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

June 21, 2022

Mr. Floyd Bradley, Administrator
Springfield Health & Rehab
105 Chester Rd
Springfield, VT 05156-2106

Dear Mr. Bradley:

Enclosed is a copy of your acceptable plans of correction for the revisit survey conducted on **May 17, 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 _____	R 05/17/2022

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 000}	Initial Comments An unannounced onsite revisit to the 03/09/22 re-certification survey was completed by the Division of Licensing and Protection on 05/17/22. The facility was found to be in substantial compliance with Emergency Preparedness.	{E 000}		
{F 000}	INITIAL COMMENTS An unannounced onsite revisit to the 03/09/22 recertification survey was completed by the Division of Licensing and Protection on 5/17/2022. The facility was not found to be in substantial compliance with the following regulatory violations that were identified on the 03/09/22 survey:	{F 000}	The filing of this Plan of Correction does not constitute an admission of the allegations set forth in the statement of deficiencies. Springfield Health & Rehabilitation Center has prepared and executed a plan of correction as evidence of the facilities' continued compliance with applicable federal and state laws.	
{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 or theft. §483.10(i)(2) Housekeeping and maintenance	{F 584}		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Floyd Bradley — TITLE: Interim Administrator — (X6) DATE: 6/30/22

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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{F 584}	Continued From page 1 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 correct deficient practice identified during a recertification survey by not ensuring that a clean and homelike environment was provided for the residents who reside on Unit 2 West. Findings include: Observations on 5/17/22 revealed the following: Room #214 at 10:14 AM: the floors appear to not have been swept, there was a build up of debris in the corners. Room #215 at 10:18 AM: the floor was very dirty, a bottle, straw wrappers, crumbs and food, and razor caps were seen on the floor. Room #216 at 10:35 AM: the floor was dirty with wrappers in multiple spots. There were resident incontinence products on the dresser. Room #218 at 9:53 AM: the floor was dirty and a	{F 584}	F584 All residents who reside on Unit 2 West are at risk for this alleged deficient practice. The Director of Housekeeping has returned from being out with covid, new staff have been hired and daily audits are in place. 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. Daily audits are being completed and reviewed by the DNS. Environmental rounds will be conducted by the Administrator, the Director of Housekeeping and multiple other department heads 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. **TAG F 584 POC Accepted on 06/21/22 by S. Freeman/P. Cota**	

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{F 584}	Continued From page 2 medication cup was on the floor by the head of the resident's bed. Room #219: The finish was peeling off of the top dresser drawer, alcohol wipes, nebulizer unit dose vial, and other debris on the floor. Room #220 at 9:41 AM: the clock on the wall stated 2:39. Soap, deodorant and cleaner were on the back of the toilet. Room #221 was observed to have dirt, food, and papers on the floor, the finish on a bedside table was peeling over half of the top, the bathroom floor was visibly soiled with dirt and footprints. Room #222 at 9:56 AM: dirty floor with footprints on the floor and the floor mat (a mat placed on the floor to minimize injury if the resident should roll out of bed), there was debris under the bed with two small brown particles that the roommate stated was "poop." The resident also stated that there have been "depends left under [her/his roommate's] bed for four or five days, and there is still poop under [her/his roommates] bed" The bathroom had toilet paper all over the floor. The toilet bowl had feces on the sides, and there was a brown substance that was splattered and dried on the wall. The room smelled of urine. Room #223: the floor was dirty with food spots, the bathroom floor has dirty footprints and what appeared to be dried spillage. There was one open incontinence product on the floor under a chair and one on the floor in the frame of the closet. Room #224: There were resident incontinence products in the resident's wheelchair and a package on the floor by the doorway. Room #226: 3 packs of clean resident incontinence products stacked on the floor. On 5/17/2022 at 10:40 AM during a walk through of the 2 East Unit rooms with the Administrator	{F 584}		

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{F 584}	Continued From page 3 and the Nurse Educator, the Administrator confirmed that the rooms were not clean, but stated that the housekeeper was working their way down the hall and had not had time to clean all of the rooms. He also stated that they have increased the pay for housekeepers but cannot fill the openings. Per the Administrator they have just lost two housekeepers who were recently hired. On 5/17/2022 at 4:10 PM while in Room #219 the Unit Manager confirmed that although the housekeeper had been in and cleaned the room there was still debris through the floor in the room such as a 2 x 2 gauze pad, a packet of medicated ointment, and several other package wrappers.	{F 584}		
{F 656} SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse	{F 656}		

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{F 656}	Continued From page 4 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 completely implement their plan of correction by implementing a person-centered comprehensive care plan for 1 of 3 residents in the applicable sample. (Resident #17). Findings include: The facility plan of correction with a completion date of 4/22/22 reflects that Resident # 17's care plan was updated for accuracy. Per record review Resident #17's care plan focus for impaired cognitive function has an intervention dated 3/9/2022 for "May hang sign in room to remind staff to promptly remove tray table [an over bed table with rolling wheels] after all	{F 656}		

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{F 656}	Continued From page 5 meals." An intervention initiated on 12/15/2021 states "tray table to remain in the room for meals only, please remove when meals are done." Per observations on 5/17/2022 at 10:00 AM and again at 10:30 AM a tray table was located in resident #17's room while food was not being served. During a walk through of the unit with the Administrator and the Nurse Educator at 10:30 AM Resident #17 was observed in their room with the tray table still located in the room. When asked about the tray table being in the room the Administrator reported that it had been taken care of. Per the Nurse Educator s/he believes that the resident is no longer care planned for the tray table to be removed when meals are not being served however, the intervention does remain on the resident's care plan. Per observation at 3:45 PM the tray table was still in Resident #17's room, and the care plan continued to reflect the need to remove the tray table when not in use for meals.	{F 656}	F 656 In this resident's care plan the plan for the tray table to be removed from the residents room immediately after meals was in the care plan twice. It had been removed from one area, but overlooked in the other area of the care plan to be removed. It has been removed from all areas of the care plan at this time, as has the sign to remove the tray table. A house wide audit was conducted of any residents requiring the tray table be removed when not served meals to ensure their care plans were accurate. No residents were noted. UM's, DNS and NPE were re-educated on updating care plans in the most efficient and appropriate manner to avoid duplicate interventions. 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	
{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).	{F 726}		

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{F 726}	Continued From page 6 §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: Based on staff interview and record review the facility failed implement their plan of correction 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. Findings include: Per review of five agency nursing staff education records, three Licensed Nursing Assistants and two Licensed Practical Nurses, there was no evidence that nursing competencies had been assessed. On 5/17/2020 at 5:10 PM the Nurse Educator confirmed that the competency paperwork that the agency sent to the facility for temporary employees did not include information that nursing staff were competent in specific skills;	{F 726}	F726 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 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 for full time and agency hires. 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. **TAG F 656 POC Accepted on 06/21/22 by S. Freeman/P.Cota**	

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{F 726}	Continued From page 7 therefore, s/he could not confirm that the five employees had the competencies to provide care. The corrective actions did not include a house wide audit for LNA and nurses for competencies or weekly audits x4 and monthly audits x2 thereafter, as indicated on the accepted plan of correction. During an interview on 5/17/2022 at 2:40 PM, the Administrator and Nurse Educator confirmed that the audits had not been done for competencies.	{F 726}	**TAG F 726 POC Accepted on 06/21/22 by S. Freeman/P.Cota** 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. All residents who have dementia and reside at the facility are at risk for this alleged deficient practice. A house wide audit was completed on all licensed nurses and LNA's to ensure dementia training has been completed as required. The DNS and 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.	
{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 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	{F 741}		

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{F 741}	Continued From page 8 (Phase 3)]. §483.40(a)(2) Implementing non-pharmacological interventions. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review the facility failed implement their plan of correction 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 five agency nursing staff education records, three Licensed Nursing Assistants (LNAs) and two Licensed Practical Nurses, there was no evidence that the three LNAs had dementia training or were competent on how to address the behavioral health needs of residents with dementia. During an interview on 5/17/2022 at 2:40 PM, the Nurse Educator confirmed that she could not produce evidence that the three LNAs had dementia training. The corrective actions did not include a house wide audit for LNA and nurses for dementia training or weekly audits x4 and monthly audits x2 thereafter, as indicated on the accepted plan of correction. During an interview on 5/17/2022 at 2:40 PM, the Administrator and Nurse Educator confirmed that the audits had not been done for dementia training.	{F 741}	**TAG F 741 POC Accepted on 06/21/22 by S. Freeman/ P.Cota**	