AGENCY OF HUMAN SERVICES
DEPARTMENT OF DISABILITIES, AGING AND INDEPENDENT LIVING

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

February 22, 2023

Mr. Bruce Kimball, Administrator
Springfield Health & Rehab
105 Chester Rd
Springfield, VT 05156-2106

Dear Mr. Kimball:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **January 26, 2023.** 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

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 ______	01/26/2023

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 onsite, unannounced investigation of Emergency Preparedness on 1/26/2023. There were no regulatory findings related to this investigation.	E 000		
F 000	INITIAL COMMENTS The Division of Licensing and Protection conducted an onsite, unannounced recertification survey from 1/24/2023 through 1/26/2023. The following regulatory deficiencies were cited as a result:	F 000		
F 636 SS=E	Comprehensive Assessments & Timing CFR(s): 483.20(b)(1)(2)(i)(iii) §483.20 Resident Assessment The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. §483.20(b) Comprehensive Assessments §483.20(b)(1) Resident Assessment Instrument. A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following: (i) Identification and demographic information (ii) Customary routine. (iii) Cognitive patterns. (iv) Communication. (v) Vision. (vi) Mood and behavior patterns. (vii) Psychological well-being. (viii) Physical functioning and structural problems.	F 636	**Please see attached**	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature]	NHA	2/19/23

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	475025	A. BUILDING ____ B. WING ____	01/26/2023

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 636	Continued From page 1 (ix) Continence. (x) Disease diagnosis and health conditions. (xi) Dental and nutritional status. (xii) Skin Conditions. (xiii) Activity pursuit. (xiv) Medications. (xv) Special treatments and procedures. (xvi) Discharge planning. (xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS). (xviii) Documentation of participation in assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and nonlicensed direct care staff members on all shifts. §483.20(b)(2) When required. Subject to the timeframes prescribed in §413.343(b) of this chapter, a facility must conduct a comprehensive assessment of a resident in accordance with the timeframes specified in paragraphs (b)(2)(i) through (iii) of this section. The timeframes prescribed in §413.343(b) of this chapter do not apply to CAHs. (i) Within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. (For purposes of this section, "readmission" means a return to the facility following a temporary absence for hospitalization or therapeutic leave.) (iii)Not less than once every 12 months. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility failed to conduct initially and periodically a	F 636		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	475025	A. BUILDING ______ B. WING ______	01/26/2023

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 636	Continued From page 2 comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity for 11 of 21 applicable residents (Residents # 15, 27, 35, 4, 19, 18, 6, 49, 45, 34, 30). Findings include: 1. Resident # 15 was admitted to the facility on 7/6/21. A Minimum Data Set (MDS) dated 10/31/22 indicated that Resident # 15 had not been assessed for pain. 2. Resident # 27 was admitted to the facility on 11/4/21. An MDS dated 1/2/23 indicated that Resident # 27 had not been assessed for pain. 3. Resident # 35 was admitted to the facility on 10/21/22. An MDS dated 1/10/23 indicated that Resident # 35 had not been assessed for pain. 4. Per record review, Resident #4 had an MDS assessment conducted on 11/15/2022. The question "should pain assessment interview be conducted?" was marked as "yes" by the MDS Coordinator. Each question for the interview was marked as "not assessed." 5. Per record review, Resident #19 had an MDS assessment conducted on 12/13/2022. The question "should pain assessment interview be conducted?" was marked as "yes" by the MDS Coordinator. Each question for the interview was marked as "not assessed." 6. Per record review, Resident #18 had an MDS assessment conducted on 10/6/2022 and 1/6/2023. The question "should pain assessment interview be conducted?" was marked as "yes" by the MDS Coordinator on both assessments. Each question for the interview was marked as "not	F 636		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	475025	A. BUILDING ______ B. WING ______	01/26/2023

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 636	Continued From page 3	F 636		

assessed" on both interviews.

Per interview on 1/25/2023 at approximately 3:42 PM, the MDS Coordinator confirmed that residents who were marked as requiring pain assessment interview with "not assessed" marked in all fields were not completed as required.

7. Resident # 6 was admitted to the facility on 4/4/22. A Minimum Data Set (MDS) dated 1/3/23 indicated that resident #6 had not been assessed for pain, as evidenced by Section J of the MDS was coded "Yes" indicating that the pain assessment interview should be conducted. Further review reveals that all the pain assessment interview question that followed are coded "not assessed".

8. Resident # 49 was admitted to the facility on 1/1/22. A MDS dated 12/22/22 indicated that Resident # 49 had not been assessed for pain, as evidenced by section J of the MDS was coded "Yes" indicating that the pain assessment interview should be conducted. Further review reveals that all the pain assessment interview question that followed are coded "not assessed".

9. Resident # 45 was admitted to the facility on 5/5/21. A MDS dated 1/5/22 indicated that Resident # 45 had not been assessed for pain, as evidenced by Section J of the MDS was coded "Yes" indicating that the pain assessment interview should be conducted. Further review reveals that all the pain assessment interview questions that followed are coded "not assessed".

10. Resident # 34 was admitted to the facility on 1/1/21. A MDS dated 12/12/22 indicated that

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	475025	A. BUILDING ______ B. WING ______	01/26/2023

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 636	Continued From page 4 Resident # 34 had not been assessed for pain, as evidenced by Section J of the MDS was coded "Yes" indicating that the pain assessment interview should be conducted. Further review reveals that all the pain assessment interview question that followed are coded "not assessed". 11. Resident # 30 was admitted to the facility on 9/7/21. A MDS dated 12/2/22 indicated that resident #30 had not been assessed for pain, as evidenced by Section J of the MDS was coded "Yes" indicating that the pain assessment interview should be conducted. Further review reveals that all the pain assessment interview questions that followed are coded "not assessed".	F 636		
F 656 SS=E	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §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	**Please see attached**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	475025	A. BUILDING ______ B. WING ______	01/26/2023

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 656	Continued From page 5	F 656		

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.
§483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must-
(iii) Be culturally-competent and trauma-informed.
This REQUIREMENT is not met as evidenced by:
Based on observation, interview and record review, the facility failed to develop/implement comprehensive, person-centered care plans regarding mental health, injury, and catheter care for four of 21 residents (Residents #45, 42, 19, and 9). Findings include:

1. Per record review, Resident #19 has a diagnosis of Post-Traumatic Stress Disorder (PTSD). Review of the care plan does not show any care plan focus for PTSD or include any interventions related to Resident #19's triggers

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	475025	A. BUILDING ______ B. WING ______	01/26/2023

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 656	Continued From page 6	F 656		

and how to avoid re-triggering the Resident during interactions and care.

Per interview on 1/26/2023 at approximately 12:00 PM, the Interim Director of Nursing confirmed that there was nothing in Resident #19's care plan regarding their triggers.

2. Per observation on 1/24/2023 at approximately 1:00 PM, Resident #42 has a foley catheter in place (a catheter that drains urine from the bladder) and review of Resident #42's record confirms this. Per review of Resident #42's care plan, there is a focus for "urinary incontinence/indwelling catheter" that was initiated on 11/24/2020. One of the interventions states "catheter care every shift" initiated on 1/19/2023. Per review of Resident #42's orders, an order for "Foley Catheter Care every shift for urinary elimination" was initiated on 11/23/2020 but discontinued on 1/19/2023. Review of Resident #42's treatment administration record shows that catheter care was documented as provided every shift by nursing until 1/19/2023. After 1/19/2023, there is nothing in the record to verify that Resident #42 had received any catheter care.

Per interview on 1/26/2023 at approximately 12:00 PM, the Interim Director of Nursing confirmed that provision of catheter care is not documented anywhere in the record beyond the date of 1/19/2023.
3. On 01/24/23 Resident #45 is observed to be sitting in a recliner chair in his/her room. Interview with Resident #45 reveals that S/he is experiencing pain and proceeded to raised his/her left arm and express facial grimacing . Resident #45 reveals that s/he had fallen

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	475025	A. BUILDING ___ B. WING ___	01/26/2023

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 656	Continued From page 7 recently, but s/he could not remember when, but knows that is when the pain started. Per Medical Record review, a progress note on 1/10/23 at 11:02 PM states Resident # 45 was found on the floor in his/her room laying on his/her left side. Progress note on 1/22/23 reveals Resident #45 was experiencing Left arm uncontrolled pain, Physician orders given to obtain X- ray and manage pain with Tylenol. X Ray report dated 1/23/23 reveals that resident #45 is diagnosed with a left 9th rib fracture. Review of Resident #45 care plan reveals pain problem was not updated with increased pain level. The Care plan does not address left 9th rib fracture. On 1/26/23, an interview with the Director of Nursing (DON) indicates that DON would expect that the pain care plan would be updated with increased complaints of pain. DON also would expect that the Left Rib fracture would be addressed on the care plan. DON confirms that the care plan has not been updated appropriately for increase pain or for Left rib fracture. 4. Per record review, resident #9's care planned intervention reads, "catheter care twice a day and PRN" (as needed). There was no documentation of catheter care found in this resident's records from the time period of 01/11/23 through 01/25/23. The facility policy for Catheter Care reads that catheter care is to be performed twice daily and as needed. Resident #9 has a medical diagnosis list which includes a history of acute urinary tract infections; the most recent infection required hospitalization	F 656		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	475025	A. BUILDING ______ B. WING ______	01/26/2023

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 656	Continued From page 8 on 10/23/22. The diagnosis list also includes Benign Prostatic Hypertrophy and Inflammatory Reaction to Indwelling Catheter. Review of the resident's Physician's Orders showed an order was in place for catheter care to be performed every shift, but this order was discontinued on 01/11/23. A staff interview was performed on 01/25/23 at 1:50 PM with the nurse assigned to Resident #9. S/he stated catheter care should be signed out in the electronic Treatment Administration Record by nursing staff. This nurse stated s/he performed catheter care on all assigned shifts s/he worked, but s/he could show no documentation in the medical record of this. On 01/26/23 at 10:50 AM the Director of Nursing confirmed the physician's order for catheter care had been discontinued on 01/11/23 and was not reinstated until the night shift on 01/25/23. S/he stated an order should have been in place for catheter care per facility policy and per resident's care plan.	F 656		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff.	F 657	**Please see attached**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	475025	A. BUILDING ______ B. WING ______	01/26/2023

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 657	Continued From page 9 (E) To the extent practicable, the participation of 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 resident's care plan. (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 by: Based upon interview and record review, the facility failed to revise Care Plans to prevent future falls for 2 residents [Resident # 11 and #19] of 21 sampled residents. Findings include: 1.) Per record review, Res. #11 was admitted to the facility with diagnoses that include muscle weakness, difficulty in walking, and repeated falls. Review of the resident's Care Plan reveals the resident was identified as having "a potential for falls related to: Cognitive Impairment, Impulsivity or poor safety awareness, Incontinence, Dementia, Parkinson's disease". Review of Nurses Notes for Res. #11 on 1/11/23 record "Heard resident yelling hello out of room. Upon entering room resident was lying on side of bed on floor on right side. Resident stated, "I was trying to get out of bed."." Further record review reveals on 1/23/23 a Change in condition form records Res. #11 "slid down the side of bed onto buttock".	F 657		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	475025	A. BUILDING ______ B. WING ______	01/26/2023

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 657	Continued From page 10	F 657		

Review of Res. #11's Care Plan reveals no new interventions added to prevent future falls after either of falls. The Care Plan records the last fall prevention intervention entered on 8/2/22.
A single intervention dated 1/18/23, a week after the fall on 1/11/23, reads "Monitor toileting needs before meals and at hour of sleep." The Care Plan lists this as a revision/new intervention, with the previous version, entered on 5/9/22, reading "Monitor toileting needs".
Per interview with the facility's Director of Nursing [DON] on 1/26/23 at 9:06 AM, the DON confirmed this was not a new intervention but repeating the previous one. The DON confirmed "Monitoring toileting needs" would include "before meals and hour of sleep". The DON further confirmed that there were no new interventions or revisions added to Res. #11's Care Plan after either fall on 1/11/23 and 1/23/23 to prevent the resident from falling again.

2. Per record review, Resident #19 has diagnoses of morbid obesity, muscle weakness, and unspecified abnormalities of gait and mobility. Resident #19's care plan identifies them as being "at risk for falls secondary to deconditioning, gait/balance problems." There are no care plan interventions added or revised after 1/7/2023.

Per review of progress notes, a nursing note from 1/7/2023 states, "Notified that resident was lying on side mat on side of bed. Resident was able to get out of bed onto the pad. Resident wasn't on the floor and didn't have any injuries."

Per review of the facility's policy for "Falls Management" the policy states "unless there is

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	475025	A. BUILDING ______ B. WING ______	01/26/2023

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 657	Continued From page 11 evidence suggesting otherwise, a fall is considered to have occurred when a patient is found on the floor." Per interview on 1/26/2023 at approximately 12:00 PM, the Interim Director of Nursing confirmed that there were no updates to Resident #19's care plan after 1/7/2023 and that the circumstances of this incident meet the facility's definition of a fall.	F 657		
F 689 SS=D	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 upon interview and record review, the facility failed to ensure that the resident environment remains as free of accident hazards as is possible including evaluating and analyzing hazards and risks, implementing interventions to reduce hazards and risks, and monitoring for effectiveness and modifying interventions when necessary for 2 residents [Resident #11 and #19] of 21 sampled residents. Findings include: 1.) Per record review, Res. #11 was admitted to the facility with diagnoses that include muscle weakness, difficulty in walking, and repeated falls. Review of the resident's Care Plan reveals the	F 689	**Please see attached**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	475025	A. BUILDING ______ B. WING ______	01/26/2023

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 689	Continued From page 12 resident was identified as having "a potential for falls related to: Cognitive Impairment, Impulsivity or poor safety awareness, Incontinence, Dementia, Parkinson's disease". Review of the facility's Falls Management Policy, revised 6/15/22, includes "A fall is defined as unintentionally coming to rest on the ground, floor, or other lower level, but not as a result of an overwhelming external force (e.g., patient pushes another patient). An episode where a patient lost their balance and would have fallen if not for another person or if they had not caught themselves is considered a fall. A fall without injury is still a fall. Unless there is evidence suggesting otherwise, a fall is considered to have occurred when a patient is found on the floor. The policy further states "Patients experiencing a fall will receive appropriate care and post-fall interventions will be implemented." Under 'Practice Standards' in the policy is listed "Implement and document patient-centered interventions according to individual risk factors in the patient's plan of care." Review of Nurses Notes for Res. #11 on 1/11/23 record "Heard resident yelling hello out of room. Upon entering room resident was lying on side of bed on floor on right side. Resident stated, "I was trying to get out of bed."." Further record review reveals on 1/23/23 a Change in condition form records Res. #11 "slid down the side of bed onto buttock". Review of Res. #11's Care Plan reveals no new interventions added to prevent future falls after either of falls. The Care Plan records the last fall prevention intervention entered on 8/2/22. A single intervention dated 1/18/23, a week after the fall on 1/11/23, reads "Monitor toileting needs	F 689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	475025	A. BUILDING ______ B. WING ______	01/26/2023

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 689	Continued From page 13 before meals and at hour of sleep." The Care Plan lists this as a revision/new intervention, with the previous version, entered on 5/9/22, reading "Monitor toileting needs". Per interview with the facility's Director of Nursing [DON] on 1/26/23 at 9:06 AM, the DON confirmed this was not a new intervention but repeating the previous one. The DON confirmed "Monitoring toileting needs" would include "before meals and hour of sleep". Review of the facility's Fall/Incident log reveals only a single fall recorded for Res. #11 in January, on 1/11/23. Though the Change in Condition form dated 1/23/23 records Res.# 11 "slid down the side of bed onto buttock" [facility policy defines a fall as "a fall is considered to have occurred when a patient is found on the floor"] the form records the fall as "Other change in condition", while leaving the option "fall" unchecked. Nursing Documentation the next day records "reason for stay/documentation: Status post fall". Review of the facility's Post-Fall Management also includes: "Document circumstances of the fall". An interview was conducted with the facility's Director of Nursing [DON] on 1/26/23 at 9:06 AM. The DON confirmed that when Res. #11 "slid down the side of bed onto buttock" on 1/23/23 that the resident experienced a fall. The DON confirmed that the fall on 1/23/23 should have been documented as fall but was not, and circumstances of the fall were not included in the resident's medical record. The DON also confirmed that the fall on 1/23/23 was not included in the facility's Fall/Incident Log, and that the Fall/Incident Log only records 1 of Res. #11's 5 falls in the last 6 months. The DON reported	F 689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	475025	A. BUILDING ______ B. WING ______	01/26/2023

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 689	Continued From page 14 that the Fall/Incident Log is reported to the facility's Quality Assurance and Performance Improvement committee to help determine facility policy. The DON confirmed that the facility's Falls Management policy was not followed regarding identifying falls, documenting circumstances, and implementing new post-fall interventions to prevent future falls. 2. Per record review, Resident #19 has diagnoses of morbid obesity, muscle weakness, and unspecified abnormalities of gait and mobility. Resident #19's care plan identifies them as being "at risk for falls secondary to deconditioning, gait/balance problems." Per review of progress notes, a nursing note from 1/7/2023 states, "Notified that resident was lying on side mat on side of bed. Resident was able to get out of bed onto the pad. Resident wasn't on the floor and didn't have any injuries." There is no evidence in the record that the facility's post-fall procedure was initiated. Per review of the facility's incident and accident log, there is no fall listed for Resident #19 on 1/7/2023. There is also no evidence in the record that any assessment was done as to whether Resident #19 intentionally or unintentionally placed themselves on the mat beside their bed. Per review of the facility's policy for "Falls Management" the policy states "unless there is evidence suggesting otherwise, a fall is considered to have occurred when a patient is found on the floor." Per interview on 1/26/2023 at approximately 12:00 PM, the Interim Director of Nursing	F 689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	475025	A. BUILDING ______ B. WING ______	01/26/2023

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 689	Continued From page 15 confirmed that the circumstances of this incident meet the facility's definition of a fall and that the facility's post-fall protocol should have been initiated.	F 689		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel	F 690	**Please see attached**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	475025	A. BUILDING ______ B. WING ______	01/26/2023

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 690	Continued From page 16	F 690		

receives appropriate treatment and services to restore as much normal bowel function as possible.
This REQUIREMENT is not met as evidenced by:
Based on observation, interview, and record review, the facility failed to ensure that residents with urinary catheters receive appropriate treatment and services to prevent urinary tract infections for 2 of 2 sampled residents (Residents #42 and #9). Findings include:

1. Per observation on 1/24/2023 at approximately 1:00 PM, Resident #42 has a foley catheter in place (a catheter that drains urine from the bladder).

Review of Resident #42's record confirms the placement of the foley catheter. Per review of Resident #42's orders, an order for "Foley Catheter Care every shift for urinary elimination" was initiated on 11/23/2020 but discontinued on 1/19/2023. Review of Resident #42's treatment administration record shows that catheter care was documented as provided every shift by nursing until 1/19/2023. After 1/19/2023, there is nothing in the record to verify that Resident #42 had received any catheter care.

Per the facility's procedure guide titled "Catheter: Indwelling Urinary - Care Of" the procedure states the following:
- "1. Perform Catheter care twice a day and PRN (as needed)."
- "21. Document 21.1 Catheter Care."

Per interview on 1/26/2023 at approximately 12:00 PM, the Interim Director of Nursing confirmed that provision of catheter care is not

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	475025	A. BUILDING ______ B. WING ______	01/26/2023

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 690	Continued From page 17 documented anywhere in the record beyond the date of 1/19/2023. 2. Per record review, resident #9's care planned intervention reads, "catheter care twice a day and PRN" (as needed). There was no documentation of catheter care found in this resident's records from the time period of 01/11/23 through 01/25/23. The facility policy for Catheter Care reads that catheter care is to be performed twice daily and as needed. The policy also reads that this care will be documented in the resident's records. Review of the resident's Physician's Orders showed an order was in place for catheter care to be performed every shift, but this order was discontinued on 01/11/23. On 01/26/23 at 10:50 AM the Director of Nursing confirmed the physician's order for catheter care had been discontinued on 01/11/23 and was not reinstated until the night shift on 01/25/23. S/he stated an order should have been in place for catheter care per facility policy and per resident's care plan.	F 690		
F 692 SS=D	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte	F 692	**Please see attached**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	475025	A. BUILDING ______ B. WING ______	01/26/2023

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 692	Continued From page 18	F 692		

balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise;

§483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health;

§483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet.
This REQUIREMENT is not met as evidenced by:
Based on staff interview and record review, the facility failed to provide proper assessment to ensure that residents maintain acceptable parameters of nutritional status for one of 21 residents (Resident #19). Findings include:

1. Per record review, Resident #19 weighed 329.5 lbs on 03/23/2022. On 09/01/2022, the resident weighed 270.4 pounds, which is a -17.94 % loss over 6 months. There are no weights recorded for Resident #19 for the months of October, November, and December 2022.

Per review of Resident #19's orders, an order was placed for "weight in the moring every 31 days for health monitoring" on 7/1/2022 and was not discontinued until 12/20/2022. A new order for monthly weights was placed on 1/1/2023.

Per a progress note on 10/20/2022, the note states, "Please obtain updated weight for assessment and MDS (minimum data set) purposes."

Per a Nutrition Problem assessment conducted on 12/20/2022 for Resident #19, the assessment states, "Weight loss trend since admission,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	475025	A. BUILDING ______ B. WING ______	01/26/2023

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 692	Continued From page 19 however current assessment of weight undeterminable." Per interview on 1/26/2023 at approximately 12:00 PM, the Director of Nursing confirmed that no weights could be found for the months of October, November, and December of 2022.	F 692		
F 699 SS=D	Trauma Informed Care CFR(s): 483.25(m) §483.25(m) Trauma-informed care The facility must ensure that residents who are trauma survivors receive culturally competent, trauma-informed care in accordance with professional standards of practice and accounting for residents' experiences and preferences in order to eliminate or mitigate triggers that may cause re-traumatization of the resident. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility failed to ensure that residents who are trauma survivors receive trauma informed care that mitigates triggers that may re-traumatize residents for one of 21 residents (Resident #19). Findings Include: Per record review, Resident #19 has a diagnosis of Post Traumatic Stress Disorder. Per review of Resident #19's record, there was no evidence found that Resident #19 was assessed for triggers that may re-traumatize the Resident. There was also no evidence found in Resident #19's plan of care regarding the Resident's triggers or how staff can provide care that avoids re-traumatizing the Resident. Information about Resident #19's traumatic experiences is not readily available in the record to direct care staff.	F 699	**Please see attached**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	475025	A. BUILDING ______ B. WING ______	01/26/2023

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 699	Continued From page 20 Per interview on 1/26/2023 at approximately 12:00 PM, the Interim Director of Nursing confirmed that they were not aware of this information being available in Resident #19's record.	F 699		
F 730 SS=F	Nurse Aide Peform Review-12 hr/yr In-Service CFR(s): 483.35(d)(7) §483.35(d)(7) Regular in-service education. The facility must complete a performance review of every nurse aide at least once every 12 months, and must provide regular in-service education based on the outcome of these reviews. In-service training must comply with the requirements of §483.95(g). This REQUIREMENT is not met as evidenced by: Based on interview, the facility failed to complete nurse aide performance reviews at least every 12 months as required. Findings include: On 01/24/23, a sampling of two Licensed Nurse Aide Performance Review records were requested by the survey team for review. Per interview with the facility's Administrator and Administrator in Training on 01/26/23 at 9:05 AM, the facility was unable to produce the requested records or demonstrate that the required reviews were conducted.	F 730	**Please see attached**	
F 756 SS=D	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist.	F 756	**Please see attached**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	475025	A. BUILDING ______ B. WING ______	01/26/2023

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 756	Continued From page 21	F 756		

§483.45(c)(2) This review must include a review of the resident's medical chart.

§483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon.
(i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug.
(ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified.
(iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record.

§483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident.
This REQUIREMENT is not met as evidenced by:
Based on record review and staff interview the facility Pharmacist failed to provide a report on drug review and or irregularities for 1 of 21 sampled residents (Resident #6). Findings

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	475025	A. BUILDING ______ B. WING ______	01/26/2023

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 756	Continued From page 22 include: 1. Per record review for Resident # 6, there is no evidence of Pharmacy reviews for the following months; October 2022, September 2022 and July 2022. On 1/25/23 the Director of Nursing (DON) was informed of missing pharmacy reviews and on 1/26/23 the DON confirmed that at this time, she was unable to locate the pharmacy reviews for Resident #6.	F 756		
F 882 SS=F	Infection Preventionist Qualifications/Role CFR(s): 483.80(b)(1)-(4) §483.80(b) Infection preventionist The facility must designate one or more individual(s) as the infection preventionist(s) (IP) (s) who are responsible for the facility's IPCP. The IP must: §483.80(b)(1) Have primary professional training in nursing, medical technology, microbiology, epidemiology, or other related field; §483.80(b)(2) Be qualified by education, training, experience or certification; §483.80(b)(3) Work at least part-time at the facility; and §483.80(b)(4) Have completed specialized training in infection prevention and control. This REQUIREMENT is not met as evidenced by: Based upon interview and record review the facility failed to ensure the staff member designated as the facility's Infection Preventionist had obtained specialized IPC training beyond initial professional training or education prior to	F 882	**Please see attached**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	475025	A. BUILDING ______ B. WING ______	01/26/2023

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 882	Continued From page 23 assuming the role. Findings include: An interview was conducted with the staff member designated as the facility's Infection Preventionist on 1/26/23 at 11:23 AM. The staff member stated that they had assumed the role of the facility's Infection Preventionist in October 2022. Per record review and confirmed by the staff member, the staff member stated they had not been able to complete the required Infection Preventionist certification training.	F 882		

F636 MDS Assessments

1. Residents 4, 6, 15, 18, 19, 27, 30, 34, 35, 45, 49 MDS assessments cited can not be corrected.
2. The DNS/Designee will complete a review of completed MDS assessments during the last 30 days to validate completion of pain assessments.
3. The MDS Coordinator will be educated on completing the pain assessment section of the MDS and Nurses will be educated on completing pain assessments/interviews.
4. The DNS/Designee will audit 5 MDS Assessments per week for 4 weeks then monthly for 2 months. DNS/Designee will report findings to the QAPI Committee for review.

Tag F 636 POC accepted on 2/22/23 by K. Ruffe/P. Cota

F656 Dev/Implement Care Plan

1. Residents 19's care plan was updated to include interventions related to how to avoid re-triggers for the resident during interactions and care.
   Resident #45's care plan was updated to include the new fracture and treatment for acute pain.
   Resident #9's and #42's care plans and orders have been updated to include catheter care.

2. Residents with diagnoses related to injuries, mental health, and indwelling catheters will be reviewed to validate these diagnoses are reflected in the care plans.

3. Nurses will be educated on developing and implementing care plans.

4. The DNS/Designee will audit 5 care plans per week for 4 weeks then monthly for 2 months. DNS/Designee will report findings to the QAPI committee for review.

Tag F 656 POC accepted on 2/22/23 by K. Ruffe/P. Cota

F657 Care Plan Revision

1. Residents #11 and #19 care plans have been revised to reflect the most recent fall intervention.
2. The DNS/Designee will review falls over the last 30 days to validate the care plans are updated to include the most recent fall intervention .
3. The DNS/Designee will educate nurses in regards to care plan revisions related to falls.
4. The DNS/Designee will audit 5 residents with falls per week for 4 weeks, then monthly for 2 months, to validate care plan revisions after falls. The DNS/Designee will report findings to the QAPI committee for review.

Tag F 657 POC accepted on 2/22/23 by K. Ruffe/P. Cota

F689 Accidents

1. Resident #11's care plan was updated to include new post-fall interventions to prevent future falls.

   Resident #19's fall on 1/07/2023 was investigated and post fall interventions added to the plan of care.

2. The DNS/Designee will complete a review of residents with falls within the last 30 days to validate

new post-fall interventions to prevent future falls was added to the resident's plan of care and incidents meeting criteria for fall have been investigated.

3. DNS/Designee will educate nurses on the Fall Management Program.

4. The DNS/Designee will audit 5 residents with falls per week for 4 weeks then monthly for 2 months to validate falls management program is followed including identifying falls, documenting circumstances, and new post-fall interventions to prevent future falls. The DNS/Designee will report findings to the QAPI committee for review.

Tag F 689 POC accepted on 2/22/23 by K. Ruffe/P. Cota

F690 Catheter Care

1. Resident #42 and #9 has orders for foley catheter care to prevent UTI and this care is being documented in the medical record.

2. An audit of residents with foley catheters was completed to validate foley catheter care orders are in place and being documented to prevent UTI.

3. The facility obtains orders for the care of foley catheters to prevent UTI, that care is documented in the medical record. The facility Licensed staff will be re-educated to this process.

4. DNS/Designee will complete audits of those residents with foley catheters to validate the MD order includes care of the foley catheter to prevent UTI weekly for 4 weeks, then monthly for 2 months. This

audit will include validation of care documented in the medical record. The DNS/Designee will report findings to the QAPI committee for review.

Tag F 690 POC accepted on 2/22/23 by K. Ruffe/P. Cota

F692 Nutrition/Hydration Status

1. Resident #19 order to obtain weights is being followed allowing for proper assessment of nutrition needs.
2. An audit of residents orders for weights was completed to validate weights are obtained and available for proper assessment of the residents nutritional needs.
3. The facility obtains weights as ordered to allow for proper assessments of the resident's nutritional needs. The licensed staff will be re-educated to this process.
4. DNS/Designee will complete weekly audits of resident's weight orders to validate weights are obtained and documented weekly for 4 weeks, then monthly for 2 months. The DON/Designee will report findings to the QAPI committee for review.

Tag F 692 POC accepted on 2/22/23 by K. Ruffe/P. Cota

F699 Trauma informed Care

1. Resident #19's care plan has been updated to reflect trauma informed care.
2. Social Service Director or designee will review residents with diagnosis related to trauma to ensure care plan reflects trauma informed care.

3. Social Service Director and nurses will be educated on F699 Trauma Informed Care
4. The Social Service Director/Designee will audit up to 5 new admissions per week for 4 weeks then monthly for 2 months to validate compliance with F699.

Tag F 699 POC accepted on 2/22/23 by K. Ruffe/P. Cota

F730 Nurse Aide Performance Evaluations

1. Nurse aide performance evaluations will be up to date.
2. The NHA or designee will review the employee files of all active Licensed Nurse Aides to validate current performance evaluations.
3. The DNS and NHA will be educated on F730 Nurse Aide Performance Evaluations.
4. The NHA/Designee will audit 5 nurse aide files per week for 4 weeks to validate performance evaluations are current and report findings to the QAPI committee for review.

Tag F 730 POC accepted on 2/22/23 by K. Ruffe/P. Cota

F756 Drug Regimen Review

1. The most recent pharmacy recommendations and review for resident 6 was located and was completed and addressed by the MD.
2. The DNS/Designee will review pharmacy recommendations for the last 30 days to validate completion of the review and follow-up is documented as per the MD response.
3. The DNS/Designee will educate licensed nurses on pharmacy

recommendations and follow-up.

4. The DNS/Designee will audit 5 residents with pharmacy recommendations per week for 4 weeks then monthly for 2 months. DON/Designee will report findings to the QAPI committee for review.

Tag F 756 POC accepted on 2/22/23 by K. Ruffe/P. Cota

F882 Infection Preventionist Qualifications

1. The Infection Preventionist has completed IP certification.
2. The NHA or designee will validate certification.
3. The NHA/Designee will educate the DNS and IP on F882 Infection Preventionist Qualifications.
4. The NHA will validate IP qualifications with any change in Infection Preventionist designation monthly times 3 months and report findings to the QAPI Committee for review.

Tag F 882 POC accepted on 2/22/23 by K. Ruffe/P. Cota