

DEPARTMENT OF DISABILITIES, AGING AND INDEPENDENT LIVING

Division of Licensing and Protection HC 2 South, 280 State Drive Waterbury, VT 05671-2060 http://www.dail.vermont.gov Survey and Certification Voice/TTY (802) 241-0480 Survey and Certification Fax (802) 241-0343 Survey and Certification Reporting Line: (888) 700-5330 To Report Adult Abuse: (800) 564-1612December 21, 2022

January 3, 2023

Ms. Wendy Ness, Administrator Springfield Health & Rehab 105 Chester Rd Springfield, VT 05156-2106

Dear Ms. Ness:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on December 1, 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

Lamela MCotaRN

8028855755

FAX1

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PRINTED: 12/15/2022

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: ... COMPLETED A. BUILDING 475025 R WING 12/01/2022 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 105 CHESTER RD SPRINGFIELD HEALTH & REHAB SPRINGFIELD, VT 05156 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (XS) (EACH DEFICIENCY MUST BE PRECEDED BY FULL COMPLETION PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) INITIAL COMMENTS F 000 The Division of Licensing and Protection conducted an onsite, unannounced investigation of four complaints from 11/30/2022 through 12/1/2022. The following regulatory deficiencies were identified: F 657 Care Plan Timing and Revision F 657 #1 Resident #1 fall care plan has been revised \$8=D CFR(s): 483.21(b)(2)(i)-(iii) #2 Residents with falls in the past 30 days §483.21(b) Comprehensive Care Plans have had their fall care plan reviewed and §483.21(b)(2) A comprehensive care plan must interventions have been added if indicated. (i) Developed within 7 days after completion of #3 Licensed nurses will be educated on the comprehensive assessment. adding a new intervention to a residents plan (II) Prepared by an Interdisciplinary team, that of care after a fall. includes but is not limited to-(A) The attending physician. #4 Residents who have had a fall will be (B) A registered nurse with responsibility for the audited weekly x 4 weeks then monthly x 2 months to ensure that a new intervention is (C) A nurse aide with responsibility for the added to the plan of care after a fall. Results resident. will be presented and reviewed at QAPI on a (D) A member of food and nutrition services staff. monthly basis until substantial compliance 1/3/2023 (E) To the extent practicable, the participation of has been determined. the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the Tag F657 POC accepted on 01/03/2023 by resident's care plan. K.Ruffe/P.Cota (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (III)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced DIRECTOR'S OR PROVIDER/SUPPLIER REPRESEM ATIVE'S SIGNATURE

eficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days owing 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 regulable to continued program participation.

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 12/15/2022
FORM APPROVED

CENTERS FOR MEDICARE & MEDICAID SERVICES				OMB NO. 0938-0391					
TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED			
		475025	B. WING			1:	C 2/01/2022		
NAME OF PROVIDER OR SUPPLIER SPRINGFIELD HEALTH & REHAB				105 (EET ADDRESS, CITY, STATE, ZIP CODE CHESTER RD KINGFIELD, VT 05156				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIVE (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE		
F 657	facility falled to revise for one of 3 sampled Findings include: Per record review, a at 2:10 PM reads, "R usual, entered room face down on floor palinjury at this time, no assisted resident back." Per review of Reside "[Resident #1] is at ri 12/1/2020, there were the care plan interve fall. Per record review, R similar nature to the 9/3/2022. A progress AM reads, "At appro (licensed nursing as resident was on floof face down on floor at blood was noted on and swelling." Per interview on 12/PM, the Administration new interventions.	iew and record review, the the care plan following a fall residents (Resident #1). progress note from 9/3/2022 esident hollering more than and observed resident laying arallel to bed. Assessed for thinding any multiple staffick to bed."	F	657					
F 725 SS=F	fall. Sufficient Nursing S CFR(s): 483.35(a)(1 §483.35(a) Sufficier	taff ()(2)	F	725					

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

FORM APPROVED OMB NO. 0938-0391

PRINTED: 12/15/2022

NAME OF PROVIDER OR SUPPLIER #75025 #75026	TATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 475025		(X2) MULTIPLE CO	(X3) DATE SURVEY COMPLETED					
NAME OF PROVIDER OR SUPPLIER SPRINGFIELD HEALTH & REHAB SUMMARY STATEMENT OF DEFICIENCIES 105 CHESTER RD 105 CHESTER			IDENTIFICATION NUMBER: -	A. BUILDING	.BUILDING				
SPRINGFIELD HEALTH & REHAB (XX) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 725 Continued From page 2 the appropriate competencies and skills sets to provide nursing and related services to assure resident saseswents 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)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nurse aides. §483.35(a)(2) Except when waived under paragraph (a) of this section, in the facility must designate a licensed nurse to serve as a charge and compliance has been in administration and paragraph (b) of this section, the facility must designate a licensed nurse to serve as a charge and compliance has been in administration compliance. SPARINGFIELD, VT 05156 PROVIDER'S PLAN OF CORRECTIVE ACTION SHOULD BE CROSS-REFFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX TAG PROVIDER'S PLAN OF CORRECTIVE ACTION SHOULD BE CROSS-REFFERENCED TO THE APPROPRIATE DEFICIENCY) #1 Resident #2, #3 and #4 are receiving their medication administration audit will be reviewed from the past seven days and the MD will be notified of any medication administration audit will be reviewed for the past seven days and the MD will be notified of any medication administration audit will be chucated on the process to follow if a medication administration audit report will be reviewed weekly x 4 weeks then monthly x 2 months to ensure medication administration compliance. Results will be presented and reviewed at QAPI on a monthly basis until substantial compliance has been			475025	B. WING		12/01/2022			
PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY PULL REGULATORY OR LSC IDENTIFYING IMPORMATION) F725 Continued From page 2 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 must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when walved under paragraph (e) of this section, licensed nurse; and (ii) Other nursing personnel, including but not limited to nurse aides. \$483.35(a)(2) Except when walved under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge with the facility was a compliance. Results will be presented and reviewed and reviewed and reviewed and passis until substantial compliance has been	NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 105 CHESTER RD					
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)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when walved under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge	PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI	(X8) COMPLETION ATE DATE			
This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and record review, the facility failed to ensure that the facility has sufficient nursing staff to provide nursing services to maintain the highest practicable well-being of each resident for 3 sampled residents (Residents #2-4). Findings include: 1. Per observation of the first-floor unit on 10/30/22 at approximately 1000, the nurse assigned to care for all residents on the floor was	F 725	the appropriate comprovide nursing and resident safety and practicable physical well-being of each resident assessmer and considering the diagnoses of the factordance with the at §483.70(e). §483.35(a)(1) The fiby sufficient number types of personnel nursing care to all resident care plans (i) Except when wathlis section, license (ii) Other nursing plimited to nurse aid §483.35(a)(2) Exceparagraph (e) of the designate a license nurse on each tour This REQUIREMED by: Based on observation types of each residents (Resider 1. Per observation 10/30/22 at approximation and provided the safety of the servation 10/30/22 at approximation and safety	related services to assure attain or maintain the highest in mental, and psychosocial esident, as determined by ints and individual plans of care number, acuity and cility's resident population in efacility assessment required facility must provide services are of each of the following on a 24-hour basis to provide esidents in accordance with it is ived under paragraph (e) of ed nurses; and ersonnel, including but not es. The provide in accordance with it is section, the facility must ed nurse to serve as a charge of duty. Note in met as evidenced with it is not met as evidenced with the highest practicable resident for 3 sampled in the highest practicable resident for 3 sampled ints #2-4). Findings include:	F 725	receiving their medication as ordered #2 The medication administration audit will be reviewed for the past seven days and the MD will be notified of any medications omitted #3 Licensed nursing staff will be educated on the process to follow if a medication cannot be administered as ordered. #4 The medication administration audit report will be reviewed weekly x 4 weeks then monthly x 2 months to ensure medication administration compliance. Results will be presented and reviewed at QAPI on a monthly basis until substantial compliance has been determined. Tag F725 POC Accepted on				

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION UMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED			
		475025	в. WING			1	C 12/01/2022	
NAME OF PROVIDER OR SUPPLIER SPRINGFIELD HEALTH & REHAB			STREET ADDRESS, CITY, STATE, ZIP CODE 105 CHESTER RD SPRINGFIELD, VT 05156			1,201,201		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	JD PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X6) COMPLETION DATE	
F 725	stated that they were medications schedule. Per observation of the 10/30/22 at approximassigned to care for a the facility's nurse ed Preventionist. Per interview on 11/3 the facility Administration been struggling with vacancies, even with nurses. The Administration facility was working to census between the residents from their editat they can only find sides of one unit. The that they were current on the second floor and the second floor and they were struggling. Per interview on 11/3 PM, an agency RN (they have been at the weeks. Of those 12 every day, often dounight shift). They state work because they their medications or	trying to finish morning and for 8:00 AM. e second-floor unit on the second and	F	725				

medications and treatments during their shifts, or

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

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CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A, BUILDING B. WING 475025 12/01/2022 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 105 CHESTER RD **SPRINGFIELD HEALTH & REHAB** SPRINGFIELD, VT 05156 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID COMPLETION (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) F 725 Continued From page 4 F 725 stay beyond their double shift into the morning to help pass medications. Per the nurse, they have been asked by the facility to be the only nurse for the entire facility on plots shift on one occasion. though that did not end up being the case. Per phone interview on 12/1/22 at approximately 10:00 AM, a facility LPN (licensed practical nurse) who primarily works on the night shift stated that there is often no one scheduled to come in and relieve them in the morning. They often stay into the morning in order to give residents their medications. They confirmed that they have been the only nurse on night shift for the whole facility on one occasion, though they could not remember when it was. Per record review, Residents #2, #3, and #4 all had the following note in their chart on 11/25/22, written by the MDS Coordinator; "MD (medical director) aware that AM medications on 11/24/22 were not given." Per interview on 12/1/22 at approximately 11:00 AM, the MDS Coordinator confirmed that the nurse assigned to the second-floor unit on the 12/24/22 day shift did not give morning medications to residents on the west wing, despite being assigned to both the east and west wing. It was the MDS Coordinator's job to inform the Medical Director and document the notification in all applicable resident records. Per interview on 12/1/22 at approximately 12:20 PM, the Administrator confirmed that the nurse assigned to the second floor on 12/24/22 day shift was aware that they were assigned all residents on the second floor but did not give morning

medications to residents on the west wing. The

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PRINTED: 12/15/2022 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A, BUILDING_ C 475025 B. WING_ 12/01/2022 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 105 CHESTER RD SPRINGFIELD HEALTH & REHAB SPRINGFIELD, VT 05156 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) F 725 Continued From page 5 F 725 Administrator also confirmed that this was a nurse sent from another facility to fill a vacancy in the facility's schedule.

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FORM APPROVED Division of Licensing and Protection (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: . A. BUILDING: B. WING 12/01/2022 475025 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 105 CHESTER RD SPRINGFIELD HEALTH & REHAB SPRINGFIELD, VT 05156 PROVIDER'S PLAN OF CORRECTION (X5) SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) \$320 S320 7.13 (d)(1) QUALITY OF CARE - STAFFING \$\$=F LEVELS 7.13 (d)(1) The facility shall maintain staffing #1 Staffing levels are meeting levels adequate to meet resident needs. the required minimum to allow for 3.0 hours of direct care per 1. At a minimum, nursing homes must provide: resident day. 1/3/2023 i. no fewer than three (3) hours of direct care per #2 All residents have the resident per day, on a weekly average, including potential to be affected. nursing care, personal care and restorative nursing care, but not including administration or #3 The scheduler will be educated on the state required supervision of staff; and staffing minimums. ii. of the three hours of direct care, no fewer than #4 PPD will be audited weekly x two (2) hours per resident per day must be assigned to provide standard LNA care (such as 4 weeks then monthly x 2 to personal care, assistance with ambulation, ensure that state minimum of 3.0 feeding, etc.) performed by LNAs or equivalent hours of direct care per resident staff and not including meal preparation, physical day are being met. Results will therapy or the activities program. be presented and reviewed at QAPI on a monthly basis until substantial compliance has been This REQUIREMENT is not met as evidenced determined. Based on staff interview and record review, the facility failed to maintain required minimum staffing levels to allow for 3.0 hours of direct care per resident per day (PPD) on a weekly average, including nursing care, personal care and restorative nursing care. Findings include: Tag S320 POC Accepted on 01/03/2023 Per review of the daily nursing PPD hours as by K.Ruffe/P.Cota calculated by the facility's timecard software, the average direct care PPD by qualifying nursing staff were as follows: Week of 11/1/22 through 11/7/22 - 2.97 Week of 11/8/22 through 11/14/22 - 2.89 Week of 11/15/22 through 11/21/22 - 2.52 Week of 11/22/22 through 11/28/22 - 2.49 Division of Licensing and Protection

NTATIVE'S SIGNATURE DIRECTOR'S OR PROVIDER/SC

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<u>Division</u>	of Licensing and Prote	ection			FOF	RM APPROVED	
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	LE CONSTRUCTION	(X3) DATE	SURVEY	
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						c	
		475025	B. WING		1 12	C 12/01/2022	
NAME OF P	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, ST	ATE ZIP CODE	 	TO IVEVEL	
SPRINGFI	IELD HEALTH & REHAB		STER RD	A1C, CI. 300C			
		SPRING	FIELD, VT 0515	56			
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TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION : CROSS-REFERENCED TO THE A	SHOULD RF	(X5) COMPLETE	
	·	·	17.5	DEFICIENCY)	PPROPRIATE	DATE	
\$320	Continued From page	e 1	S320			 	
		80/22 at approximately 3:00					
	PM, the facility sched	duler was asked to manually					
l İ	calculate the PPD ba	sed on actual staff worked	ļ				
	hours (as documente	ed by punches in and out) for	1			j	
	a random sample of o	dates listed as having PPD					
	11/23/22, 11/24/22, 1	1/20/22, 11/21/22, 11/22/22, 1/28/22). The manual					
	calculations confirme	d PPD below 3.0 for all					
i	days.		ľ				
İ	Devision design						
	Per interview on 12/1/	/22 at approximately 1300,					
ļ	PPD below 3.0 during	g confirmed the days with					
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