VERMONT

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

April 13, 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 investigation survey conducted on **March 30, 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 _____	C 03/30/2023

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 000	INITIAL COMMENTS The Division of Licensing and Protection conducted an onsite, unannounced investigation of two facility reported incidents on 3/29/2023, and was completed on 3/30/23. The following regulatory deficiency was cited as a result:	F 000		
F 656 SS=D	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 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	F 656	1. Resident # 1 Care plan is being followed to include keeping the door open at all times. 2. An audit of resident's with trauma informed care plans was audited to validate that the interventions are showing up on the Kardex and are being followed. DNS/Designee will validate that nursing staff have demonstrated access to Kardex on Point Click Care. 3. DNS/Designee will educate nursing staff on use of the Kardex which reflects the interventions in regards to care plans.	4/18/23

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: MHA | (X6) DATE: 4-5-23

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.

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F 656	Continued From page 1 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 interview and record review, the facility failed to implement the care plan for one of 3 sampled residents (Resident #1). Findings include: Per record review, Resident #1 has diagnoses of Post Traumatic Stress Disorder, Bipolar Disorder, Generalized Anxiety Disorder, and Major Depressive Disorder. Resident #1 has a care plan for "Past experience of trauma as evidenced by feeling upset when reminded of a stressful experience from the past" which was initiated on 2/5/2023. An intervention implemented on 2/17/2023 under this care plan focus states, "[Resident #1] is triggered by the door to [their] room being shut. Door is to remain open at all times. Privacy curtain will be used during patient care." The Kardex point of care documentation system for Nurse Aides also instructs staff to keep Resident #1's door open as they are triggered by their door being closed.	F 656	4. DNS/Designee will observe 5 staff members for compliance with Care Plan/Kardex per week for four weeks and then monthly for two months and report findings to the QAPI Committee for review. **Tag F 656 POC accepted on 4/12/23 by K. Ruffe/P. Cota**	

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F 656	Continued From page 2 The facility investigated a complaint by Resident #1 that took place on 2/28/2023. Resident #1 stated in an interview with the Social Services Director on 3/1/2023, "[LNA 1] shut my door. I was very scared when [they] did that and [they do] that often. They leave me in the dark." Per review of a documented phone interview conducted with LNA 1 over the phone on 3/2/2023, LNA 1 stated that they "shut the door to 'decrease agitation' ... the door is shut frequently for these reasons and it sometimes works. She then stated that she was not aware that the door shouldn't be shut." Per review of a documented interview conducted with LNA 2 on 3/3/2023, LNA 2 stated "On Tuesday night [2/28/2023], I did witness [LNA 1] walk past her door and slam it shut. I told [them they] cannot do that and I opened the door." Per interview on 2/29/2023 at approximately 12:30 PM, the Administrator confirmed that the care plan for Resident #1 was not followed.	F 656		