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

January 18, 2024

Mr. Scott Mow, Administrator
Springfield Health & Rehab
105 Chester Rd
Springfield, VT 05156-2106

Dear Mr. Mow:

Enclosed is a copy of your acceptable plans of correction for the complaint investigation conducted on **December 21, 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,

PamelaMCotaRN
Pamela M. Cota, RN
Licensing Chief

Enclosure

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 12/21/2023

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

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F 000	INITIAL COMMENTS The Division of Licensing and Protection conducted an unannounced, onsite complaint investigation, including report(s) #22433, #22460, #22481, and #22531 from 12/19/23 through 12/20/23 with additional record review on 12/21/23 to determine compliance with 42 CFR Part 483 requirements for Long Term Care Facilities. Deficiencies were cited as a result of this survey.	F 000	This plan of correction was written to follow state and federal guideines. It is not an admission of noncompliance. However, it is the facility's commitment to demonstrate and maintain compliance.	
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 services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition;	F 584	F 584 Specific Corrective Action 1. Rooms #123,124,203,206 and 209 were cleaned including floors and toilet areas. 2. Resident rooms were observed for cleanliness (including floors and toilet areas) any issues identified were addressed per housekeeping. 3. The facility employees Housekeeping staff to provide services necessary to maintain a sanitary, orderly, and comfortable environment. Housekeeping staff were educated on facility policy regarding daily and weekly room cleaning and the importance of room cleanliness and keeping a homelike environment. 4. NHA will complete observation of resident rooms to validate cleanliness. These audits will be completed 3x per week for 4 weeks , then 2x a week for 4 weeks, then weekly for 4 weeks. These audits will be brought to the monthly QAPI Committee for further review and recommendations. Date of Compliance 1/30/2024.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE NHA | (X6) DATE 1-12-24

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 §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, resident interview, and staff interview, the facility failed to ensure residents have a clean and comfortable environment as evidenced by a dirty and unsanitary resident environment. Findings include: Unit observations and interviews occurring on 12/20/23 between approximately 9:00 AM and 9:30 AM on both resident care units with the following findings: -The floor in room #203 had multiple, large drops of a sticky substance where dried dirt had been tracked in by shoes and stuck to the floor. There were also many muddy footprints that had dried on the floor (the most recent muddy day in the location of the facility was two days prior). -The floor in room #209 had multiple dried, muddy footprints and old stains of a colored liquid. The bathroom toilet had an over-toilet commode that was caked in layers of creams and powders. The toilet bowl had large, dried feces	F 584	**Tag F 584 POC accepted on 1/18/24 by K. Ruffe/P. Cota**	

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F 584	Continued From page 2 splatters and mold growing in the bowl below the water line. At this time, the Resident in Bed #2 stated that housekeeping does not clean their room on a regular basis. -The floor in room #206 had multiple dried, muddy footprints and clumps of dried mud on the floor. The toilet bowl had large, dried feces splatters and mold growing in the bowl below the water line. Per joint observation and interview on 12/20/23 at approximately 9:30 AM, the Clinical Lead confirmed that the floors and toilets in these rooms were very dirty and that they would have housekeeping address it right away. On 12/20/23 at approximately 9:40 AM, additional observations and interviews were conducted on the units: -The floor in room #203 had multiple dried footprints and trash debris strewn across the floor and behind/under furniture. There were several clumps of dust behind the furniture as well. The resident in Bed #1 confirmed that housekeeping does not clean their room on a regular basis. -The floor in room #123 had dried mud and trash debris strewn across the floor under the beds in the room. -The floor in room #124 had dried mud, trash debris, and a thick layer of dust underneath and around the perimeter of the beds in the room.	F 584		
F 585 SS=C	Grievances CFR(s): 483.10(j)(1)-(4) §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity	F 585	F585 Specific Corrective Action 1. Postings that include information on how to file a grievance have been placed in high traffic areas at an observable height for residents on the units.	

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F 585	Continued From page 3 that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay. §483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph. §483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident. §483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include: (i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may	F 585	F585 continued..... 2. All residents have the potential to be affected by the deficient practice 3. The facility makes information on how to file a grievance or complaint available to the resident and/or resident representative. Facility administration staff have been re-educated to this process. 4. The NHA will audit resident floors to validate that information on how to file a grievance are posted on resident units for residents and/or resident representatives. Included in this audit will be ensuring grievance forms are readily available at Wheelchair level. These audits will be weekly x 4, bi-weekly x 4 weeks, then Monthly x 3 months. These audits will be brought to the monthly QAPI Committee for further review and recommendations. Date of Compliance 1/30/2024 **Tag F 585 POC accepted on 1/18/24 by K. Ruffe/P. Cota**	

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F 585	Continued From page 4	F 585		

be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system;
(ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations;
(iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated;
(iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law;
(v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued;
(vi) Taking appropriate corrective action in accordance with State law if the alleged violation

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F 585	Continued From page 5 of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to make information on how to file a grievance available to residents as evidenced by a lack of posted procedures on resident units. Findings include: Per observation on 12/20/23 at approximately 9:30 AM, neither of the resident care units had prominently posted signage to inform residents on the facility's process for filing a grievance with the grievance official. Shortly after this initial observation, findings were shared with the Clinical Lead. A joint observation confirmed that neither resident care unit had posted signage detailing the procedure on how residents or representatives can file a grievance with the facility. The Clinical Lead confirmed that the proper signage had not been posted. Per review of the facility's policy titled "Grievance/Concern", the policy states, "A description of the procedure for voicing grievances/concerns will be on each unit in a prominent location."	F 585		
F 657 SS=E	Care Plan Timing and Revision	F 657		

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F 657	Continued From page 6 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. (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 on staff interview and record review, the facility failed to ensure that care plans were reviewed by the interdisciplinary team within 7 days after completion of the comprehensive assessment for two of three sampled residents (Resident #1 and #2). Findings include: 1. Per record review, Resident #1 was admitted	F 657	F657 Specific Corrective Action 1. Resident #1 had a Care plan meeting on 12/28/2023. Resident #2 will have care plan meetings scheduled by 1/30/24 2. An audit of resident records was completed to validate that residents Care plan meetings have been scheduled within 7 days of completion of a comprehensive assessment by MDS. 3. The facility utilizes the MDS schedule to invite residents and their representatives to an interdisciplinary care plan meeting per the resident's preference to the meeting, within 7 days of completing the comprehensive assessment. The facility IDT will be re-educated to this process. 4. The NHA will complete audits of resident records to ensure care plan meetings have been completed within 7 days of completing the comprehensive assessment. These audits will be weekly x 4, bi-weekly x 4 weeks, then Monthly x 3 months. These audits will be brought to the monthly QAPI Committee for further review and recommendations. Date of compliance 1/30/2024. **Tag F 657 POC accepted on 1/18/24 by K. Ruffe/P. Cota**	

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F 657	Continued From page 7	F 657		

to the facility on 5/6/23. Per Minimum Data Set (MDS) records, comprehensive assessments were performed for Resident #1 on 5/10/23, 8/10/23, and 10/11/23. Records of care plan revision history show that the care plan was created on 5/16/23 and reviewed on 8/18/23 and 10/19/23.

Per review of care plan meeting progress notes, a care plan meeting took place on 5/11/23 and consisted of members of the interdisciplinary team, including Resident #1 and their family. There are no other progress notes to date documenting any interdisciplinary team meetings to discuss reviewing/revising the care plan for Resident #1.

Per interview on 12/20/23 at approximately 2:00 PM, the Administrator confirmed that no evidence could be found that any care plan meetings with the interdisciplinary team had taken place for Resident #1 following the completion of the 8/10/23 and 10/11/23 comprehensive assessments.

2. Per record review, comprehensive assessments were performed for Resident #2 on 10/18/23, 7/18/23, 4/17/23, 1/18/23, 10/18/22, 7/21/22, and 4/20/22. Records of care plan revision history show that the care plan was reviewed/revised on 10/25/23, 7/28/23, 4/24/23, 1/27/23, 10/28/22, 8/9/22, 7/28/22, and 4/21/22.

Per review of care plan meeting progress notes, a care plan meeting took place on 4/26/2022 and consisted of members of the interdisciplinary team, including Resident #2's representative. Resident #2 was invited but declined to attend. The next documented interdisciplinary care plan

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F 657	Continued From page 8 meeting is not until 9/27/23. Per interview on 12/20/23 at approximately 2:00 PM, the Administrator confirmed that no evidence could be found that any care plan meetings with the interdisciplinary team had taken place for Resident #2 between April of 2022 and September of 2023.	F 657		
F 712 SS=B	Physician Visits-Frequency/Timeliness/Alt NPP CFR(s): 483.30(c)(1)-(4) §483.30(c) Frequency of physician visits §483.30(c)(1) The residents must be seen by a physician at least once every 30 days for the first 90 days after admission, and at least once every 60 thereafter. §483.30(c)(2) A physician visit is considered timely if it occurs not later than 10 days after the date the visit was required. §483.30(c)(3) Except as provided in paragraphs (c)(4) and (f) of this section, all required physician visits must be made by the physician personally. §483.30(c)(4) At the option of the physician, required visits in SNFs, after the initial visit, may alternate between personal visits by the physician and visits by a physician assistant, nurse practitioner or clinical nurse specialist in accordance with paragraph (e) of this section. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility failed to ensure that residents are seen by a physician once every 30 days for the first 90 days after admission and at least once every 60 days thereafter, with non-physician practitioners	F 712	F712 Specific Corrective Action 1. Resident #1 had a regulatory visit completed by the MD on 12/08/2024. Resident #2 had a regulatory visit completed by the MD on 01/12/2024. 2. An audit of physician visits was completed to validate required physician visits occurred every 30 days for the first 90 days after admission and at least 60 days thereafter. This includes that after the initial visit by the MD, visits may alternate between the physician and a physician assistant or nurse practitioner. 3. The facility ensures that required physician visits occurred every 30 days for the first 90 days after admission and at least 60 days thereafter. This includes that after the initial visit by the MD, visits may alternate between the physician and a physician assistant or nurse practitioner. Medical staff, DON, and NHA will be re-educated to this process. 4. NHA/Designee will complete audits of required physician visits to validate the process is followed timely. These audits will be weekly x 4 weeks, bi-weekly x 4 weeks, and then monthly x 3 months. Results of these audits will be brought to the monthly QAPI Committee for further review and recommendations. Date of Compliance 1/30/2024	

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F 712	Continued From page 9 providing no more than every other required visit after the initial visit for 2 of 3 sampled residents (Resident #1 and #2). Findings include: 1. Per record review, Resident #1 was admitted on 5/6/23. Per a provider progress note from 5/8/23, Resident #1's initial provider visit was performed by the facility's Nurse Practitioner employed at that time. The following provider visits were performed on 6/15/23, 7/6/23, and 8/7/23 by the same Nurse Practitioner, per progress notes. Following this, there are no provider visits documented that include a review of Resident #1's total program of care until 12/8/23. The provider visit documented in progress notes on 12/8/23 is completed by a physician, but not Resident #1's Attending Physician on file in their record at the time of the visit. Resident #1's program of care was not comprehensively assessed by a physician from admission on 5/6/23 until 12/8/23. 2. Per record review, Resident #2 was admitted to the facility on 3/30/2015. Within the last year, Resident #2 is documented has having received comprehensive provider visits on 3/22/23, 5/10/23, 6/16/23, 7/6/23, 8/7/23, and 12/8/23. All visits were conducted by nurse practitioners. Within the last year, Resident #2's program of care has not been comprehensively assessed by a physician. Per interview on 12/20/23 at approximately 2:00 PM, the Administrator confirmed that the former medical director's employment with the facility had been terminated in August of 2023 after discovering that they had not been fulfilling their duties as medical director/resident attending physician. An interim medical director was hired	F 712	**Tag F 712 POC accepted on 1/18/24 by K. Ruffe/P. Cota**	

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F 712	Continued From page 10 in October of 2023 but there was a large backlog of Residents who were overdue for physician visits. They hired a part time physician to work every Friday to help the facility get caught up with physician assessments as quickly as possible. The Administrator confirmed that there is a corrective plan in place to address the issue of physician's visits but that they are still working through the list of Residents who are overdue for physician assessment due to the large scope of the problem. As of this investigation, the issue has not been fully corrected.	F 712		