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

April 8, 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 recertification survey conducted on **March 9, 2022.** 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 _____	03/09/2022

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 The Division of Licensing and Protection conducted an unannounced emergency preparedness survey from 03/06/22 through 03/09/22. The following regulatory violations were identified:	E 000	Springfield Rivers Health and Rehab 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 applicable law.	04/22/22
E 036 SS=C	EP Training and Testing CFR(s): 483.73(d) §403.748(d), §416.54(d), §418.113(d), §441.184(d), §460.84(d), §482.15(d), §483.73(d), §483.475(d), §484.102(d), §485.68(d), §485.625(d), §485.727(d), §485.920(d), §486.360(d), §491.12(d), §494.62(d). *[For RNCHIs at §403.748, ASCs at §416.54, Hospice at §418.113, PRTFs at §441.184, PACE at §460.84, Hospitals at §482.15, HHAs at §484.102, CORFs at §485.68, CAHs at §486.625, "Organizations" under 485.727, CMHCs at §485.920, OPOs at §486.360, and RHC/FHQs at §491.12:] (d) Training and testing. The [facility] must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least every 2 years. *[For LTC facilities at §483.73(d):] (d) Training and testing. The LTC facility must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of	E 036	E 036 EP Training Program The Administrator has been educated on the requirements of CFR(s): 483.73(d) EP Training and Testing and Genesis Policy 1.22 Emergency Preparedness. The facility will develop and maintain an emergency preparedness training and testing program that is based on the emergency plan from the risk assessment, policies and procedures and a communication plan. The training and testing program will be reviewed and updated at least annually. The EP Training Program will be presented to the QAPI team for review and recommendations as needed. **TAG E 036 POC Accepted by G. Mercure/P. Cota on 4/7/22**	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Christopher Phillips | Administrator | 4/07/22

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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E 036	Continued From page 1	E 036		

this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least annually.

*[For ICF/IIDs at §483.475(d):] Training and testing. The ICF/IID must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least every 2 years. The ICF/IID must meet the requirements for evacuation drills and training at §483.470(i).

*[For ESRD Facilities at §494.62(d):] Training, testing, and orientation. The dialysis facility must develop and maintain an emergency preparedness training, testing and patient orientation program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training, testing and orientation program must be evaluated and updated at every 2 years.
This REQUIREMENT is not met as evidenced by:
Based on review of the facilities Emergency Preparedness documentation, the facility failed to DEVELOP an Emergency Preparedness training and testing PROGRAM related to the emergency plan, risk assessment, policies and procedures

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E 036	Continued From page 2 and the communication plan to be reviewed and updated on a yearly basis. Findings Include: Per review of the facility's Emergency Preparedness documentation kept in a red binder, there was no evidence of any training/testing program for all staff regarding the emergency plan, risk assessment, policies and procedures and the communication plan for the year 2021. This was confirmed by the Maintenance Director on 03/09/22 at approximately 02:30PM.	E 036		
E 037 SS=C	EP Training Program CFR(s): 483.73(d)(1) §403.748(d)(1), §416.54(d)(1), §418.113(d)(1), §441.184(d)(1), §460.84(d)(1), §482.15(d)(1), §483.73(d)(1), §483.475(d)(1), §484.102(d)(1), §485.68(d)(1), §485.625(d)(1), §485.727(d)(1), §485.920(d)(1), §486.360(d)(1), §491.12(d)(1). *[For RNCHIs at §403.748, ASCs at §416.54, Hospitals at §482.15, ICF/IIDs at §483.475, HHAs at §484.102, "Organizations" under §485.727, OPOs at §486.360, RHC/FQHCs at §491.12:] (1) Training program. The [facility] must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of all emergency preparedness training.	E 037	E307 EP Training Program The Administrator and Maintenance Director were re-educated on the EP Training Program CFR 483.73(d)(1). The Facility Maintenance director will conduct staff training regarding Emergency Preparedness policies and procedures to all new and existing staff, and individuals providing services under arrangement and an annual basis thereafter. House wide education was conducted on the EP policies and procedures. The Administrator or designee will conduct random weekly audits or X 4 and monthly X 2. of all new hires to ensure continued compliance. These audit results will be reviewed at QAPI for any further interventions.	

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E 037	Continued From page 3 (iv) Demonstrate staff knowledge of emergency procedures. (v) If the emergency preparedness policies and procedures are significantly updated, the [facility] must conduct training on the updated policies and procedures. *[For Hospices at §418.113(d):] (1) Training. The hospice must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing hospice employees, and individuals providing services under arrangement, consistent with their expected roles. (ii) Demonstrate staff knowledge of emergency procedures. (iii) Provide emergency preparedness training at least every 2 years. (iv) Periodically review and rehearse its emergency preparedness plan with hospice employees (including nonemployee staff), with special emphasis placed on carrying out the procedures necessary to protect patients and others. (v) Maintain documentation of all emergency preparedness training. (vi) If the emergency preparedness policies and procedures are significantly updated, the hospice must conduct training on the updated policies and procedures. *[For PRTFs at §441.184(d):] (1) Training program. The PRTF must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles.	E 037	**TAG E 037 POC Accepted by G. Mercure/P. Cota on 4/7/22**	

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E 037	Continued From page 4 (ii) After initial training, provide emergency preparedness training every 2 years. (iii) Demonstrate staff knowledge of emergency procedures. (iv) Maintain documentation of all emergency preparedness training. (v) If the emergency preparedness policies and procedures are significantly updated, the PRTF must conduct training on the updated policies and procedures. *[For PACE at §460.84(d):] (1) The PACE organization must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing on-site services under arrangement, contractors, participants, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Demonstrate staff knowledge of emergency procedures, including informing participants of what to do, where to go, and whom to contact in case of an emergency. (iv) Maintain documentation of all training. (v) If the emergency preparedness policies and procedures are significantly updated, the PACE must conduct training on the updated policies and procedures. *[For LTC Facilities at §483.73(d):] (1) Training Program. The LTC facility must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected role.	E 037		

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E 037	Continued From page 5 (ii) Provide emergency preparedness training at least annually. (iii) Maintain documentation of all emergency preparedness training. (iv) Demonstrate staff knowledge of emergency procedures. *[For CORFs at §485.68(d):](1) Training. The CORF must do all of the following: (i) Provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. All new personnel must be oriented and assigned specific responsibilities regarding the CORF's emergency plan within 2 weeks of their first workday. The training program must include instruction in the location and use of alarm systems and signals and firefighting equipment. (v) If the emergency preparedness policies and procedures are significantly updated, the CORF must conduct training on the updated policies and procedures. *[For CAHs at §485.625(d):] (1) Training program. The CAH must do all of the following: (i) Initial training in emergency preparedness policies and procedures, including prompt reporting and extinguishing of fires, protection, and where necessary, evacuation of patients, personnel, and guests, fire prevention, and cooperation with firefighting and disaster	E 037		

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E 037	Continued From page 6	E 037		

authorities, to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles.
(ii) Provide emergency preparedness training at least every 2 years.
(iii) Maintain documentation of the training.
(iv) Demonstrate staff knowledge of emergency procedures.
(v) If the emergency preparedness policies and procedures are significantly updated, the CAH must conduct training on the updated policies and procedures.

*[For CMHCs at §485.920(d):] (1) Training. The CMHC must provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles, and maintain documentation of the training. The CMHC must demonstrate staff knowledge of emergency procedures. Thereafter, the CMHC must provide emergency preparedness training at least every 2 years.
This REQUIREMENT is not met as evidenced by:
Based on review of the facility Emergency Preparedness documentation, the facility failed to offer INITIAL training regarding Emergency Preparedness policies and procedures to all new and existing staff, and individuals providing services under arrangement and on an annual basis thereafter.
Findings Include:

Per review of the facility's Emergency Preparedness documentation kept in a red binder, there was no evidence of any ACTUAL

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E 037	Continued From page 7 training regarding Emergency Preparedness policies and procedures to all new and existing staff and individuals providing services under arrangement for the year 2021. This was confirmed by the Maintenance Director on 03/09/22 at approximately 02:30PM.	E 037		
E 039 SS=C	EP Testing Requirements CFR(s): 483.73(d)(2) §416.54(d)(2), §418.113(d)(2), §441.184(d)(2), §460.84(d)(2), §482.15(d)(2), §483.73(d)(2), §483.475(d)(2), §484.102(d)(2), §485.68(d)(2), §485.625(d)(2), §485.727(d)(2), §485.920(d)(2), §491.12(d)(2), §494.62(d)(2). *[For ASCs at §416.54, CORFs at §485.68, OPO, "Organizations" under §485.727, CMHCs at §485.920, RHCs/FQHCs at §491.12, and ESRD Facilities at §494.62]: (2) Testing. The [facility] must conduct exercises to test the emergency plan annually. The [facility] must do all of the following: (i) Participate in a full-scale exercise that is community-based every 2 years; or (A) When a community-based exercise is not accessible, conduct a facility-based functional exercise every 2 years; or (B) If the [facility] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required community-based or individual, facility-based functional exercise following the onset of the actual event. (ii) Conduct an additional exercise at least every 2 years, opposite the year the full-scale or	E 039	E039 EP Testing Requirements All residents have potential to be affected by the alleged deficient practice. The facility has conducted a community based to tabletop exercise as required. The Emergency Preparedness Drill is scheduled to be conducted with City of Springfield Fire Department Fire Chief Russ Thompson on April 7, 2022. The Administrator and Maintenance Director have has been reeducated on EP Testing Requirements CFR 483. 73 (d)(2). The Administrator will provide completed drill information to the Regional Director of Operations upon completion of this plan of correction. The drill and table top exercise summaries will be brought to QAPI for review and interventions if needed.	

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E 039	Continued From page 8 functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [facility's] emergency plan, as needed. *[For Hospices at 418.113(d):] (2) Testing for hospices that provide care in the patient's home. The hospice must conduct exercises to test the emergency plan at least annually. The hospice must do the following: (i) Participate in a full-scale exercise that is community based every 2 years; or (A) When a community based exercise is not accessible, conduct an individual facility based functional exercise every 2 years; or (B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospital is exempt from engaging in its next required full scale community-based exercise or individual facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section	E 039	**TAG E 039 POC Accepted by G. Mercure/P. Cota on 4/7/22**	

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E 039	Continued From page 9	E 039		

is conducted, that may include, but is not limited to the following:
(A) A second full-scale exercise that is community-based or a facility based functional exercise; or
(B) A mock disaster drill; or
(C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.

(3) Testing for hospices that provide inpatient care directly. The hospice must conduct exercises to test the emergency plan twice per year. The hospice must do the following:
(i) Participate in an annual full-scale exercise that is community-based; or
(A) When a community-based exercise is not accessible, conduct an annual individual facility-based functional exercise; or
(B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospice is exempt from engaging in its next required full-scale community based or facility-based functional exercise following the onset of the emergency event.
(ii) Conduct an additional annual exercise that may include, but is not limited to the following:
(A) A second full-scale exercise that is community-based or a facility based functional exercise; or
(B) A mock disaster drill; or
(C) A tabletop exercise or workshop led by a facilitator that includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed

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E 039	Continued From page 10	E 039		

messages, or prepared questions designed to challenge an emergency plan.
(iii) Analyze the hospice's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the hospice's emergency plan, as needed.

*[For PRFTs at §441.184(d), Hospitals at §482.15(d), CAHs at §485.625(d):]
(2) Testing. The [PRTF, Hospital, CAH] must conduct exercises to test the emergency plan twice per year. The [PRTF, Hospital, CAH] must do the following:
(i) Participate in an annual full-scale exercise that is community-based; or
(A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or
(B) If the [PRTF, Hospital, CAH] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event.
(ii) Conduct an [additional] annual exercise or and that may include, but is not limited to the following:
(A) A second full-scale exercise that is community-based or individual, a facility-based functional exercise; or
(B) A mock disaster drill; or
(C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared

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E 039	Continued From page 11	E 039		

questions designed to challenge an emergency plan.

(iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the [facility's] emergency plan, as needed.

*[For PACE at §460.84(d):]
(2) Testing. The PACE organization must conduct exercises to test the emergency plan at least annually. The PACE organization must do the following:
(i) Participate in an annual full-scale exercise that is community-based; or
(A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or
(B) If the PACE experiences an actual natural or man-made emergency that requires activation of the emergency plan, the PACE is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event.

(ii) Conduct an additional exercise every 2 years opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted that may include, but is not limited to the following:
(A) A second full-scale exercise that is community-based or individual, a facility based functional exercise; or
(B) A mock disaster drill; or
(C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions

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 _____	03/09/2022

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 039	Continued From page 12	E 039		

designed to challenge an emergency plan.
(iii) Analyze the PACE's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the PACE's emergency plan, as needed.

*[For LTC Facilities at §483.73(d):]
(2) The [LTC facility] must conduct exercises to test the emergency plan at least twice per year, including unannounced staff drills using the emergency procedures. The [LTC facility, ICF/IID] must do the following:
(i) Participate in an annual full-scale exercise that is community-based; or
(A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise.
(B) If the [LTC facility] facility experiences an actual natural or man-made emergency that requires activation of the emergency plan, the LTC facility is exempt from engaging its next required a full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event.
(ii) Conduct an additional annual exercise that may include, but is not limited to the following:
(A) A second full-scale exercise that is community-based or an individual, facility based functional exercise; or
(B) A mock disaster drill; or
(C) A tabletop exercise or workshop that is led by a facilitator includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.
(iii) Analyze the [LTC facility] facility's response to and maintain documentation of all drills, tabletop

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 _____	03/09/2022

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

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E 039	Continued From page 13	E 039		

exercises, and emergency events, and revise the [LTC facility] facility's emergency plan, as needed.

*[For ICF/IIDs at §483.475(d)]:
(2) Testing. The ICF/IID must conduct exercises to test the emergency plan at least twice per year. The ICF/IID must do the following:
(i) Participate in an annual full-scale exercise that is community-based; or
(A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or.
(B) If the ICF/IID experiences an actual natural or man-made emergency that requires activation of the emergency plan, the ICF/IID is exempt from engaging in its next required full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event.
(ii) Conduct an additional annual exercise that may include, but is not limited to the following:
(A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or
(B) A mock disaster drill; or
(C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.
(iii) Analyze the ICF/IID's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the ICF/IID's emergency plan, as needed.

*[For HHAs at §484.102]
(d)(2) Testing. The HHA must conduct exercises

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 _____	03/09/2022

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 039	Continued From page 14	E 039		

to test the emergency plan at least annually. The HHA must do the following:
(i) Participate in a full-scale exercise that is community-based; or

(A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise every 2 years; or.

(B) If the HHA experiences an actual natural or man-made emergency that requires activation of the emergency plan, the HHA is exempt from engaging in its next required full-scale community-based or individual, facility based functional exercise following the onset of the emergency event.
(ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following:

(A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or

(B) A mock disaster drill; or

(C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.
(iii) Analyze the HHA's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the HHA's emergency plan, as needed.

*[For OPOs at §486.360]
(d)(2) Testing. The OPO must conduct exercises

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 _____	03/09/2022

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 039	Continued From page 15 to test the emergency plan. The OPO must do the following: (i) Conduct a paper-based, tabletop exercise or workshop at least annually. A tabletop exercise is led by a facilitator and includes a group discussion, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. If the OPO experiences an actual natural or man-made emergency that requires activation of the emergency plan, the OPO is exempt from engaging in its next required testing exercise following the onset of the emergency event. (ii) Analyze the OPO's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the [RNHCI's and OPO's] emergency plan, as needed. *[RNCHIs at §403.748]: (d)(2) Testing. The RNHCI must conduct exercises to test the emergency plan. The RNHCI must do the following: (i) Conduct a paper-based, tabletop exercise at least annually. A tabletop exercise is a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (ii) Analyze the RNHCI's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the RNHCI's emergency plan, as needed. This REQUIREMENT is not met as evidenced by: Based on review of the facilities Emergency Preparedness documentation, the facility failed to CONDUCT exercises twice a year (one full	E 039		

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	475025	A. BUILDING _____ B. WING _____	03/09/2022

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

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E 039	Continued From page 16 scale/community based and another mock drill, tab- top or workshop) to test the facility's emergency plan. Findings Include: Per review of the facility's Emergency Preparedness documentation kept in a red binder, there was no evidence of two annual exercise trainings for the year 2021. This was confirmed by the Maintenance Director on 03/09/22 at approximately 02:30PM.	E 039	F584 All residents who reside on Unit 2 West are at risk for this alleged deficient practice. A team was brought in to conduct house wide cleaning for an immediate fix. The Administrator and Director of Housekeeping were reeducated on providing a clean and homelike environment for the residents. A complete room schedule was created for complete room cleans and will be reviewed daily at morning meeting. Environmental rounds will be conducted by the Administrator and the Director of Housekeeping for random weekly audits X 4 and monthly X 2. The results of these audits will be brought to QAPI and reviewed for further interventions if needed. The facility has now raised it's hourly rates for housekeeping, offered sign on bonuses and conducted another round of community outreach for recruits in efforts to fulfill staffing needs.	
F 000	INITIAL COMMENTS The Division of Licensing and Protection conducted an unannounced recertification survey from 03/06/22 through 03/09/22. The following regulatory violations were identified:	F 000		
F 584 SS=E	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss	F 584		

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	475025	A. BUILDING _____ B. WING _____	03/09/2022

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
F 584	Continued From page 17 or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation and staff interviews, the facility failed to provide a clean and homelike environment for the residents who reside on Unit 2 West. Findings include: 1. Per initial facility tour (1st and 2nd floors), on 03/06/22 at approximately 3:30 PM, all floors, including halls, resident rooms and dining-rooms were dirty. There were areas of dried-up spilled contents (pink in color) in the hall and the dining-room of the first floor along with other debris such a straw wrappers and paper pieces and used medication cups in various resident rooms.	F 584	**TAG F 584 POC Accepted by G. Mercure/P. Cota on 4/7/22**	

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 _____	03/09/2022

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 584	Continued From page 18	F 584		

Per interview on 03/06/22 at 6:30 PM with the DON, "Our house-keeping staff have not been able to keep up." It was confirmed that the floors needed attention.

2. During observation of Unit 2 on 3/7/22 from 11:00 AM- 1:00 PM, all 12 resident rooms #214-#226 of the West hallway had extremely dirty floors, many with scattered food, spilled beverages, papers, plastic tags, locked cabinets for personal belongings, and dust coated furniture and wall heaters. The following condition of the West Unit's rooms were identified:

Room #214 furniture was heavily covered in dust, a cookie was on the floor, and the bathroom sink had rust colored staining around the drain.
Room #215 dust on dresser and rust colored stain in the drain of the sink.
Room #216 floor with dirt and food particles and dust on the dresser.
Room #218 a urinal was on the floor and the sink in the bathroom had rust colored staining around the sink drain. Resident was in the bed with the sheets off the head of the bed.
Room #219 a fracture pan (bedpan) was on the floor under the resident's bed and a urinal on the floor. Resident in bed with the fitted sheet off the foot of the bed to mid mattress.
Room #220 The floor inside the room was very dirty with visible dirt and debris through the entire room.
Room #221 dirt, food, and papers on the floors under the bed.
Room #223 two residents were observed in the room. One in bed and the other sitting in a chair. There was an over bed table with spilled liquid which appeared to be chocolate milk on the plate, the table, and the floor. The mattress of the

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 _____	03/09/2022

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
F 584	Continued From page 19	F 584		

empty bed had no linens on it and there were multiple areas of brown smears. There were two large, plastic cabinets, with dial pad locks keeping the doors shut. There were also two bureaus that has child locks on the out sides of each drawer. The bathroom sink had rust-colored stains around drain and at faucets.
Room #226 had a strong odor, there were 6 unopened cans of refried beans on the wall heater, and the floor had dried spill marks on it.
On 3/8/2022 at approximately 9:30 AM, the housekeeping manager was observed sweeping two large piles of dirt and debris from the floor.

Per interview with the Unit Manager on 3/7/2022 at 3:30 PM housekeeping has been struggling with staff. S/he confirmed that the resident rooms were not as clean as they should be. When asked why the residents in room #223 had locks on the cabinets and dressers s/he stated it was to keep them from getting in them and ruining their stuff.

Per interview a contract Licensed Practical Nurse (LPN) on 3/9/2020 at a 4:00 PM s/he has been assigned to the facility since December 2021. The LPN stated "when I first started here, I almost asked my agency for a different assignment. It was so dirty, it is not good for what we do here."

Per interview with the housekeeping manager on 3/9/22 at approximately 4:30 PM the house keeping department has not been fully staffed. Attempts have been made to hire new staff, but they have had difficulty hiring and/or keeping staff. The housekeeping manager had cleaned all the rooms on 2 West on 3/8/2022. S/he confirmed that before that the rooms on 2 West

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 _____	03/09/2022

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 584	Continued From page 20 were very dirty and unkept prior to that. 3. Per record review both residents who reside in room #220 (Resident #20 and #22) have diagnoses of Alzheimer's/Dementia. During the initial observation on 3/7/2022 at approximately 11:00 AM the door to room # 220 was noted to have a bookcase door decal covering the door to the room, and a black surface, the approximate size of a door mat on the floor at the entrance to the room (both are used as interventions to detour residents with dementia from entering or passing an area). Per interview with the Unit Manager on 3/9/2022 at 8:30 AM s/he did not know why the decal and black floor covering were placed there. S/he reported that both residents do exit the room. However, s/he did confirm that they are typically used as a deterrence for dementia residents. When Resident #20 was asked by this surveyor what the black space was for s/he stated "I don't know maybe to keep people from going there. To tell them hey, don't do that." On 3/9/2022 at 3:40 PM the black floor covering had been removed. Unit Manager confirmed that the door decal and black surface had been implemented when a different resident resided in room #220, and that it had not been removed to accommodate residents #20 and #22.	F 584		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must:	F 609	F609 Resident #28 still resides at facility and have their needs met. All residents that are care planned for two caregivers due to accusatory behaviors are at risk for this alleged deficient practice.	

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 _____	03/09/2022

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
F 609	Continued From page 21 §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on resident and staff interview, and record review, the facility failed to report and allegation of verbal abuse by a staff member towards a resident to the State Survey Agency or Adult Protection Service for one (1) of four (4) sampled residents. Findings include: Per record review, resident #28 admitted to the facility on 01/22/19 with the following diagnoses: Morbid obesity, bipolar disorder, seizure-like	F 609	A house wide audit was conducted on all residents who have a care-plan of two care-givers due to accusatory behaviors. All staff were re-educated on the Abuse Policy and all allegations of abuse, even from a "known accuser", are to be reported through the proper channels and investigated even if the resident is care-planned as having this known behavior. The Director of Nursing or designee will conduct random weekly audits X 4 and then monthly X 2. These audit results will be brought to the QAPI team for review and recommendations as needed **TAG F 609 POC Accepted by G. Mercure/P. Cota on 4/7/22**	

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 _____	03/09/2022

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 609	Continued From page 22	F 609		

activity psychogenic, Type II diabetes, COPD, abusive head trauma, history of back surgery, hypertension, migraine, history of bilateral humerus fracture, failed arthroplasty, and history of respiratory failure.

The care plan for this resident has the following problem noted: ADL (activities of daily living) self-care performance deficit related to osteomyelitis of right shoulder, and impaired mobility. The associated intervention: Requires extensive to total assist with ADL's, totally dependent on staff to provide a shower.

The Multiple Data Set (MDS) assessment of 01/12/22, section E notes no psychosis, and no behavioral indicators for this resident.

On 03/07/22 12:29 PM during interview with this resident, she stated "The second shift has travelers (this refers to traveling staff who are employed by contract through an outside agency) who show me no respect, do not answer my bell and when they come in, they are rude. Last week a Licensed Nursing Assistant (LNA) gave me a shower and refused to wash my body, and washed only my hair because [he/she] was short on time, [she/he] told me to shut the F up. [He/she]'s a big [boy/girl] and I'm frightened of [him/her]."

Resident reported this incident to two staff. One staff member is a nurse and one is an LNA but the resident was unable to recall the names of whom she/he reported to. All of these staff still work in the facility per the resident, but she/he believes this particular LNA is working on another floor.

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 _____	03/09/2022

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
F 609	Continued From page 23 On 03/07/22 at 04:28 PM, interview with the Director of Nursing Services (DNS] reveals he/she was aware of this complaint and conducted an investigation without findings. There is no written record of this investigation per the DNS. The DNS further stated this was an unfounded complaint, and the LNA was moved to another floor to avoid irritating the resident. This was not reported to the State per the DNS "because, this resident exhibits accusatory behavior and is care planned for it". The DNS confirmed she had not reported this incident to the State Survey Agency or to Adult Protective Services.	F 609		
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	F623 All residents who are discharged or transferred are at risk for this alleged deficient practice. A house wide audit was conducted on all residents in the last six months who transferred out of the facility for compliance. The Administrator, DNS, Social Service Director, Admissions Coordinator and Business office Manager were educated on the OPS404 Discharge/Bed Hold Policy. The Administrator or designee will conduct random weekly audits X 4 and then monthly X 2 of all discharges to ensure proper documentation of transfer or discharge notifications and Ombbudsman notification. The audit results will be brought to the QAPI team for review and recommendations as needed.	

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 _____	03/09/2022

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
F 623	Continued From page 24 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	F 623	**TAG F 623 POC Accepted by G. Mercure/P. Cota on 4/7/22**	

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 _____	03/09/2022

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F 623	Continued From page 25	F 623		

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 review of an Admission/Discharge To/From Report, and the facility's policy & procedure "OPS404 Discharge and Transfer", the facility failed to notify residents and/or their representatives of a transfer or

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F 623	Continued From page 26 discharge. Findings include: Per review of the facility Admission/Discharge To/From Report (Discharges 09/01/21 through 03/06/22) displays a list of residents admitted to the hospital in the past 6 months. There is no documentation to show that the facility provided a written notice of transfer to these residents or their representatives or a copy of the notice of transfer/discharge to the Long -Term Care Ombudsman. The Director of Nursing (DON) confirmed that written notices had not been provided per interview on 03/09/22 at 08:45 AM.	F 623		
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 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.	F 625	F625 All residents who are discharged or transferred are at risk for this alleged deficient practice. A house wide audit was conducted on all residents in the last six months who transferred out of the facility for compliance. The Administrator, DNS, Social Service Director, Admissions Coordinator and Business office Manager were educated on the OPS404 Discharge/Bed Hold Policy. The Administrator or designee will conduct random weekly audits X 4 and then monthly X 2 of all discharges to ensure proper documentation of transfer or discharge notifications and Ombbudsman notification. The audit results will be brought to the QAPI team for review and recommendations as needed.	

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	475025	A. BUILDING _____ B. WING _____	03/09/2022

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F 625	Continued From page 27 §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 review of an Admission/Discharge To/From Report, and the facility's policy & procedure "OPS404 Discharge and Transfer", the facility failed to provide a written copy of a Bed Hold Policy Notice to residents and/or their representatives prior to transfer or discharge or in case of emergency, with-in 24 hours. Findings include: Per review of the facility Admission/Discharge To/From Report (Discharges 09/01/21 through 03/06/22) displays a list of residents admitted to the hospital in the past 6 months. There is no documentation to show that the facility provided resident's and/or their representatives written bed hold policy notices. Per interview on 03/09/22 at 08:45 AM, The Director of Nursing (DON) confirmed that there was no documentation to show that bed hold policy notices had been given to residents and/or their representatives.	F 625	**TAG F 625 POC Accepted by G. Mercure/P. Cota on 4/7/22**	
F 637 SS=D	Comprehensive Assessment After Signifcant Chg CFR(s): 483.20(b)(2)(ii) §483.20(b)(2)(ii) Within 14 days after the facility determines, or should have determined, that there has been a significant change in the	F 637		

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F 637	Continued From page 28 resident's physical or mental condition. (For purpose of this section, a "significant change" means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and record review the facility failed to ensure that a resident who experienced a significant change was comprehensively assessed using the CMS - specified Resident Assessment Instrument (RAI) process (MDS). Findings include: Per record review resident #69 experienced a significant decline in their ability to perform 7 of their activities of daily living (ADLs). A Quarterly MDS dated 1/10/22 reflects that the resident required the following assistance: * Bed mobility: Supervision (oversight, encouragement or cueing) with one physical assist; * Walk in room: Independent; * Transfer: Supervision with setup; * Dressing: Limited assist of one staff member; * Eating: Independent (resident involved in activity, staff provide weight-bearing support) Supervision; * Toilet: Supervise Setup; * Personal Hygiene: Limited assist of one staff member.	F 637	F637 Resident #69 continues to reside at the facility and has had her MDS reviewed for accuracy. All residents who experience a significant change in status are at risk for this alleged deficient practice. A house wide audit was conducted on all residents who have had a significant change for appropriate and timely comprehensive assessment. The MDS RN and LPN were re-educated on following the RAI manual for significant changes and comprehensive assessments. The Director of Nursing or designee will conduct random weekly audits X 4 and then monthly X 2. The audit results will be brought to the QAPI team for review and recommendations as needed. **TAG F 637 POC Accepted by G. Mercure/P. Cota on 4/7/22**	

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F 637	Continued From page 29 A Quarterly MDS dated 2/15/2022 reflects: * Bed Mobility: Extensive assist of 1 staff member (resident involved in activity, staff provide weight-bearing support.); * Walk in room: Total dependant of on staff; * Dressing: Extensive assist of one staff member; * Transfer: Extensive assist of 2 staff members; * Eating: Supervision of 1 staff member; * Toilet: Total Dependent (full staff performance every time during entire 7-day period) of 1 staff member; * Personal Hygiene: Extensive assist of on staff member. Per interview with the Unit Manager on 3/9/2022 at 3:29 PM the resident had previously been able to ambulate independently. S/he had a fall and has not been able to since. The UM confirmed that a significant change in status had not been identified, and that a significant change MDS should have been completed.	F 637		
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	F 656	F656 Resident # 69, #33and #17continue to reside at the facility and have had their care-plans updated for accuracy. All residents who reside at the facility are at risk for this alleged deficient practice. A house wide audit of all residents care-plan's for weight loss, tray tables not being left in rooms and scoop mattresses have been completed and updated.	

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F 656	Continued From page 30 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 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 observations, staff interview, and record review, the facility failed to develop or implement a person-centered comprehensive care plan for 3 residents in the applicable sample. (Resident #33, #69, and #17). Findings include: 1. Per record review, resident #69 experienced an increase in care needs. A care plan focus for ADL (Activities of daily living) self care deficit reflects that s/he requires:	F 656	All Licensed Nurses were re-educated Policy OPS416 Person Centered Care Plans. The Director of Nursing or designee will conduct random weekly audits X 4 and then monthly X 2. These audit results will be brought to the QAPI team for review and recommendations as needed. **TAG F 656 POC Accepted by G. Mercure/P. Cota on 4/7/22**	

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F 656	Continued From page 31	F 656		

Bed Mobility- Independent with reposition and turn in bed (Initiated on 3/7/2021).
Mobility- reminders to use walker for ambulation in room and in halls (Initiated 8/18/2021 and revised on 10/16/2021).
Dressing- 1 limited staff participation to dress (Initiated 3/7/2021).
Transfer- independent for transfers (Initiated on 3/7/2021 and revised 10/16/2021).
Eating 1 set up staff participation
Toilet use- 1 assist limited (Initiated on 3/7/2021 and revised 4/10/2021).
Personal Hygiene- 1 set up/cueing staff participation with personal hygiene and oral care (Initiated 3/7/2021).

The Quarterly MDS dated 2/15/2022 reflects that the resident requires:
* Bed Mobility- Extensive assist of 1 staff member (resident involved in activity, staff provide weight-bearing support.)
* Walk in room- Total dependant of on staff.
* Dressing- Extensive assist of one staff member.
* Transfer- Extensive assist of 2 staff members.
* Eating- Supervision of 1 staff member.
* Toilet- Total Dependent (full staff performance every time during entire 7-day period) of 1 staff member.
* Personal Hygiene - Extensive assist of on staff member.

During interview with the Unit Manager on 3/9/2022 at 3:29 PM s/he confirmed that Resident #69 had experienced a decline in ADL performance, and that the care plan had not been updated to reflect the residents current ADL needs.

2. Per record review, Resident #33's weights

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F 656	Continued From page 32	F 656		

indicate a 27.5% significant weight loss from 142.0 lbs on 9/29/21 down to 103.0 lbs on 2/1/22. MDS significant change completed on 1/18/2022 indicates extensive assistance of one for eating. 1/15/22 Progress note states resident "is needing more assistance with ADL needs to be feed. Sleeping more and less time walking the Hall. Will look in to a referral for Therapy." The current Physicians Orders reflect regular diet, regular texture, thin consistency; House Supplement four times a day; every shift Offer fluids and snacks; May follow RD recommendations for regular texture therapeutic diet changes, nutritional supplements, small or large portions of meals, fortified foods, weight orders, vitamin and mineral supplementation. Give bedtime snack and document amount consumed at bedtime. The most recent care plan dated 2/17/22 does not address nutrition risks, weight loss, or needed eating assistance.

During interview on 03/09/22 at 3:47 PM the Unit Manager confirmed that the resident had a significant weight loss and it was not reflected in the care plan.

3. Per review of resident #17's record, a Nursing note dated 12/15/2021 at 10:55 PM states "went to patients room and noted tray table laying on the floor on its side in front of patients feet. blood noted on the ground and left foot 2.5inch laceration noted on left big toe, bleeding stopped and dcd (dry clean dressing) applied..." The most recent care plan dated 1/14/2022 states "tray table to remain in the room for meals only, please remove when meals are done," as an intervention for impaired cognitive function and "scoop mattress for bed safety," as an intervention for falls.

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F 656	Continued From page 33 Per multiple observations on 3/7/2022 through 3/9/2022, a table tray was located in resident #17's room while they were not being served food. There was also a regular, non-scoop mattress at every observation. During interview with the Unit Manager (UM) on 3/8/22, at 3:51 PM, s/he confirmed that Resident #17's care plan reflects the tray tables are not supposed to be left in the room. S/he also confirmed that Resident #17 is care planned for a scoop mattress however, s/he does not need a scoop mattress. The UM stated "that shouldn't be on the care plan."	F 656		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure the accuracy of administering the correct medication or dosage to one resident (#51) out of 25 opportunities for medication errors. Findings include: Observation of the evening medication pass on first floor, A unit on 03/06/22 at approximately 07:00 PM, revealed that the nurse drew up 18 Units of insulin for resident (#51) as prescribed, from another resident's (# 44) medication supply	F 658	F658 Resident #51 continues to reside at the facility. All residents who reside at the facility that have a prescription for insulin are at risk for this alleged deficient practice. The individual nurse was provided individual education and med pass competency. House-wide competencies were completed with all nurses on insulin administration. All licensed nurses were reeducated on the 5 rights of medication administration and Policy NRS305 Medication Administration - General. The Director of Nursing or designee will conduct random weekly audits X 4 and then monthly X 2. The audit results will be brought to the QAPI team for review and recommendations as needed.	

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F 658	Continued From page 34 of Lantus Solution 100 UNIT/ML (Insulin Glargine). This is the same medication as prescribed for resident #51, however it did not belong to him/her. This surveyor alerted the nurse that she/he drew up the medication from the wrong vial. The nurse proceeded to move forward to give what had been drawn up since it was the same prescribed medication. When asked if resident #51 had any of her own insulin, the nurse went to the back up closet to look. She/he returned empty handed and looked again in the medication cart. She/he found the correct vial of insulin belonging to resident #51. She disposed of the initial drawn up solution in the syringe and started over. This nurse confirmed on 03/06/22 at 07:00 PM that she/he was going to use medication that belonged to another resident which goes against professional standards. Reference: Lippincott Manual of Nursing Practice 19th edition. Wolters Kluwer Health/Lippincott Williams, Page 17.	F 658	**TAG F 658 POC Accepted by G. Mercure/P. Cota on 4/7/22**	
F 687 SS=E	Foot Care CFR(s): 483.25(b)(2)(i)(ii) §483.25(b)(2) Foot care. To ensure that residents receive proper treatment and care to maintain mobility and good foot health, the facility must: (i) Provide foot care and treatment, in accordance with professional standards of practice, including to prevent complications from the resident's medical condition(s) and (ii) If necessary, assist the resident in making appointments with a qualified person, and arranging for transportation to and from such	F 687	F687 Resident #17 continues to reside at the facility and have their needs met. All residents who reside at the facility that have a need for podiatry services are at risk for this alleged deficient practice.	

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F 687	Continued From page 35 appointments. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and record review the facility failed to ensure that 1 resident in the applicable sample (Resident #17) received proper foot care. Findings include: Per observation on 3/7/22 at 2:30 PM, resident #17 was sitting barefoot in a chair. His/her feet were covered in what appeared to be dried chocolate milk and dirt. His/her feet were slightly red, and toenails were long and thick. Per record review: The most recent podiatry note dated 7/22/21 states nursing to ensure proper foot care and foot gear. Current orders state: Consult Podiatry - Evaluate and Treat as needed. The 1/14/22 Care Plan includes "skin checks each shift, report any changes." There are no progress notes about the condition of resident #17's feet or care since the last podiatry appointment except for two notes regarding a laceration on her/his toe in December 2021. Weekly skin reviews for February and March do not have any notes about the resident's feet. Per interview with Unit Manager on 3/9/22 at 1:10 PM podiatry did not come the past few times because of COVID. Skin reviews are done weekly by nursing and that is when her feet would be assessed. Per observation in the presence of the Unit Manager on 3/9/22 at 1:15 PM, resident #17 allowed the Unit Manager to take his/her socks off and reported not to have any foot pain. The	F 687	A house wide audit of all residents toenails has been completed and all issues found were addressed accordingly and weekly skin sheets updated. All Licensed nurses and LNA's were reeducated on OPS166 Nail Care Policy. The Director of Nursing or designee will conduct random weekly audits X 4 and then monthly X 2. These audit results will be brought to the QAPI team for review and recommendations as needed. **TAG F 687 POC Accepted by G. Mercure/P. Cota on 4/7/22**	

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	475025	A. BUILDING _____ B. WING _____	03/09/2022

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
F 687	Continued From page 36 bottoms of his/her feet were very dirty, dry, slightly red, and covered in chocolate. Toenails were long and thick. Between his/her toes was a dark brown substance and under her/his toenails was blood like material. The Unit Manager stated that this is something LNAs are expected to alert the nurse to. 3/9/22 at approximately 2:00 PM, Unit Manager reported to surveyor that s/he has cleaned resident #17's feet, it was in fact blood under the toenails, and the resident would most likely be losing a toenail. Resident #17 is on the list to be seen by podiatry on Monday. During interview with the Director of Nursing (DON) on 3/9/22 at 2:30 PM, s/he confirmed that review of feet should be included and documented in the weekly skin review or in progress notes.	F 687		
F 689 SS=E	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 observation, staff interviews, and record review the facility failed to ensure that the resident environment remains as free of accident hazards as is possible for 5 of 33 residents in the applicable sample (Residnets #17, #26, #64, #56,	F 689	F689 Residents #66,56,29,17 and 26 all continue to reside at the facility and have their needs met. All residents who reside at the facility that have a need for oxygen therapy, are an elopement risk or have a care plan for not keeping tray table in the room when not having meals are at risk for this alleged deficient practice.	

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 _____	03/09/2022

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SPRINGFIELD HEALTH & REHAB	105 CHESTER RD SPRINGFIELD, VT 05156

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F 689	Continued From page 37 and #29 . Findings include: 1. Per observations on 3/7/2022 at approximately 12:00 PM, portable oxygen tanks were found unsecured, creating a potential accident hazard in rooms #219 and #222 where Residents #66, #56, and #29 reside. Per interview with the Licensed Practical Nurse on 3/7/2022 at approximately 3:30 PM the oxygen tanks should not be left unsecured in the residents rooms. S/he immediately removed the tanks and placed them in the oxygen storage room. 2. Per review of resident #17's record, a Nursing note dated 12/15/2021 at 10:55 PM states "went to patients room and noted tray table laying on the floor on its side in front of patients feet. blood noted on the ground and left foot 2.5inch laceration noted on left big toe , bleeding stopped and dcd (dry clean dressing) applied..." The most recent care plan dated 1/14/2022 states "tray table to remain in the room for meals only, please remove when meals are done," as an intervention for impaired cognitive function and "scoop mattress for bed safety," as an intervention for falls. Per multiple observations on 3/7/2022 through 3/9/2022, a table tray was located in resident #17's rooms while they were not being served food. There was also a regular, non-scoop mattress at every observation. During interview with the Unit Manager (UM) on 3/8/22, at 3:51 PM, s/he confirmed that Resident #17's care plan reflects the tray tables are not supposed to be left in the room. S/he also	F 689	Licensed nursing staff were provided education on OPS100 and NSG225. Elopement risk assessment performed for #26 who scored 7.0 moderate risk, but does not exit seek or wander so is low risk for elopement. She has not had wanderguard nor is it indicated. House-wide audit of all residents that 1. require oxygen therapy, 2. are at risk for elopement or 3. are care-planned to have tray removed after meals from room. The Director of Nursing or designee will conduct random weekly audits X 4 and then monthly X 2 of the same above. The audit results will be brought to the QAPI team for review and recommendations as needed. **TAG F 689 POC Accepted by G. Mercure/P. Cota on 4/7/22**	

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SPRINGFIELD HEALTH & REHAB	105 CHESTER RD SPRINGFIELD, VT 05156

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F 689	Continued From page 38	F 689		

confirmed that Resident #17 is care planned for a scoop mattress however, s/he does not need a scoop mattress. The UM stated "that shouldn't be on the care plan."

3. Per record review Resident #26 has a care plan focus of " High risk for falls [related to] Gait/balance" S/he has had unwitnessed falls in her/his room on 2/23, 2/24, 3/1, 3/7, and 3/8.

During observation of the Unit 2 West on 3/7/2022 at 2:53 PM two surveyors heard a bang from behind Resident #26's closed door. Upon entrance to the room the surveyors found Resident #26 sitting on the floor, holding her/his left ankle and shin area. When asked if s/he had fallen s/he stated "yes". One surveyor went for staff assistance. On the way to the residents room the Licensed Nursing Assistant responded "Oh, [s/he] is care planned for the floor." The Unit Manager then stated "[s/he] is care planned for putting [her/himself] on the floor". The Incident Note written on 3/7/2022 at 4:16 PM states "visitor heard a thump and alerted staff who entered room and found [resident] on [her/his] buttocks in [her/his] bedroom. Resident unable to describe to staff what had happened. There was noted to be liquid soap on the floor. Able to move all four extremities, at baseline for resident, and with no increased pain/discomfort noted... No acute injury or abnormality noted. Ongoing edema noted to right ankle. No redness, warmth or pain noted to area..."

Resident #26 also has a care plan focus of "elopement risk/wanderer AEB [as evidenced by] wandering and looking for a way to leave." Skilled Nursing Notes written on 7/15 and 7/21

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 _____	03/09/2022

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SPRINGFIELD HEALTH & REHAB	105 CHESTER RD SPRINGFIELD, VT 05156

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F 689	Continued From page 39 reflect that a "Wander Guard is in place." The care plan does not reflect the use of a wander guard or any other monitoring or supervision of the resident's whereabouts. Per interview with the Unit Manager on 03/09/22 at 3:47 PM s/he confirmed that the care plan does not reflect the use of a wander guard or any indication for monitoring or supervising the resident. S/he also stated that It is difficult for staff to supervise residents with their doors shut. S/he stated that many residents prefer to have their doors shut and not all have evidence of scheduled monitoring or supervision schedules.	F 689		
F 697 SS=D	Pain Management CFR(s): 483.25(k) §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interview, and record review, the facility failed to ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the resident's preferences as evidenced by a lack of pain monitoring for one of 22 residents (Resident #53). Findings include: Per interview on 3/8/2022 at approximately 11:30	F 697	F697 Residents # 53 continues to reside at the facility and have their needs met. All residents who reside at the facility that experience pain are at risk for alleged deficient practice. All licensed nurses were provided education that all admissions require orders to monitor for pain. A house wide audit of all admissions to the facility for pain monitoring orders was conducted. The Director of Nursing or designee will conduct random weekly audits X 4 and then monthly X 2. The audit results will be brought to the QAPI team for review and recommendations as needed.	

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	475025	A. BUILDING _____ B. WING _____	03/09/2022

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
F 697	Continued From page 40	F 697	**TAG F 697 POC Accepted by G. Mercure/P. Cota on 4/7/22**	

AM, Resident #53 stated that he/she does not feel that his/her pain is adequately controlled. He/she stated that pain medication is as needed, so he/she must request the medication from nurses. By the time he/she receives the medication, the pain is very high. Resident #53 stated that the pain medications are effective when received, and is otherwise satisfied with the pain regimen.

Per record review, Resident #53 was admitted to the facility on 2/3/2022. Per review of Resident #53's admission MDS (minimum Data Set) assessment from 2/9/2022, Resident #53 uses "as needed" pain medication and his/her pain is constant, impacts sleep, and impacts day-to-day functioning. Per review of Resident #53's care plan, a care plan focus for "The resident has acute pain/chronic pain" was initiated on 2/3/2022 with the intervention "anticipate the resident's need for pain relief." An order for "Tramadol (a pain medication) 50 mg tablet - Give 1 tablet by mouth as needed for pancreatitis pain twice daily" was placed on 2/3/2022 and an order for "Tylenol 500 mg - give 1 tablet by mouth every 8 hours as needed for pain" was placed on 2/9/2022. An order for "Monitor for pain every shift: attempt non-pharmacological interventions for pain management such as: relaxation, light touch, imagery, exercise, music etc. every shift" was not placed in the chart until 3/6/2022.

Per review of the facility's admission instructions for standing orders, an order for "pain monitoring: monitor for pain every shift" should be added to each resident's chart upon admission.

Per interview on 3/9/2022 at approximately 4:00 PM, the Director of Nursing confirmed that there

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	475025	A. BUILDING _____ B. WING _____	03/09/2022

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SPRINGFIELD HEALTH & REHAB	105 CHESTER RD SPRINGFIELD, VT 05156

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F 697	Continued From page 41 was no regular pain monitoring performed for Resident #53 to help staff anticipate pain from admission on 2/3/2022 until 3/6/2022.	F 697		
F 726 SS=F	Competent Nursing Staff CFR(s): 483.35(a)(3)(4)(c) §483.35 Nursing Services 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)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. §483.35(a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs. §483.35(c) Proficiency of nurse aides. The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. This REQUIREMENT is not met as evidenced by:	F 726	F726 The facility failed to ensure that licensed nurses and other nursing personnel have the knowledge, competencies and kill sets to provide care and respond to each resident's individualized needs as identified in his/her care plan. All residents who receive medications and care at the facility are at risk for this alleged deficient practice. A house wide audit was done on all licensed nurses and LNA's to ensure competencies have been completed as required. The Director of Nursing and Nurse Educator received re-education on the orientation and competency requirements following the Orientation Checklist procedure. The DNS or designee will conduct random weekly audits X 4 then monthly X 2 on all new hires in the nursing department. These audit results will be brought to QAPI for review and additional interventions if required.	

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	475025	A. BUILDING _____ B. WING _____	03/09/2022

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 726	Continued From page 42	F 726	**TAG F 726 POC Accepted by G. Mercure/P. Cota on 4/7/22**	

Based on observation, resident and staff interview, and record review the facility failed to ensure that licensed nurses and other nursing personnel have the knowledge, competencies and skill sets to provide care and respond to each resident's individualized needs as identified in his/her assessment and care plan.

1. During interview on 3/8/2022 at 11:24 AM, Resident #64 reported that s/he was given her/his roommate's medications. S/he had told the nurse that s/he "normally doesn't take the meds crushed up with thick water, but [the nurse] told me yes, they were mine. They returned five minutes later to tell me that I was given the wrong meds and that I should speak up next time and question the nurse. I was real sleepy the rest of the day."

Per interview with the Director of Nursing on 3/9/2022 at approximately 11:15 AM s/he had been aware of the medication error. An internal investigation was in progress. The LPN was new to the floor, and had just started less than a month ago. The two residents looked alike and the nurse mistook one for the other. Education was provided to the LPN after the incident.

Review of the Licensed Practical Nurse's (LPNs) education file revealed a two page Individual Education Tracking form dated 2/7/2022 (date of hire) and reflects that the employee's title is LNA (Licensed Nursing Assistant). There are initials in the presenter column on both pages with a line drawn down through each column with an arrow at the end. There was no space for signature of presenter or employee to indicate they had provided or received the training. There was also no evidence provided that would reflect that the

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	475025	A. BUILDING _____ B. WING _____	03/09/2022

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SPRINGFIELD HEALTH & REHAB	105 CHESTER RD SPRINGFIELD, VT 05156

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F 726	Continued From page 43 LPN had been evaluated for competency related to resident care needs based on the facility assessment or resident specific care plans provided by the facility. During an interview on 3/9/2022 at 2:00 PM the Licensed Practical Nurse stated that s/he was new to the Unit. S/he had not been assessed for competency during or after orientation. S/he had shadowed a nurse on a cart for about two weeks when s/he started, and had lost her/his sign off sheet that would indicate what had been reviewed. 2. Per review of education files for a Licensed Nursing Assistant (LNA) hired on 12/27/2021, a LNA hired on 1/3/2022, and a Registered Nurse hired on 12/20/2021, there was no evidence that nursing skills competencies had been assessed. On 3/9/2022 at 10:38 AM the Director of Nursing (DON) and Nurse Educator confirmed that nursing competency had not been assessed. The plan was to conduct a skills fair in the future. Per the Nurse Educator at 4:15 PM, the lack of competency evaluation had been identified and will be included in the quality assurance performance improvement program.	F 726		
F 741 SS=E	Sufficient/Competent Staff-Behav Health Needs CFR(s): 483.40(a)(1)(2) §483.40(a) The facility must have sufficient staff who provide direct services to residents 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	F 741	F741 The facility failed to ensure that staff were knowledgeable, trained, and competent to address the behavioral health needs of residents with dementia and dementia related diseases.	

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	475025	A. BUILDING _____ B. WING _____	03/09/2022

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SPRINGFIELD HEALTH & REHAB	105 CHESTER RD SPRINGFIELD, VT 05156

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F 741	Continued From page 44 resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with §483.70(e). These competencies and skills sets include, but are not limited to, knowledge of and appropriate training and supervision for: §483.40(a)(1) Caring for residents with mental and psychosocial disorders, as well as residents with a history of trauma and/or post-traumatic stress disorder, that have been identified in the facility assessment conducted pursuant to §483.70(e), and [as linked to history of trauma and/or post-traumatic stress disorder, will be implemented beginning November 28, 2019 (Phase 3)]. §483.40(a)(2) Implementing non-pharmacological interventions. This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interview, and record review the facility failed to ensure that staff were knowledgeable, trained, and competent to address the behavioral health needs of residents with dementia and dementia related diseases. Findings include: Per review of three employee education files a two page Individual Education Tracking form was with initials in the presenter column on both pages with a line drawn down through each column was present. There was no space for signature of presenter or employee to indicate they had provided or received the training. Review of a Licensed Practical Nurse's Individual Education Tracking date 2/7/2022 reflects a Title	F 741	All residents who have dementia and reside at the facility are at risk for this alleged deficient practice. A house wide audit was done on all licensed nurses and LNA's to ensure dementia training has been completed as required. The Nurse Educator received re-education on the dementia training requirement for new hires and annually. The DNS or designee will conduct random weekly audits X 4 then monthly X 2 on all new hires and during annual review in the nursing department. These audit results will be brought to QAPI for review and additional interventions if required. **TAG F 741 POC Accepted by G. Mercure/P. Cota on 4/7/22**	

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 _____	03/09/2022

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SPRINGFIELD HEALTH & REHAB	105 CHESTER RD SPRINGFIELD, VT 05156

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F 741	Continued From page 45	F 741		

of LNA, initials in the presenter column and no signatures. There was also no evidence that staff had been evaluated for competency related to resident care needs based on the facility assessment or resident specific care plans provided by the facility.

Per review of the facility Resident Matrix (a Centers for Medicare and Medicaid [CMS] form completed by the facility, used to identify pertinent care areas) 33 of 77 residents residing in the facility have diagnoses of Alzheimer's/Dementia. Page #12, 13, and 14 of the Facility Assessment reflect that staff training and competencies will include Caring for persons with Alzheimer's or other dementia.

During interview with the Staff Educator on 3/9/2022 at 11:29 AM s/he confirmed that s/he does not provide a dementia specific training/competency program. The Staff Educator stated that s/he used a video series in the past, but no longer has access to them. Now s/he discusses topics of dementia during orientation that include; communication, stages of dementia, difficult residents with dementia, and challenges with dementia. However, there is no documented evidence that staff are assessed for competency related to dementia. S/he also confirmed that there are residents throughout the building with diagnoses of dementia and dementia related diseases.

Per interview on 3/9/2022 at 2:00 PM a Licensed Practical Nurse who was hired on 2/7/2022 did not remember receiving dementia specific training during orientation. There were no competencies completed with her/him, they just checked her/his nursing license.

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	475025	A. BUILDING _____ B. WING _____	03/09/2022

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SPRINGFIELD HEALTH & REHAB	105 CHESTER RD SPRINGFIELD, VT 05156

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F 741	Continued From page 46 Per interview with the Activities Director on 03/09/22 at 02:15 PM the activity staff have had no specific dementia training, and s/he was not aware that it was required. S/he stated that in the future s/he would like to provide more training, and s/he can see where they could benefit from additional training.	F 741		
F 759 SS=D	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure that it's medication error rate was no greater than 5% during a medication observation for two residents (#51 and # 28) out of 25 opportunities for medication errors. The error rate was calculated at 6.67% Findings include: 1. Observation of the evening medication pass on first floor, A unit on 03/06/22 at approximately 07:00 PM, revealed that the nurse drew up 18 Units of insulin for resident (#51) as prescribed, from another resident's (# 44) medication supply of Lantus Solution 100 UNIT/ML (Insulin Glargine). This is the same medication as prescribed for resident #51, however it did not belong to him/her. This surveyor alerted the nurse that she/he drew up the medication from the	F 759	F759 The individual nurse was provided individual education and med pass competency. House-wide competencies were completed with all nurses on insulin administration and inhaler administration. All licensed nurses were reeducated on the 5 rights of medication administration and Policy NRS305 Medication Administration - General. The DNS or designee will conduct random weekly audits X 4 and then monthly X 2. The audit results will be brought to the QAPI team for review and recommendations as needed. **TAG F 759 POC Accepted by G. Mercure/P. Cota on 4/7/22**	

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 _____	03/09/2022

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 759	Continued From page 47 wrong vial. The nurse proceeded to move forward to give what had been drawn up since it was the same prescribed medication. When asked if resident #51 had any of her own insulin, the nurse went to the back up closet to look. She/he returned empty handed and looked again in the medication cart. She/he found the correct vial of insulin belonging to resident #51. She disposed of the initial drawn up solution in the syringe and started over. This nurse confirmed on 03/06/22 at 07:00 PM that she/he was going to use medication that belonged to another resident which goes against professional standards. 2. Resident # 28 has a physician order for Symbicort inhaler, 2 puffs, inhale orally 2 time a day with water spit after use. During a medication pass on 3/7/22 at 7:04. The administering nurse did not provide the mouth rinse following administration of the medication as ordered. This was confirmed by the nurse at 7:07 PM on 3/7/22.	F 759		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable	F 812	F812 All residents are at risk for this potential alleged deficient practice. A house wide audit was conducted in dietary for proper food storage, dating, cleanliness and equipment in need of repair. The Dietary Manager and all dietary staff were educated on the 5.6 Dry Storage, 5.7 Refrigerator/Freezer Storage, cleaning procedures, reporting any items broken for replacement needs. The Administrator or designee will conduct random weekly audits X 4 and monthly X 2 in the dietary department to ensure continued compliance in proper food storage, dating, cleanliness and equipment in need of repair. These audit results will be brought to QAPI for review and further interventions if needed.	

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 _____	03/09/2022

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 812	Continued From page 48 safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observations, staff interview and record review, the facility failed to store, prepare, distribute and serve food in accordance with professional standards for food service safety. Findings include: The following observations were made during the initial kitchen tour on 03/08/2022 at 4:00PM. 1. Hand sanitizer mounted on wall inside the kitchen at entrance. 2. Observation of dented cans (butterscotch pudding, canned peaches) on shelf with all other non-dented cans. When asked about using dented cans, the night cook stated "if it was the only one available we would probably use it." 3. A large bag (20#) of gluten free flour opened and placed inside a large acrylic container with tape on top dated 3/10/21. When the lid was opened, a rancid smell was noted. The Kitchen manager stated we don't currently have any resident on a gluten free diet, but if some one came in we would have the flour to use. The original bag holding the flour had an expiration date of May 7, 2021. The kitchen manager confirmed the flour was outdated and discarded it. 4. A Robot Coupe Blixer used to puree food, has an open circle at the top with approximately 2 inches in circumference with all of the edges	F 812	**TAG F 812 POC Accepted by G. Mercure/P. Cota on 4/7/22**	

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	475025	A. BUILDING _____ B. WING _____	03/09/2022

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SPRINGFIELD HEALTH & REHAB	105 CHESTER RD SPRINGFIELD, VT 05156

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F 812	Continued From page 49	F 812		

broken. The Kitchen manager confirmed that the mixer was currently in use and stated a replacement has been requested but a new one has not been received yet and notes it has been glued numerous times.
5. A 3 plug outlet in the ceiling (not in use) appeared to have webs hanging from it. Staff wiped it and confirmed that it was a spider web and dust.
6. A pitcher used to scoop ice observed in a broken plastic holder near the ice machine. The holder was dirty inside and contained a clothing tag. The Kitchen manager stated that this holder is not clean.
7. There were plastic containers of strawberries and raspberries with spoiled berries.
8. In the Walk in freezer, chicken patties in a plastic bag without date, a large bag of diced frozen chicken without date and french toast frozen in a bag without date.
9. On the steam table, three 5 gallon trays were noted to have dried food residue in corners.
10. Serving tools in 3 separate grey bins in the food prep area are soiled with accumulated crumbs and debris.
11. 4 Plastic drink pitchers and a coffee carafe in clean dish area are stacked inside one another and noted to be wet inside.
12. The nozzles on juice dispensers were sticky and soiled with a viscous substance.

On 03/08/2022 the kitchen manager arrived in the facility within minutes of initiating the initial tour and was present and confirmed all of the above findings during the tour.

On 03/09/22 at 04:47 PM, the 2nd floor kitchenette freezer contained a bag of Morning Star Vegitizers open without name or date on the

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	475025	A. BUILDING _____ B. WING _____	03/09/2022

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 812	Continued From page 50 bag. This was confirmed by evening unit nurse at the time of the observation. Per facility "HCSG Policy 031 Food: Safe Handling for Foods from Visitors" - When food items are intended for later consumption, the responsible facility staff member will: Ensure that the food is stored separate or easily distinguishable from the facility food. Ensure that foods are in a sealed container to prevent cross contamination. Label foods with the resident name and the current date.	F 812		
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is-	F 842	F842 Resident #48 continues to reside at the facility and have their needs met. All residents with pressure ulcers who reside at the facility are at risk for this potential alleged deficient practice. A house wide audit of weekly skin check forms for all residents with pressure ulcers was conducted to ensure proper documentation is present. All licensed nurses were re-educated on the Genesis Wound and Skin Protocol and the weekly documentation requirements. The Director of Nursing or designee will conduct random weekly X 4 and monthly X 2 audits of all residents with pressure ulcers to ensure continued compliance. These audit results will be brought to QAPI for review and further interventions if needed.	

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	475025	A. BUILDING _____ B. WING _____	03/09/2022

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
F 842	Continued From page 51 (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic	F 842	**TAG F 842 POC Accepted by G. Mercure/P. Cota on 4/7/22**	

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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 842	Continued From page 52 services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility failed to maintain medical records that are accurately documented related to weekly skin checks for one of 22 residents (Resident #48). Findings include: Per record review, a change in condition form was completed on 12/28/2021 for Resident #48 for a new pressure ulcer on their sacrum (lower back). Per review of weekly skin check documentation on 1/1/2022, 1/8/2022, 1/15/2022, 1/22/2022, 1/29/2022, 2/52022, 2/12/2022, 2/19/2022, 2/26/2022, and 3/5/2022, Resident #48's skin is documented as intact with no documentation regarding the presence of a pressure ulcer. Per interview on 3/8/22 at approximately 4:00 PM, the DON (Director of Nursing) stated that they track all in-house wounds and assess them on a weekly basis in collaboration with unit managers. The DON confirmed that Resident #48's pressure ulcer has been present since its discovery on 12/28/2021. The DON also confirmed that, while weekly skin checks are not the tool used by the facility for in-depth tracking and assessment of the progress of the wound, the weekly skin checks should reflect the presence of all current wounds at the time the assessment is performed.	F 842		
F 868 SS=C	QAA Committee CFR(s): 483.75(g)(1)(i)-(iii)(2)(i) §483.75(g) Quality assessment and assurance. §483.75(g)(1) A facility must maintain a quality assessment and assurance committee consisting	F 868	F868 The facility has secured a new Medical Director and the Medical Director is aware of the requirement. The Administrator and Director of Nursing have been educated on the QAA Committee requirement to have the Medical Director in attendance at QAPI meetings. QAPI was held in March and the Medical Director was in attendance. The QAPI team will provide a copy of the attendance sheet for the POC book monthly X 2 (April, May).	

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	475025	A. BUILDING _____ B. WING _____	03/09/2022

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
F 868	Continued From page 53 at a minimum of: (i) The director of nursing services; (ii) The Medical Director or his/her designee; (iii) At least three other members of the facility's staff, at least one of who must be the administrator, owner, a board member or other individual in a leadership role; §483.75(g)(2) The quality assessment and assurance committee must: (i) Meet at least quarterly and as needed to identifying issues with respect to which quality assessment and assurance activities are necessary. This REQUIREMENT is not met as evidenced by: Based on interview and review of the facility's Quality Assurance and Performance Improvement (QAPI) Committee meeting agenda (only) and list of attendees, the list was not composed of all members required, for attendance on a quarterly basis. Findings include: Review of the facilities last 6 months of the QAPI committees list of attendees, did not include the Medical Director. Per interview on 03/09/22 with the Director of Nursing (DON), reveals that the Medical Director has not attended QAPI meetings since July 2021 and that he/she is being replaced by a new Medical Director soon.	F 868	**TAG F 868 POC Accepted by G. Mercure/P. Cota on 4/7/22**	
F 880 SS=F	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program	F 880	F880 All residents are at risk for this alleged deficient practice. 1. Screening Process: The doors were programmed to be locked at all times, requiring all visitors to be manually let in the facility and actively screened. All staff have been re-educated on the screening process.	

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	475025	A. BUILDING _____ B. WING _____	03/09/2022

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
F 880	Continued From page 54 designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the	F 880	2. The New Admissions/Readmissions and Patients Who Leave the Facility >24 hrs Guidelines was reviewed with staff and was determined to facility was doing more than required per the guidelines. All signage was removed as the admitted residents did not require isolation/quarantine. No harm to any residents for these additional precautions. The Administrator, DNS, IP Nurse, UM, Admission Coordinator have all been educated on the Admission Protocol for Covid isolation requirements. A new process is in place for each admission, which includes providing a copy of the Covid isolation requirement flow sheet to the units with the new/readmits paperwork when the are admitted so all floor staff are aware of the individual residents isolation requirements. 3. Proper PPE: All staff have been reeducated on proper PPE usage based on the most current guidelines. The Administrator or designee will conduct random weekly X 4 and monthly X 2 audits on the following: 1. new/readmit residents for the completed Admission Flow sheet and verify room signage matches, 2. screening forms for proper screening procedures 3. PPE audits on staff in resident care areas. These audit results will be reviewed at QAPI for continued compliance and further interventions if needed.	

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	475025	A. BUILDING _____ B. WING _____	03/09/2022

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
F 880	Continued From page 55 least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to consistently implement a system to help prevent the development and transmission of COVID-19 for all residents and staff as evidenced by a lack of following policies, procedures, and accepted national standards to prevent the spread of COVID-19. Findings include: 1. Per observation on Sunday, 3/6/2022 at approximately 3:00 PM, the survey team and one visitor entered the facility lobby through unlocked doors. There was no one present in the lobby to perform a COVID-19 entrance screening for the survey team or visitor. There were no signs	F 880	**TAG F 880 POC Accepted by G. Mercure/P. Cota on 4/7/22**	

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 _____	03/09/2022

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
F 880	Continued From page 56	F 880		

present instructing after-hours visitors on how to contact facility staff in order to be screened before entering patient care areas and no communication device available for contacting staff. There was a sign at the entrance that stated that the front doors will be locked outside the hours of 8am to 4:30 PM. A member of the survey team entered the first-floor unit in order to alert staff to the presence of the survey team and the one visitor on the ground floor waiting to be granted entrance. Neither the survey team nor the visitor were screened for COVID-19 by staff before entering the patient care units. There was no signage present that explained the symptoms/conditions the visitor should not enter the facility with.

Per review of the facility's policy Infection Control Policies and Procedures - Covid-19, under the section Entrance Screening the policy states, "active screening of all persons entering the center (such as employees, visitors, medically necessary personnel, contracted staff/vendors, and volunteers) will be done upon entry into the center."

Per interview on 3/6/2022 at approximately 6:45 PM, the DON (Director of Nursing) stated that there is a receptionist present on weekend days from 8:00 AM to 12:00 PM to perform entrance screenings but that there is no one present from 12:00 PM to 4:30 PM to perform screening prior to the doors locking. After the doors lock, visitors must ring the doorbell outside the facility to be let in and screened by staff.

2. Per observation on 3/6/2022 at approximately 4:15 PM, several resident rooms on level one units A and B had yellow signs on the doors

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 _____	03/09/2022

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
F 880	Continued From page 57	F 880		

instructing all staff who enter to use both contact and droplet transmission based precautions when entering the room. The PPE (personal protective equipment) listed on the signs includes an N95 mask, an eye shield, a gown, and gloves. Various staff members were observed to be entering and exiting these resident rooms wearing only n95 masks.

Per interview on 3/6/2022 at approximately 4:15 PM, Nurse 1 stated that they believed that the signs are meant to instruct staff entering to "wear a mask."

Per interview on 3/6/2022 at approximately 6:45 PM, the DON stated that there are no COVID-19 positive residents in the facility and that there should be no TBP (transmission-based precaution) signage on any resident rooms.

Per observation on 3/7/2022 at approximately 11:00 AM, three resident rooms (#227, #224, and #228) still had yellow contact/droplet precaution signs on the doors to these occupied rooms.

Per interview a few moments after this observation, the DON stated that these three resident rooms have yellow TBP signs on them because they are new admissions, and all new admissions who are fully vaccinated require a 10 day isolation period with COVID-19 TBP in place (not congruent with policy, see below). Unvaccinated new admissions require a 14 day isolation period. The DON also stated that the TBP expectations for new admissions includes an N95 mask, an eye shield, a gown, and gloves when providing care to those residents.

Per observation an hour later at approximately

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 _____	03/09/2022

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
F 880	Continued From page 58	F 880		

12:00 PM, LNA (licensed nursing assistant) was observed to be providing care to Resident #227 in the room wearing only a surgical mask and no eye protection, gown or gloves. OT (occupational therapist) was also in the room providing Resident #227 with care wearing only an N95 mask and no eye protection, gown, or gloves. RN (Registered Nurse) was present in the room delivering a meal tray and setting Resident #227 up for eating wearing an N95 mask and an eye shield, no gown, or gloves.

Per interview on 3/7/2022 at approximately 12:00 PM, RN 1 stated that the yellow TBP signs outside of Resident #227's room meant that staff entering only needed to wear an N95 mask and an eye shield. Gowns and gloves were not required, despite the yellow sign instructing their use. They stated that no staff have been using gowns or gloves in these rooms with yellow signage.

Per interview on 3/7/2022 at approximately 1:30 PM, the facility's IP (Infection Preventionist) stated that only N95 masks and eye shields are required when caring for residents who have yellow TBP signs on their door, despite the fact that the yellow signs instruct staff to use gown and gloves. The IP also stated that this signage is "confusing" for staff and that they would like to create a better system for clearly defining the PPE required for new admissions to the facility.

Per review of the facility's procedure, Admissions/Readmissions and Placement Guidance of Presumed COVID-19 Negative Patients, newly admitted residents who have had a COVID-19 negative test on admission and are vaccinated/boosted/recovered do not require

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 _____	03/09/2022

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 880	Continued From page 59	F 880		

observation/isolation.

Per interview on 3/7/2022 at approximately 3:00 PM, The DON and Regional Director of Clinical Services confirmed that all 3 residents with yellow signs on their rooms met this criteria and never needed to be on TBP since their negative tests prior to 3/6/2022, per policy.

3. Per observation 3/7/2022 at approximately 12:00 PM, LNA 1 was observed to be providing care to Resident #227 in the room wearing only a surgical mask. OT 1 was also in the room providing Resident #227 with care wearing only an N95 mask. RN (Registered Nurse) 1 was present in the room delivering a meal tray and setting Resident #227 up for eating wearing an N95 mask and an eye shield.

Per interview on 3/7/2022 at approximately 12:00 PM, RN 1 stated that all staff were expected to wear a mask and an eye shield for all direct patient care in the facility.

Per observation on 3/8/2022 at approximately 10:15 AM on level 1, LNA 1 and LNA 2 were both observed to be exiting a resident room after providing direct care without eye shields.

Per interview with LNA 1 at the same time, LNA 1 confirmed that they should be wearing an eye shield during direct patient care but that they forgot.

Per observation on 3/8/2022 at approximately 10:30 AM on level 2, LNA 3 was observed to be sitting and speaking with a maskless resident without an eye shield. Their faces were within approximately 1 foot of one another.

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 _____	03/09/2022

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
F 880	Continued From page 60 Per review of the facility's policy Infection Control Policies and Procedures - Covid-19, under the section General Standard Precautions, the policy states, "Implement universal facemasks/respirators and eye protection while in the center." Per interview on 3/9/2022 at approximately 4:00 PM, the DON confirmed that all staff are expected to wear a facemask and eye protection at a minimum during direct patient care.	F 880		