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

July 8, 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 **June 12, 2024.** 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 06/12/2024

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 An unannounced, on-site complaint investigation for intakes #23056 and #23066 was conducted by the Division of Licensing and Protection on 6/12/24 to determine compliance with 42 CFR Part 483 requirements for Long Term Care Facilities. The following regulatory violations were identified:	F 000	This plan of correction was written to follow state and federal guidelines. It is not an admission of noncompliance. However, it is the facility's commitment to demonstrate and maintain compliance. F657 Specific Corrective Action	
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. (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.	F 657	1. Resident #1 care plan was revised to mitigate elopement risk. 2. An audit of residents with a history of elopement was completed to validate the CP has been updated following the elopement to mitigate further elopement risk. 3. The facility ensures that Patients/Residents will be evaluated for elopement risk upon admission, re-admission, quarterly, change in condition, and following an episode of elopement as part of the clinical assessment process. Those determined to be at risk will receive appropriate interventions to the care plan to reduce risk and minimize injury. Licensed staff, DON, NHA, SS Director will be re-educated to this process. 4. DON/Designeewill complete audits to validate residents are evaluated for elopement risk upon admission, readmission, change in condition and new incident of elopement. That evaluation will include updates to the plan of care to mitigate elopement risk. These audits will be weekly x 4 weeks, bi-weekly x 4 weeks, 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 7/12/2024.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

[signature] | NHA | 7-5-24

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.

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 06/12/2024

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 1 This REQUIREMENT is not met as evidenced by: Per interview and record review the facility failed to revise the comprehensive care plan related to a resident elopement from the facility for one sampled resident [Res.#1]. Findings include: Review of the medical record for Resident #1 reveals h/she is a 70-year-old admitted on 12/1/23 with diagnoses that include alcohol abuse, vascular dementia, psychotic disturbance, mood disturbance and anxiety. An interview was conducted on 6/12/24 at 12:48 PM with Resident #1's assigned Licensed Practical Nurse [LPN] during events on 5/25/24. The LPN stated on the morning of 5/25/24, Resident #1 had the wander guard present, and had triggered the alarm, then exited the building. The LPN stated that staff observed via the camera that Resident # 1 was outside and s/he "was just sitting there". The LPN reported later "We didn't realize [s/he] had left. We were in the process of searching for [h/her] for approximately 30 minutes when police called and reported picking up the resident." Per record review, on 5/25/24 at 9:28 PM, after Resident 1# eloped from the facility then left the facility Against Medical Advice [AMA] that same day, Resident #1 "returned from the ER via ambulance and is now readmitted to this facility." Per record review, prior to eloping and leaving AMA, the resident was identified in their Care Plan as "at risk for elopement related to: Resident/Patient expresses desire to leave the facility prematurely (not medically ready for discharge)."	F 657	**Tag F 657 POC accepted on 7/8/24 by T. Dougherty/P. Cota**	

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 06/12/2024

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 2 Review of the facility's Elopement Policy includes: Follow-up: 4.1 Once the patient is found: Review the details associated with the elopement and revise the patient's care plan as indicated to mitigate elopement risk. [Center Operations Policies and Procedures: Elopement of Patient- revised 10/24/22] Further record review reveals upon Resident # 1 returning to the facility after eloping and leaving AMA, the resident's Care Plan no longer identified the resident as an elopement risk. Per interview with the facility's Director of Nursing [DON] on 6/12/24 at 1:28 PM, the DON confirmed Res.#1's Care Plan should identify the resident as having eloped and at risk for elopement, along with interventions to prevent future elopements, but the Care Plan does not.	F 657		
F 660 SS=D	Discharge Planning Process CFR(s): 483.21(c)(1)(i)-(ix) §483.21(c)(1) Discharge Planning Process The facility must develop and implement an effective discharge planning process that focuses on the resident's discharge goals, the preparation of residents to be active partners and effectively transition them to post-discharge care, and the reduction of factors leading to preventable readmissions. The facility's discharge planning process must be consistent with the discharge rights set forth at 483.15(b) as applicable and- (i) Ensure that the discharge needs of each resident are identified and result in the development of a discharge plan for each resident. (ii) Include regular re-evaluation of residents to identify changes that require modification of the	F 660	F660 Specific Corrective Action 1. The events happened in the past and cannot be corrected 2. All residents have the potential to be affected by the deficient practice. 3. The facility ensures that If the patient continues to insist on discharge AMA and refuses a safe planned discharge: A Discharge Transition Plan will be provided to the patient or patient representative". Licensed staff, NHA, DON, Medical Director, ARNP, and SS director will be re-educated to this process. 4. NHA/Designee will audit resident records for those resident's requesting to be discharged against medical advice to validate that a Discharge Transition Plan was provided to the patient or patient representative. These audits will be weekly x 4 weeks, bi-weekly x 4 weeks, 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 7/12/2024	

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 06/12/2024

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 660	Continued From page 3 discharge plan. The discharge plan must be updated, as needed, to reflect these changes. (iii) Involve the interdisciplinary team, as defined by §483.21(b)(2)(ii), in the ongoing process of developing the discharge plan. (iv) Consider caregiver/support person availability and the resident's or caregiver's/support person(s) capacity and capability to perform required care, as part of the identification of discharge needs. (v) Involve the resident and resident representative in the development of the discharge plan and inform the resident and resident representative of the final plan. (vi) Address the resident's goals of care and treatment preferences. (vii) Document that a resident has been asked about their interest in receiving information regarding returning to the community. (A) If the resident indicates an interest in returning to the community, the facility must document any referrals to local contact agencies or other appropriate entities made for this purpose. (B) Facilities must update a resident's comprehensive care plan and discharge plan, as appropriate, in response to information received from referrals to local contact agencies or other appropriate entities. (C) If discharge to the community is determined to not be feasible, the facility must document who made the determination and why. (viii) For residents who are transferred to another SNF or who are discharged to a HHA, IRF, or LTCH, assist residents and their resident representatives in selecting a post-acute care provider by using data that includes, but is not limited to SNF, HHA, IRF, or LTCH standardized patient assessment data, data on quality	F 660	**Tag F 660 POC accepted on 7/8/24 by T. Dougherty/P. Cota**	

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 06/12/2024

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 660	Continued From page 4 measures, and data on resource use to the extent the data is available. The facility must ensure that the post-acute care standardized patient assessment data, data on quality measures, and data on resource use is relevant and applicable to the resident's goals of care and treatment preferences. (ix) Document, complete on a timely basis based on the resident's needs, and include in the clinical record, the evaluation of the resident's discharge needs and discharge plan. The results of the evaluation must be discussed with the resident or resident's representative. All relevant resident information must be incorporated into the discharge plan to facilitate its implementation and to avoid unnecessary delays in the resident's discharge or transfer. This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to provide a discharge plan for a resident who attempted to leave against medical advice for 1 sampled resident [Resident #1]. Findings include: Review of the medical record for Resident #1 reveals the resident is a 70-year-old admitted on 12/1/23 with diagnoses that include alcohol abuse, vascular dementia, psychotic disturbance, mood disturbance and anxiety, along with difficulty in walking, abnormalities of gait and mobility, and a history of falling. Review of the facility's Discharge Against Medical Advice [AMA] policy includes: "If the patient continues to insist on discharge AMA and refuses a safe planned discharge: A Discharge Transition Plan will be provided to the patient or patient representative".	F 660		

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 06/12/2024

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 660	Continued From page 5 Per further record review and confirmed during interviews with Resident #1 Unit Manager [UM], the Director of Nursing (DON) and the Administrator, there is no documentation that a Discharge Transition Plan was created for Resident #1 or that Resident #1 was given one. The DON confirmed Resident #1 signed an AMA form but stated "the AMA form is not the Discharge Transition Plan." The Administrator reported "I don't remember documentation about it [Discharge Transition Plan]".	F 660	F689 Specific Corrective Action 1. The events happened in the past and cannot be corrected. 2. An audits of residents with a risk for elopement was completed to validate that residents with a risk for elopement are supervised when not in a secure safe location, such as outside. 3. The facility ensures that residents at risk for elopement are supervised when not in a secure safe environment, such as when sitting outside. The facility also ensures that if a patient lacks medical decision making capacity and insists on discharge AMA the facility will notify the physician/APP, Administrator, DON, and/or Director of Social Services, and attempt to discern the reason for the patient wanting to leave and attempt to address any relevant issues. The facility ensures the staff will discuss the possibility of a safe planned discharge and document actions the facility took to attempt to provide other options in the medical record. If the resident refuses a safe planned discharge, the facility will contact the patient representative, law enforcement, Adult Protective Services, and the Ombudsman. If the resident still insists on a discharge AMA, the facility will consider the patient an elopement risk and document per Elopement policy. The IDT and licensed staff will be re-educated to this process.	
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 each resident receives adequate supervision to maintain safety and prevent accidents regarding elopement and leaving the facility Against Medical Advice for 1 sampled resident [Res.#1]. Findings include: Review of the medical record for Res.#1 reveals the resident is a 70-year-old admitted to the facility on 12/1/23 with diagnoses that include alcohol abuse, vascular dementia, psychotic disturbance, mood disturbance and anxiety, along	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 _____	C 06/12/2024

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 6 with difficulty in walking, abnormalities of gait and mobility, and a history of falling. Interviews with staff familiar with Res.#1 were conducted on 6/12/24. Staff, the Director of Nursing [DON] and the facility's Administrator [ADM] described the resident as "cognitively delayed" and "has a dementia diagnosis", stating the resident " ...is tricky. My first impression is this [person] is out of [h/her] mind ...some of the things [s/he] says are not realistic". The ADM reported "I talk to [h/her] every day. [S/he] has had incidents with drugs and alcohol and bad decisions. Cognitively there is a big question ...Anything complex I can see [s/he] is going to struggle". The facility conducted an elopement evaluation of Res.#1 on 12/5/23. The evaluation identifies the resident as having a diagnosis of dementia and "Patient has expressed the desire to leave: e.g., go home, talked about going on a trip, attempted to pack belongings" and "exhibits attempts to maintain daily routines and leisure interests not consistent with their new environment routines that may result in exit-seeking behavior". The evaluation includes "Patient exhibits one or more emotional state or behavior that may result in exit-seeking behavior: Hyperactivity (e.g. Restless Walking Patterns), Restlessness and/or Agitation, Boredom." Res.#1's Care Plan, initiated on 12/1/23, identifies the resident as "at risk for elopement related to: Resident/Patient expresses desire to leave the facility prematurely (not medically ready for discharge), with a goal of "will not attempt to leave the facility without an escort by next review." Interventions include: "Utilize and monitor security bracelet per protocol." [identified	F 689	F689 continued.... 4. DON/Designee will make rounds and observations to validate that residents at risk for elopement are supervised when not in a secure or safe area. These audits will be M-F x 4 weeks, weekly x 4 weeks, then monthly x 3 months. Results of these audits will be brought to the monthly QAPI Committee for further review and recommendations. NHA/Designee will audit resident records to validate that those residents who lack medical decision making capacity and wish to be discharged AMA, the process is followed to provide other options inclusive of following the elopement policy if the resident is not agreeable to safer options. These audits will be weekly x 4 weeks, bi-weekly x 4 weeks, 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 7/12/2024 **Tag F 689 POC accepted on 7/8/24 by T. Dougherty/P. Cota**	

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 06/12/2024

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 7 as a "wander guard"] Res. #1's Care plan also identifies the resident as: - has impaired/decline in cognitive function or impaired thought processes related to a condition other than delirium: Dementia; - at risk for falls: Impaired mobility; - at risk for or is experiencing adjustment issues related to: Change in customary lifestyle and routines and/or difficulty accepting placement in center. An interview was conducted on 6/12/24 with Res.#1's Licensed Practical Nurse [LPN]. The LPN explained most of the residents with dementia have a wander guard, and the wander guard alarms are triggered on the ground floor and the elevator, and the front door closes and locks when the alarm is triggered. The LPN stated that Res.# 1 "goes outside often, it's not unusual to see [h/her] there." The LPN reported that Res.#1's wander guard triggers the alarm, but the resident is familiar with the alarm system, waits until the door locks, then unlocks the door and exits. The LPN stated, "There's a camera out front, and we will check it to see if [s/he] is there." An interview was conducted with Res. #1's Unit Manager [UM] on 6/12/24 at 12:39 PM. The UM reported that wander guards are used for safety reasons, and Res. #1 "Does go outside, it's there to alert staff." The UM stated that "Nurses do an elopement assessment and follow up with the wander guard." The UM reported that Res.#1 was identified as an elopement risk, and stated when a resident's wander guard triggered an alarm, for example at the facility's front entrance, Staff are "expected to go down and see what is going on- we have an elopement protocol."	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 _____	C 06/12/2024

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 8	F 689		

Per review of the Springfield Police Report to Adult Protective Services- Intake Report #0016 -5/25/24 9:45 AM:
"On 05/25/2024 I was on duty as a Police Officer in the town of Springfield. I was called to a report of an elderly [person] walking on Chester Rd. It was later found to be the victim [Res.#1]who had left the Springfield Health and Rehab facility without their knowledge. The victim made comments that [s/he] was going to walk to Rutland, which is approximately 37 miles away ...It should also be noted the victim did not know which town [s/he] was currently in."

An interview was conducted on 6/12/24 with Res.#1's Licensed Practical Nurse [LPN] from 5/25/24. The LPN stated on the morning of 5/25/24, Res. #1 had the wander guard present, had triggered the alarm, and exited the building. The LPN stated that staff observed via the camera that the resident was outside and s/he "was just sitting there". The LPN reported later "We didn't realize [s/he] had left. We were in the process of searching for [h/her] for approximately 30 minutes when police called reporting picking up the resident."

Per review of the facility's Elopement Protocol under "Unwitnessed Elopement":
Follow-up:
4.1 Once the patient is found:
4.1.1 Perform a physical examination and psychosocial evaluation. Notify physician/advanced practice provider (APP) of any changes from baseline.
4.1.2 Notify all parties previously contacted (patient representative, law enforcement, etc.) to inform them of the patient's return or status.

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 06/12/2024

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 9 4.1.3 Review the details associated with the elopement and revise the patient's care plan as indicated to mitigate elopement risk. 4. I.3.1 Review with staff and patient representative. 5. Documentation/investigation: 5.1 The nurse will: 5.1.1 Document the elopement in the Nurses' Notes including date, time, place, notification, and other pertinent information; 5.1.3 Enter the elopement into the PCC Risk Management Portal as a new event within 24 hours of the occurrence. 5.2 The Elopement Investigation will be completed within five days [Center Operations Policies and Procedures: Elopement of Patient- revised 10/24/22] Per review of Res.#1's medical record, there is no documentation of Res.#1 eloping unwitnessed from the facility on 5/25/24. Additionally, there is no documentation of any of the Elopement Protocol's Follow Up procedures being implemented including: Performing a physical examination and psychosocial evaluation, notifying the physician, reviewing the details associated with the elopement and revising the patient's care plan, or conducting an elopement investigation. An interview was conducted on 6/12/24 with Res.#1's Unit Manager [UM] regarding the events on 5/25/24. Regarding Res.#1 eloping from the facility, the UM reported Res. #1 "was missing for 30 minutes, while we looked outside the Police called reporting they picked up the resident." The UM stated the expectation was to document in the resident's record regarding the elopement and confirmed this was not done. Additionally, the	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 _____	C 06/12/2024

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 10	F 689		

UM confirmed that the facility's Elopement Protocol was not followed on 5/25/24 regarding Res.#1's unwitnessed elopement.
The UM reported that s/he did not file an incident report regarding Res.#1's elopement or notify the DON or ADM.

An interview was conducted on 6/12/24 at 2:34 PM with the facility's Administrator [ADM].
The ADM confirmed Res. #1's elopement should have been documented in the medical record, stating, "It absolutely should be in record, that's a risk, that's an unplanned event. Does it need to be evaluated? That's how it should have been handled."
The ADM confirmed there is no documentation of any of the Elopement Protocol's Follow Up procedures being implemented. The ADM confirmed there was no incident report filed regarding Res.#1's elopement or documentation of an investigation conducted to determine how to prevent future elopements.

2.) Review of Res.#1's admission medical history includes notes from the Veterans Affairs Medical Center which list "Patient had been evaluated by Psychiatry in October of 2022 and was found to lack capacity ...does not realize the extent of [h/her] cognitive decline."
Per review of Res.#1's medical record at Springfield H&R reveals Physician Notes for Res.#1 dated 3/18/24 record the resident "lacks capacity for complex medical decision making."

Further review of Res.#1's medical record reveals shortly after being returned to the facility after eloping on 5/25/24 the resident attempted to leave Against Medical Advice [AMA] on the same day.

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 06/12/2024

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 11	F 689		

Per review of Res.#1's Unit Manger [UM] notes dated 5/25/24 at 12:28 PM
[Res.#1] "expressed [h/her] desires to leave. [S/he] wants to go to Rutland. 'I can walk there.' This RN and other multiple staff educated [Res.#1] on the concerns and dangers of [h/her] leaving. Discussion of how to make [h/her] stay more comfortable, [Res.#1] remained adamant on leaving. [Res.#1] did mention [h/her] plan of seeing a friend who lives on North Road in Castleton, Vermont. [Res.#1] could not give a specific home address. DON and Administration aware of the situation. [Res.#1] signed paperwork. Left facility with rolling walker and a few belongings at 12:10 PM."

An interview was conducted with Res. #1's Unit Manager [UM] on 6/12/24 at 12:39 PM. Regarding Res.#1's leaving AMA, the UM referred to the event as a "Fiasco". The UM stated "I would say no, it was not a safe choice. We knew it wasn't going to go well ...using a walker [s/he] might stumble, get hit by a vehicle. [Res.#1] couldn't give an exact address where they were going, [s/he] doesn't have a place to stay. It wasn't a safe AMA."

Per interview with the Director of Nursing [DON] on 6/12/24 at 1:28 PM the DON stated:
"My understanding is [Res.#1] is essentially homeless, there is a question of vascular dementia, Wernicke's encephalopathy*."
"[Leaving] AMA is a complex medical decision, being alert and oriented is different from making complex medical decisions."
*Wernicke's encephalopathy is chronic alcohol use disorder causes symptoms such as Confusion, which may range from mild irritability

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 06/12/2024

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	F 689		

and apathy to delirium and psychosis. [https://www.ncbi.nlm.nih.gov/books/NBK470344/]

An interview was conducted on 6/12/24 at 2:34 PM with the facility's Administrator [ADM]. The ADM reported that leaving AMA Res.#1 would not be able to make it to Rutland [37 miles away] on their own. The ADM stated that Res. #1 was "not able to make long term plans, not thinking of consequences". The ADM confirmed he was aware of Physician notes stating Res.#1 was not able to make complex decisions. The ADM stated, "Anything complex I can see [Res.#1] is going to struggle."

Review of the facility's Discharge Against Medical Advice [AMA] policy includes:
"If a patient lacks medical decision-making capacity and insists on discharge AMA:
- If the patient continues to insist on discharge AMA and refuses a safe planned discharge:
5.4.2 Contact patient representative."
[Center Operations Policies and Procedures: Discharge Against Medical Advice AMA- revised 11/15/22]

Review of Res.#1's Admission record lists the resident's contacts in order as:
-the resident's son
-the resident's veterans' affairs Case Worker
-a contact with no designation
Per review of Res.#1's medical record, after the resident left AMA, there is no documentation that the resident's son or the resident's Case worker were contacted. Per record review, the Director of Nursing [DON] attempted to contact the third listed party, who has no determination as being the resident's representative, "to see if she has

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 06/12/2024

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	F 689		

spoken with [Res.#1] and if [the resident] is safe. Voicemail left due to no answer."

The facility's Discharge Against Medical Advice [AMA] policy continues:
- If the patient continues to insist on discharge AMA and refuses a safe planned discharge:
5.4.3 Contact law enforcement.
5.4.4 Contact Adult Protective Services.
5.4.5 Contact Ombudsman.
7. The Discharge Transition Plan will be provided to the patient or patient representative.

Per review of Res.#1's medical record, after the resident left AMA, there is no documentation that law enforcement was contacted by the facility. Per review of the Springfield Police intake, the facility was contacted by law enforcement and hospital staff after the resident had left AMA. Additionally, there is no documentation that Adult Protective Services [APS] or the Ombudsman were contacted regarding Res.#1 leaving AMA.

Per record review and confirmed during interviews with Res.#1's Unit Manager [UM], the DON and the ADM, there is no documentation that a Discharge Transition Plan was created for Res.#1 or that the resident was given one. The DON confirmed Res.#1 signed an AMA form but stated "the AMA form is not the Discharge Transition Plan." The DON stated that staff "absolutely should know the process."

The facility's Discharge Against Medical Advice [AMA] policy also includes:
5.5 Consider the patient an elopement risk and document per Elopement policy.

The facility's Elopement Policy includes:

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 06/12/2024

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 Follow-up: 4.1 Once the patient is found: -Review the details associated with the elopement and revise the patient's care plan as indicated to mitigate elopement risk. -Identify patient's elopement risk upon admission, re-admission Per record review on 5/25/24 at 9:28 PM, after eloping from the facility then leaving the facility AMA that same day, Res.#1 "has returned from the ER via ambulance and is now readmitted to this facility." Further record review revealed no Elopement Risk Evaluation completed upon Res.#1's readmission to the facility. Additionally, prior to eloping and leaving AMA, the resident was identified in their Care Plan as "resident as "at risk for elopement related to: Resident/Patient expresses desire to leave the facility prematurely (not medically ready for discharge)." Upon returning to the facility after eloping and leaving AMA, the resident's Care Plan no longer identified the resident as an elopement risk. Review of Physician Orders for Res. #1 reveal an order for "Wander guard/Wander Elopement Device due to poor safety awareness on walker every shift", which was continued after Res.#1's return on 5/25/24. Nursing Notes dated 5/26/24 record the wander guard "was removed when patient left AMA" and had not been replaced despite the Physician Order. Nursing Notes dated the next day on 5/27/24 record "has not gotten a new one since [s/he] left AMA on weekend shift." Per review of Res.#1's medical record, Nursing Notes dated the following day, 5/28/24, report the resident attempted to leave the facility again.	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 _____	C 06/12/2024

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 Per interview and record review, on 5/25/24 Res. #1 eloped unwitnessed from the facility, was found by the police and returned to the facility. Prior to and during their stay at the facility, Res.#1 was assessed multiple times as not having the capacity to make complex medical decisions but later the same day was allowed to leave the facility Against Medical Advice [AMA]. The facility did not report or document Res.#1's elopement or follow their Elopement Protocol. When the resident left AMA, the facility failed to follow their AMA protocol including contacting law enforcement and again implementing their Elopement Protocol. When the resident was returned to the facility, the resident was not evaluated as an elopement risk or care planned for elopement despite having just attempted to leave the facility. Additionally, Physician Orders regarding placement of a wander guard for safety were not implemented upon readmission, and per record review, the resident attempted to leave the facility again.	F 689	F842 Specific Corrective Action 1. Resident #1 medical records are accurate and includes documentation of the incident of elopement 2. All residents at risk for elopement have the potential to be affected by the deficient practice. 3. Facility staff provide documentation in the clinical record that includes the medical plan of treatment, assessments, interventions, responses to care and treatment by multiple health care providers, and identification of significant changes, accidents, or unusual occurrences that may impact the resident's physical or emotional well being and the plans for the patient at discharge. Licensed staff and IDT will be re-educated to this process.	
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted	F 842	4. DON/Designee will complete audits of resident records to validate documentation is complete and accurate that includes the medical plan of treatment, assessments, interventions, responses to care and treatment by multiple health care providers, and identification of significant changes, accidents, or unusual occurrences that may impact the resident's physical or emotional well being and the plans for the patient at discharge. These audits will be weekly x 4 weeks, bi-weekly x 4 weeks, 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 7/12/2024	

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 06/12/2024

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 842	Continued From page 16 professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law.	F 842	**Tag F 842 POC accepted on 7/8/24 by T. Dougherty/P. Cota**	

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 06/12/2024

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 842	Continued From page 17	F 842		

§483.70(i)(5) The medical record must contain-
(i) Sufficient information to identify the resident;
(ii) A record of the resident's assessments;
(iii) The comprehensive plan of care and services provided;
(iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State;
(v) Physician's, nurse's, and other licensed professional's progress notes; and
(vi) Laboratory, radiology and other diagnostic services reports as required under §483.50.
This REQUIREMENT is not met as evidenced by:
Based upon interview and record review, the facility failed to maintain medical records on each resident that are complete and accurately documented for 1 sampled resident [Res.#1]. Findings include:

Per review of the Springfield Police Report to Adult Protective Services- Intake Report #0016 -5/25/24 9:45 AM:
"On 05/25/2024 I was on duty as a Police Officer in the town of Springfield. I was called to a report of an elderly [person] walking on Chester Rd. It was later found to be the victim [Res.#1] who had left the Springfield Health and Rehab facility without their knowledge. The victim made comments that [s/he] was going to walk to Rutland, which is approximately 37 miles away ...It should also be noted the victim did not know which town [s/he] was currently in."

An interview was conducted on 6/12/24 with Res.#1's Licensed Practical Nurse [LPN] from 5/25/24. The LPN stated "We didn't realize [s/he] had left. We were in the process of searching for

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 06/12/2024

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 842	Continued From page 18 [h/her] for approximately 30 minutes when police called reporting picking up the resident." Per review of Res.#1's medical record, there is no documentation of Res.#1 eloping unwitnessed from the facility on 5/25/24. Additionally, there is no documentation of any of the facility's Elopement Protocol's Follow Up procedures being implemented including: "Document the elopement in the Nurses' Notes including date, time, place, notification, and other pertinent information" [Center Operations Policies and Procedures: Elopement of Patient- revised 10/24/22] An interview was conducted on 6/12/24 at 2:34 PM with the facility's Administrator [ADM]. The ADM confirmed Res. #1's elopement should have been documented in the medical record, stating, "It absolutely should be in record, that's a risk, that's an unplanned event." Additionally, the ADM confirmed Res.#1's record should include documentation of an incident report regarding Res.#1's elopement, documentation of an investigation conducted to determine the root cause of the elopement, an elopement risk evaluation and a portion of the resident's Care Plan which identifies Res.#1 as having eloped with revised interventions to prevent future elopements. The ADM confirmed none of this information was contained in Res.#1's medical record.	F 842		

Division of Licensing and Protection

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 06/12/2024

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) COMPLETE DATE
S208 SS=D	2.9 (a - d) REPORTS TO LICENSING AGENCY The following reports must be filed with the licensing agency: 2.9 (a) At any time a fire occurs in the facility, regardless of the size or damage, the licensing agency and the Department of Labor and Industry must be notified by the next business day. A written report must be submitted to both departments by the next business day. A copy of the report shall be kept on file in the facility. 2.9 (b) Any untimely death that occurs as a result of an untoward event, such as an accident that results in hospitalization, equipment failure, use of restraint, etc., shall be reported to the licensing agency by the next business day, followed by a written report that details and summarizes the event. 2.9 (c) Any unexplained or unaccounted for absence of a resident for a period of more than 30 minutes shall be reported promptly to the licensing agency. A written report must be submitted by the close of the next business day. 2.9 (d) Any breakdown or cessation to the facility's physical plant that has a potential for harm to the residents, such as a loss of water, power, heat or telephone communications, etc., for four hours or more, shall be reported within 24 hours to the licensing agency. This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to report a resident elopement as required to the state licensing agency for 1 sampled resident [Res.#1].	S208	S208 Specific Corrective Action 1. The facility filed a report of elopement for resident #1 with DAIL and APS. 2. All resident at risk for elopement have the potential to be affected by the deficient practice 3. The facility reports to licensing any unexplained or unaccounted for absence of a resident for a period of more than 30 minutes promptly including a written report that is to be submitted by the close of the next business day. NHA and DON will be re-educated to this process. 4. The market advisor/ designee will complete audits of incidents of elopement to validate the facility reports to licensing any unexplained or unaccounted for absence of a resident for a period of more than 30 minutes promptly including a written report that is to be submitted by the close of the next business day. These audits will be weekly x 4 weeks, bi-weekly x 4 weeks, 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 7/12/2024 **Tag S208 POC accepted on 7/8/24 by T. Dougherty/P. Cota**	

Division of Licensing and Protection
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

NHA — 7524

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 06/12/2024

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) COMPLETE DATE
S208	Continued From page 1 Findings include: Review of the medical record for Resident #1 reveals the resident is a 70-year-old admitted on 12/1/23 with diagnoses that include alcohol abuse, vascular dementia, psychotic disturbance, mood disturbance and anxiety, along with difficulty in walking, abnormalities of gait and mobility, and a history of falling. Per review of the Springfield Police Report to Adult Protective Services- Intake Report #0016 -5/25/24 9:45 AM: "On 05/25/2024 I was on duty as a Police Officer in the town of Springfield. I was called to a report of an elderly [person] walking on Chester Rd. It was later found to be the victim [Resident #1] who had left the Springfield Health and Rehab facility without their knowledge..." Per interview on 6/12/2024 at 12:39 PM Unit Manager for Res.#1 regarding eloping from the facility, the UM reported Res. #1 "was missing for 30 minutes, while we looked outside the Police called reporting, they picked up the resident." The UM reported that s/he did not file an incident report regarding Res.#1's elopement or contact the appropriate State Agency as required. Per interview of the Director of Nursing (DON) on 6/12/2024 at 1:28 PM. The DON confirmed there was no incident report filed regarding Res.#1's elopement or contact of the appropriate State Agency as required.	S208		