident Note dated 7/12/2021 at 4:11 PM states "Resident [#1] was found going toward dining room with blood on left side of head. Upon further investigation it was noted that the resident [#1] had been in an altercation with another resident [#2]. The resident in the other room stated that [Resident #1] had come into [her/his] room and sat down. [Resident #1] then tried to take [Resident #2's] oatmeal cookie from [her/him]. When [Resident #2] tried to walk past [Resident #1, s/he] started swearing at [Resident #2] and hitting [her/him] in the face. [Resident #2] did have a 2 cm laceration under [her/his] left jaw and a laceration to the top of [her/his] right wrist." Both residents required first aid from nursing.	F 689		

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F 689	Continued From page 2 Resident #1's care plan was updated on 7/12/2021 to reflect a door alarm to alert staff of leaving room. An Interdisciplinary Note dated 7/16/2021 does state "We discussed her/his current behaviors that include wandering with impact, cursing at others, verbal threats of violence, physical aggression. Triggers identified are low/high blood sugars, over stimulus environments, and noise. We discussed current interventions of the doorway sensor monitor, there is concern that it is not helpful to the noise on the unit." The Interdisciplinary Note does not indicate wether or not the discussion lead to the removal of the alarm and the care plan was not updated to reflect the removal of the door alarm. After the 7/12/2021 resident to resident altercation Resident #1 continues to be aggressive and combative. S/he also continues to wander in and out of resident rooms at times. S/he has entered rooms and been intrusive with other residents belongings. A Behavior Note dated 8/14/2021 1:55 PM states "It was reported to this writer that [Resident #1] wandered into another patients room and put on that patients jacket the other patient told [her/him] to take off the jacket and to leave the room and [Resident #1] did what the patient requested. [S/He] then went into the hallway and was combative with the nurse when [s/he] attempted to redirect [her/him] to [her/his] room.... " A Behavior note date 8/13/2021 4:50 PM states "At 0915 it was reported by ,,, LNA orienting that [s/he] found [Resident #1] in [another resident's] bathroom. [S/he] was able to redirect [her/him] back to [her/his] room. During observations of the third floor on 12/1/2021 from 3:00 PM - 3:3:00 PM , Resident	F 689		

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F 689	Continued From page 3 #1 was seen in his room sitting in a chair facing the doorway and observing the activity in the hallway. The door did not have a door alarm in place. Throughout the observations staff were seen passing through the hallway, in other resident's rooms, or located around the corner from Resident#1's room at the nurses station. Per interview with a licensed nursing assistant (LNA) on 12/1/2021 at 3:10 PM Resident #1 does have aggressive behaviors. S/he stated that "it is usually the way you approach [her/him]." S/he seems to respond better to certain staff. The LNA confirmed that there was no specific monitoring or supervision of Resident #1 and there was no door alarm on Resident #1's door. S/he stated that the resident across the hall does yell sometimes and that bothers Resident #1. When that happens they shut Resident #1's door a bit so it doesn't upset her/him. Per interview with the Director of Nursing Services (DON) on 12/1/2021 at 5:25 PM Resident #1 has a history of PTSD from being in the war. S/he has had altercations with other residents and can be aggressive and combative with staff. The resident to resident incidents being investigated happened prior to her/him being the DON and s/he is not aware of what interventions were implemented. However, it would be her/his expectation that after a resident to resident altercation the resident would have increased supervision.	F 689		
F 756 SS=D	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident	F 756		

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F 756	Continued From page 4 must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review the facility failed to ensure that the attending	F 756	Resident identifiers were not given for this tag. The July pharmacy recommendations were reviewed and completed as indicated. All pharmacy reviews since July have been verified as completed. (House wide audit). The Medical Director, Director of Nursing, Administrator, and Unit Managers have been educated on the Medication Review Process and the QAPI created. The DNS or designee will conduct random weekly audits of pharmacy reviews to ensure they are being addressed per the protocol and current QAPI. These audits will be brought to the facility QAPI meeting for review. Tag F56 POC Accepted on 1/21/22 by S. Freeman RN, Unit Manager	

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F 756	Continued From page 5 physician reviewed and addressed recommendations made by the licensed consultant pharmacist. Findings include: Per review of the pharmacist recommendations dated 8/19/2021 the following recommendations had been made on 7/21/2021 and had yet to be addressed: "Resident takes medications CRUSHED: This resident is receiving the following medication(s) which can not be crushed: * Venlafaxine ER (extended release) and Potassium Chloride ER. Please document that the resident can swallow this drug, and have "DO NOT CRUSH" added to the MAR (medication administration record) for this med or, if cannot swallow whole, please contact the provider to change this med to a crushable/liquid form. Potassium tablet cannot be crushed, they can however be slurried in a small amount of liquid- please add "DO NOT CRUSH" to this medication on the MAR to prevent a medication error-..." * This resident has an allergy listed to acetaminophen but this drug is [her/his] eMAR. Please consider deleting this allergy from the clinical record, OR add information to the allergy tab which such as prior symptoms and why he now tolerates this form." Pharmacist recommendations made on 9/14/2021 state "These recommendations are overdue. They have been duplicated and will appear with this months recommendations" The recommendations continue to identify the irregularities noted on the 8/19/2021 recommendations.	F 756		

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F 756	Continued From page 6 Pharmacist recommendations made on 10/12/2021 continue to identify the irregularities noted in the 8/19/2021 and 9/14/2021 recommendations. The current 12/1 - 12/301/2021 MAR continues to reflect: Potassium Chloride ER Tablet Extended Release 20 MEQ Give 1 tablet by mouth one time a day for supplement Venlafaxine HCl ER Tablet Extended Release 24 Hour 150 MG Give 150 mg by mouth one time a day Acetaminophen Tablet 325 MG Give 325 mg by mouth every 6 hours as needed for pain management two tablets by mouth every 6 hrs. as needed by mouth pain 1-10 Per interview with the DON on 12/10/2021 at 11:00 AM s/he confirmed that the pharmacy recommendations had not been addressed per the regulatory requirements. There is no evidence in the medical record that the physician reviewed, acted on, or documented rationale to continue with the medications as ordered based on the recommendations made.	F 756		