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

November 13, 2024

Ms. Opal Dacosta, Administrator
Springfield Health & Rehab
105 Chester Rd
Springfield, VT 05156-2106

Dear Ms. Dacosta:

Enclosed is a copy of your acceptable plans of correction for the complaint investigation conducted on **October 18, 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,

Pamela M Cota RN
Pamela M. Cota, RN, BS
Assistant Division Director
State Survey Agency Director

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 10/18/2024

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 onsite, unannounced investigation of 1 complaint (ACTS #23262) and one facility reported incident (#23265) on 9/9/2024, with additional offsite record review and interviews that ensued through 9/25/2024, to determine compliance with 42 CFR Part 483 requirements for Long Term Care Facilities. As a result of the investigation, the survey team identified substandard quality of care as a result of a violation at 483.25(k)- F 697. An unannounced, onsite extended survey was conducted on 10/16/24 with additional offsite record review and interviews that ensued through 10/18/2024 due to the determination of substandard quality of care. The following deficiencies 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.***	
F 689 SS=G	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 on observation, interview, and record review, the facility failed to ensure residents remained as free from accidents as possible related to falls for 1 of 6 sampled residents (Resident #1) by failing to provide adequate supervision and implement care plan interventions that would reduce potential serious consequences if a fall did occur. As a result,	F 689	F689 – Specific Corrective Action The plan of care for resident #1 has interventions implemented to include bed in the low position and mats on the floor. An audit of resident's records was completed and observations conducted to validate that interventions are in the plan of care and followed for the prevention of falls. The facility ensures that patients/residents are assessed for the risk of falling as part of the nursing assessment process.	

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

Dan Costa | LNHA | 11/9/2024

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F 689	Continued From page 1 Resident #1 suffered a fall that resulted in a hip fracture and significant pain. Findings include: Per record review, Resident #1 has diagnoses that include morbid obesity, anxiety, and history of uterine cancer. A 7/23/24 Nurse Practitioner (NP) note reveals that Resident #1 was transferred from the facility to the hospital on 7/11/24 for symptoms of a CVA (stroke). S/He was readmitted to the facility on 7/16/24 post CVA treatment with aphasia (speech disorder) and left sided hemiparesis (muscle weakness or partial paralysis on one side of the body). Resident #1 has the following care plan focuses, "[Resident #1] is at risk for falls secondary to deconditioning, gait/balance problems," revised on 2/21/24 and "[Resident #1] has impaired communication as evidenced by: difficulty making self understood (expressive); aphasia secondary to CVA," initiated on 7/26/2024." Interventions include, "bed centered in room, mattresses on both sides of bed as resident intentionally puts self from bed to mattress per [his/her] preference," revised on 5/18/24, "Anticipate and meet the resident's needs," created 3/18/22 "Bed in low position," created 8/2/24, and "Frequent checks on [Resident #1]," revised on 5/16/2023. A facility incident report dated 8/1/24 reveals that Resident #1 suffered an unwitnessed fall on 8/1/24 at approximately 7:30 PM and the resident was unable to give a description of the incident. The note reads, "pt [patient] was anxious and was noted to be trying to get [his/her] legs out of the bed. pt was found on the floor beside [his/her] bed. [s/he] was transferred by hoyer lift [equipment to lift and transfer a person] back to bed assessed for injuries no injuries noted."	F 689	The facility ensures that Interventions to reduce risk and minimize injury are implemented as indicated in the patient/resident's plan of care. Licensed staff and LNAs will be re-educated to this process. The DON/Designee will complete observations of resident rooms to validate that interventions for fall prevention are in place per the plan of care. These audits will be daily x 14 days, 3 x week x 4 weeks, then weekly x 8 weeks. Results of these audits will be brought to the monthly QAPI Committee for further review and recommendations. Date of Compliance 12/3/2024 **Tag F 689 POC accepted on 11/13/24 by S. Stem/P. Cota**	

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F 689	Continued From page 2	F 689		

An 8/1/24 fall evaluation note completed by a Physician Assistant after a virtual visit reads, "[Resident #1] was in bed tonight, kicked [his/her] legs out of the sheets, and rolled out of bed and onto the floor. [S/He] was not injured per nursing report. I did ask the patient if [s/he] had any pain and [s/he] was not verbal at all with me. Per nurse this is [his/her] baseline."

Per interview on 9/9/24 at 5:29 PM, the Licensed Nursing Assistant (LNA) that was assigned to Resident #1 on the shift (LNA #1) that s/he fell out of bed explained that s/he had put Resident #1 to bed after dinner with another LNA (LNA #2) using a Hoyer lift. LNA #1 stated that Resident #1 was moving his/her legs around in bed and seemed anxious. S/He told the nurse about it.

Per phone interview on 9/23/24 at 12:55 PM, LNA #2 explained that Resident #1 was unable to speak after his/her stroke but was able to communicate with facial expressions, sounds, and small body movements and occasionally s/he could answer yes or no. S/He explained that when s/he was helping LNA #1 put Resident #1 into bed on the night of his/her fall, it was clear that s/he did not want to go into bed at that time. S/He said the Licensed Practical Nurse (LPN #1) was made aware of this but the LPN gave directions to the aides for Resident #1 to stay in bed.

On 9/9/24 at 3:46 PM, LPN #1, who was assigned to Resident #1 at the time s/he fell out of bed, was interviewed. S/He explained that prior to his/her stroke in July, Resident #1 had anxiety, was able to move around in bed, and was able to talk. After Resident #1 had the stroke, s/he did not display signs of anxiety or move around in

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F 689	Continued From page 3	F 689		

bed and was unable to communicate. The LPN explained that on the night of 8/1/24 the aides reported that Resident #1 was uncharacteristically anxious and was attempting to swing his/her legs out of bed. The LPN revealed that s/he did not notify the provider of this change of increased restlessness and anxiety. When asked what interventions s/he implemented to prevent the Resident #1 from falling out of bed, s/he explained that s/he told the aides to check on him/her. S/He said that when Resident #1 was found on the floor, his/her bed had been in the highest position and there were not any fall mats on the floor next to his/her bed. S/He explained that when s/he evaluated Resident #1 after the fall, Resident #1 was unable to communicate if s/he was in any pain from the fall but did not appear to be in any more pain than normal.

Facility policy titled "NSG215 Falls Management," last revised 3/15/24 reads, "Implement and document patient centered interventions according to individual risk factors in the patient's care plan. Adjust and document individualized intervention strategies as patient condition changes."

In addition to not following Resident #1's care plan for having his/her bed in the lowest position and fall mats placed on either side of his/her bed, there was no evidence in staff interviews or documentation in Resident #1's medical record that additional intervention strategies to prevent falls were implemented. There was no evidence of increased supervision, any type of assessment related to his/her increased anxiety and restlessness, or provider notification of Resident #1's change in behavior.

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F 689	Continued From page 4 Per interview on 9/9/24 at 1:49 PM, the Interim Director of Nursing explained that LPN #1 did not alert the provider of Resident #1's change prior to fall and should have. Per interview on 9/11/24 at 2:27 PM, the Nurse Practitioner (NP) was asked about Resident #1's baseline post stroke and prior to fall and if the LPN's description of Resident #1's behavior (increased anxiety and restlessness) the day of his/her fall was concerning. S/He stated that a provider should have been alerted to Resident #1's change in behavior prior to him/her falling. As a result of the fall on 8/1/24, Resident #1 was found to have a hip fracture, which was not discovered until 19 days after his/her fall. Resident #1 suffered pain which was not communicated to a provider for 19 days and continues to have significant right hip pain. While there is only one documented incident of pain for Resident #1 between 8/1/24 and 8/20/24, interviews with LNAs reveal that Resident #1 was in an increased amount of pain post-fall. Resident #1's Medication Administration Record reveals that PRN (as needed) pain medications were given 6 times between 8/1/24 and 8/20/24. Of the 6 times the Tylenol was administered, the only time a pain evaluation was completed was on 8/10/24, where Resident #1 is documented to have 3 out of 10 pain. The Nurse Practitioner stated during a phone interview on 9/11/24 at 2:27 PM that s/he had two post fall visits with Resident #1 and was unaware that s/he was in pain because it was not documented in his/her chart. See F697 for more information. An 8/20/24 nursing note states that Resident #1	F 689		

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F 689	Continued From page 5	F 689		

was transferred to the Emergency Department (ED) for immediate evaluation and treatment for altered mental status. An 8/20/24 ED Registered Nurse (RN) note states that on admission to the ED "[Resident #1] does respond to painful stimuli and slightly moves arms when transferring from EMS stretcher to ED stretcher." Per phone interview on 9/9/24 at approximately 12:30 PM with this RN, s/he explained that Resident #1 appeared to be in pain anytime they moved his/her legs. An 8/21/24 ED Physician Assistant note reveals that a CT scan (computerized x-ray) was preformed to rule out pneumonia. An 8/20/24 radiology report, signed at 11:34 PM reveals that Resident #1 has an "Acute right femoral neck fracture [fracture in the hip joint]. Unexpected finding."

A 9/16/24 Nurse Practitioner note reveals that Resident #1 was seen for a follow up visit "related to [his/her] recent CVA, a fall with a right femur fracture with resulting physical deconditioning." Nursing evaluations up through 9/25/24 reveal that Resident #1 was still experiencing significant hip pain, some days reporting and/or displaying up to 10 out of 10 pain.

The facility continued to fail to implement care plan interventions that would reduce potential serious consequences if a fall did occur.

Per observation on 9/9/24 at approximately 11:00 AM, Resident #1 was observed in bed. The bed was in a high position and there were no mats on the floor.

Per interview on 9/9/24 at 4:19 PM, the Market Clinical Advisor confirmed that s/he just observed that Resident #1's bed was not in the lowest

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F 689	Continued From page 6 position and there were no mats on the floor and should have been per his/her care plan.	F 689		
F 692 SS=G	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 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 interviews and record review, the facility failed to identify a resident at risk for impaired hydration status, address risk factors for impaired hydration status, and ensure that a resident receive sufficient fluid intake to maintain proper hydration and health for 5 of 7 sampled residents (Residents #1, #2, #3, #4, and #5). As a result, Resident #1 was admitted to the hospital with dehydration, a urinary tract infection (UTI), and developed a stage 2 pressure ulcer. Findings	F 692	F692 – Specific Corrective Action Resident #1, #3, #4, and #5 estimated fluids needs are part of their interventions for the potential for dehydration care plan and are noted on each of the resident's Kardex. Resident #1, #3, #4, and #5 are free from s/s of dehydration. Resident #2 was discharged on 10/11/2024. An audit of resident records was completed to ensure that care plans are in place for those residents at risk for dehydration and include the estimated fluid needs on both the Care plan and the Kardex.	

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F 692	Continued From page 7 include: 1. Per record review, Resident #1 has diagnoses that include morbid obesity, type 2 diabetes, chronic kidney disease, anxiety disorder, major depressive disorder, delusional disorder, and history uterine cancer. A 7/23/24 Nurse Practitioner note reveals that Resident #1 was transferred from the facility to the hospital on 7/11/24 for symptoms of a CVA (stroke). S/He was readmitted to the facility on 7/16/24 post CVA treatment with aphasia (speech disorder) and left sided hemiparesis (muscle weakness or partial paralysis on one side of the body). Resident #1's care plan reads, "[Resident #1] has an ADL Self Care Performance Deficit r/t Activity Intolerance, Impaired Mobility, and Morbid Obesity," revised on 2/21/24 and "[Resident #1] has impaired communication as evidenced by: difficulty making self understood (expressive); aphasia secondary to CVA," initiated on 7/26/2024. A 7/22/24 Nutritional Assessment reveals that Resident has a new swallowing issue and should receive honey thickened liquids, is dependent on staff eating and drinking, and has a daily fluid need of 2100 cc (cubic centimeter; 30 cc = 1 fluid ounce). An 8/16/24 Occupational Therapy (OT) note indicates that Resident #1 requires "Substantial/Maximal Assist" for eating, including safely utilizing adaptive equipment using a two handled mug. Dependence in activities of daily living, communication problems, mental illness, diabetes, history of stroke, kidney disease,	F 692	The facility ensures that implementation of a patient's nutrition/hydration care and services occurs within the care delivery process. Staff will provide nutritional and hydration care and services to each patient, consistent with the patient's comprehensive assessment and will provide a therapeutic diet that accounts for the patient's clinical condition and preferences. Patient's hydration status will be determined through routine nursing evaluation. Those residents at risk for dehydration will have a plan of care consistent with the residents estimated fluid needs. LNAs document food and drink consumption in the medical record and report decreased fluid and food intake to the licensed nurse. Nursing staff will be re-educated on this process.	

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F 692	Continued From page 8 difficulty swallowing, and use of thickened liquids are risk factors for impaired hydration status*. Individuals who do not receive adequate fluids are more susceptible to urinary tract infections** and pressure injuries*** Resident #1 was not identified to be at risk for impaired hydration status. As a result, an interdisciplinary plan of care was not developed that identified a fluid intake goal or a hydration plan that could be monitored for effectiveness. Facility policy titled, "FNS810 Hydration Plan," effective 5/1/23, reads, "A hydration plan is developed for patients/residents (hereinafter "resident") who are at risk for dehydration ... For residents whose usual intake of fluids does not meet their needs, an individualized hydration plan is developed ... Individual hydration plan interventions are documented on ... Care plan ... Plan is monitored for effectiveness and adjusted as needed." Facility policy titled, "NSG223 Nutrition/Hydration Care and Services", revised 2/1/23, reads, "interdisciplinary plan of care for enhancing oral intake, promoting adequate nutrition and hydration, and identifying individualized goals, preferences, and choices." Resident #1 has care plan interventions that include, "Encourage resident to consume all fluids during meals. Offer/encourage fluids of Choice," created on 1/30/24. "Provide rehab eating devices: 2 handled cup with sippy lid, lip plate and plastic bowl during meals currently [s/he] is being fed at meals prn [s needed] & working w/ OT on self-feeding," revised on 8/1/24. While these interventions are part of Resident #1's plan of care, a hydration plan was not developed to identify his/her risk for inadequate	F 692	DON/Designee will complete audit of resident records and observation rounds to validate residents at risk for dehydration, have their estimated fluid needs met and are free from s/s of dehydration. These audits and observations 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: 12/3/2024 **Tag F 692 POC accepted on 11/13/24 by S. Stem/P. Cota**	

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F 692	Continued From page 9	F 692		

fluid intake. The lack of a hydration plan and identified hydration goals did not provide Resident #1's care team a plan to evaluate if s/he met his/her daily fluid intake need of 2100 cc.

Per a phone interview on 9/23/24 at 4:44 PM, the Market Clinical Lead confirmed that Resident #1 was at risk for dehydration prior to his/her hospitalization on 8/20/24, should have been care planned for the risk, and was not.

Resident #1 did not receive proper hydration and there was no evidence that providers were made aware of his/her insufficient fluid intake.

Resident #1's POC (point of care; electronic documentation system for Licensed Nursing Assistants) documentation and Medication Administration Record were reviewed for daily fluid intake. The following were based on the combined total of the physician ordered once daily house supplement and recorded fluid intake for each shift for the two weeks prior to Resident #1's 8/20/24 hospitalization. 680 cc on 8/7/24, 1020 cc on 8/8/24, 360 cc on 8/9/24, 410 cc on 8/10/24, 900 cc on 8/11/24, 600 cc on 8/12/24, 920 cc on 8/13/24, 620 cc on 8/14/24, 660 cc on 8/15/24, 660 cc on 8/16/24, 1380 cc on 8/17/24, 270 cc on 8/18/24, 248 cc on 8/19/24, and 1048 cc on 8/20/24. Resident #1 did not meet his/her daily fluid needs for the two weeks prior to 8/20/24. There are no nursing notes for the two weeks prior to 8/20/24 reflecting that Resident #1 was not drinking and no notification was made to a provider to alert them s/he was not receiving adequate fluid intake.

Per a phone interview on 9/23/24 at 12:55 PM, a Licensed Nursing Assistant (LNA) that was

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F 692	Continued From page 10	F 692		

familiar with Resident #1 explained that Resident #1 wasn't drinking because s/he wouldn't drink the thickened liquid. S/He stated that nursing staff was aware that Resident #1 wasn't drinking and s/he was not aware of anything in place to help him/her stay hydrated.

Per a phone interview on 9/11/24 at 2:27 PM, a Nurse Practitioner that had frequent visits with Resident #1 and was very familiar with their recent facility history explained that Resident #1 was at risk for developing a UTI, even more risk after s/he suffered a stroke. S/He and explained that it would be important to monitor Resident #1's fluid intake as a preventative strategy to reduce the risk for a UTI. S/He explained that s/he was not privy to documented fluid intakes and would rely on staff reports that they were not meeting their fluid goals. S/He confirmed that s/he was unaware that Resident #1 had poor fluid intake.

Per a phone interview on 9/23/24 at 4:44 PM, the Market Clinical Lead reviewed Resident #1's fluid intake and confirmed that Resident #1 did not consume the recommended amount of fluids prior to his/her hospitalization on 8/20/24. S/He explained that the expectation would be that the aides would report to the nurse low fluid intake. The nurse would document the low fluid intake and evaluate the resident. S/He confirmed that s/he did not see any notes in August 2024 prior 8/20/24 that this was done.

Resident #1 was hospitalized for 5 days related to complications of dehydration, including a UTI.

An 8/20/24 nursing note states that Resident #1 was transferred to the Emergency Department

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 10/18/2024

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 692	Continued From page 11 (ED) on 8/20/24 for evaluation and treatment of altered mental status. An 8/20/24 ED Registered Nurse (RN) note reveals Resident #1 was not alert on arrival and screened positive for severe sepsis. A urinary catheter was placed in the ED a few hours after arrival. The note reads, "While preparing to insert the indwelling urinary catheter, it was observed by ED staff that the patient had a gelatinous substance coming out of the vagina and urine was foul smelling, yellow, and cloudy resembling orange juice." Per a phone interview on 9/9/2024 at approximately 12:30 PM with this RN, s/he explained that staff attempted to put in the catheter multiple times because chunks of gelatinous discharge was coming from the vagina and urethra clogging the catheter. An 8/21/24 hospital Physician Assistant note show that Resident #1 was admitted to the hospital following the visit to the ED. The note details laboratory results obtained shortly after entering the ED revealing elevated BUN (blood urea nitrogen levels), creatine, sodium, and chloride levels (indicators of dehydration****). An 8/25/24 hospital Physician notes reveals that Resident #1 was admitted to the hospital for acute encephalopathy (a disturbance of brain function), AKI (acute kidney injury), hypernatremia (high sodium concentration in the blood), UTI with MRSA (methicillin-resistant Staphylococcus aureus), and dehydration. Resident #1 was also found to have a stage 2 pressure ulcer (Partial-thickness skin loss) on admission. 2. Per record review, Resident #2 was admitted to the facility on 9/18/24 with diagnoses that	F 692		

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 10/18/2024

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 692	Continued From page 12	F 692		

include acute kidney failure, urinary tract infection, type 2 diabetes, and morbid obesity. A 9/27/24 nutrition assessment reveals that Resident #2 fluid needs would be approximately 2,650 cc (the calculation was not completed; fluid needs were based on the metabolic adjusted body weight and fluid factor).

Per Resident #2's care plan, a care plan focus for "risk for dehydration as evidence by recent infectious process," was not added until 10/2/24. There is no care plan goal described to alert staff to his/her daily fluid needs. Resident #2's fluid intakes were not documented throughout his/her entire stay. A Licensed Nursing Assistant task to document fluid intake was not added to his/her care documentation until 10/12/24.

Per interview on 10/18/24 at 2:51 PM, the Market Clinical Lead confirmed that Resident #2 was at risk for dehydration on admission, did not have a care plan for dehydration until 10/2/24, and his/her fluid intakes should have been documented and were not.

3. Per record review, Resident #4 has diagnoses that include dementia and adult failure to thrive. Per Resident #4's care plan, s/he "has an ADL [activities of daily living] Self Care Performance Deficit [relate to] dementia]," revised on 12/29/23. A 9/13/24 nutrition assessment reveals that his/her fluid needs are 1600 cc per day. While Resident #4's care plan does have interventions to encourage fluid intake, there is no care plan goal described to alert staff to his/her daily fluid needs. Per review of Licensed Nursing Assistant documentation, Resident #4 did not meet his/her fluid needs on any day between 9/1/24 and 10/18/24.

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	475025	A. BUILDING _____ B. WING _____	C 10/18/2024

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 692	Continued From page 13	F 692		

4. Per record review, Resident #3 has diagnoses that include dementia, legal blindness, and acute kidney failure. Per Resident #3's care plan, s/he "requires assistance/is dependent for ADL care in bathing, grooming, personal hygiene, dressing, eating, bed mobility, transfer, locomotion, toileting, related to: Recent illness, fall, hospitalization resulting in fatigue, activity intolerance, confusion." A 7/29/24 nutrition assessment reveals that his/her fluid needs are 2000 cc per day and a 9/16/24 nutrition assessment reveals that his/her daily fluid needs were changed to 1720 cc. While Resident #3's care plan does have interventions to encourage fluid intake, there is no care plan focus for dehydration risk and there is not a goal described to alert staff to his/her daily fluid needs. Per review of Licensed Nursing Assistant documentation, Resident #3 did not meet his/her fluid needs on any day between 9/1/24 and 10/18/24.

5. Per record review, Resident #5 has diagnoses that include dementia and type 2 diabetes. Per Resident #5's care plan, s/he "requires assistance/is dependent for ADL care in ADLs related to limited mobility," revised on 4/11/24. A 10/4/24 nutrition assessment reveals that his/her fluid needs are 2200 cc per day. Resident #5's care plan does not have interventions to encourage fluid intake and there is not a goal described to alert staff to his/her daily fluid needs. Per review of Licensed Nursing Assistant documentation, Resident #5 did not meet his/her fluid needs on any day between 10/4/24 and 10/18/24.

Per interview on 10/16/24 at 1:57 PM, a Licensed

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 10/18/2024

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 692	Continued From page 14 Practical Nurse explained that s/he was unsure how to tell if a resident has met their fluid requirements for the day. Per interview on 10/16/24 at 2:14 PM, an LNA explained that s/he documents what residents have had for fluid in their charting system but does not report the fluid intakes to the nurse, only that a resident hasn't had anything to drink. Per interview on 10/18/24 at 2:51 PM, the Market Clinical Lead confirmed that Residents #3, #4 and #5's care plan did not include a measurable goal for daily fluid intake. * https://www.hhs.texas.gov/sites/default/files/documents/signs-symptoms-risk-factors-for-dehydration.pdf **Lean K, Nawaz RF, Jawad S, Vincent C. Reducing urinary tract infections in care homes by improving hydration. BMJ Open Qual. 2019 Jul 10;8(3):e000563. doi: 10.1136/bmjoq-2018-000563. PMID: 31363503; PMCID: PMC6629391. ***Alice C. Murr BSN, RN, Marilynn E. Doenges APRN, BC, Mary Frances Moorhouse RN, MSN, CRRN, eds. 2022. Nurse's Pocket Guide: Diagnoses, Prioritized Interventions, and Rationales - 16th Ed. F. A. Davis Company. ISBN 978-1-7196-4307-8. eISBN 978-1-7196-4768-7. STAT!Ref Online Electronic Medical Library. https://online.statref.com/document/4aBTjpol3pTWtB0kek_F0t. 10/4/2024 9:24:26 AM CDT (UTC -05:00). **** https://emedicine.medscape.com/article/906999-workup?form=fpf	F 692		

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 10/18/2024

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 697	Continued From page 15	F 697		
F 697 SS=H	Pain Management CFR(s): 483.25(k) §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to provide pain management that met professional standards for 4 of 7 sampled residents by not recognizing pain or evaluating existing pain and the causes (Resident #1) and revise a resident's care plan to address and manage pain (Residents #1, #3, #5, and #6). As a result, Resident #1 had a pattern of significant, untreated pain. Findings include: Per record review, Resident #1 has diagnoses that include morbid obesity, type 2 diabetes, and history of uterine cancer. A 7/23/24 Nurse Practitioner note reveals that Resident #1 was transferred from the facility to the hospital on 7/11/24 for symptoms of a CVA (stroke). S/He was readmitted to the facility on 7/16/24 post CVA treatment with aphasia (speech disorder) and left sided hemiparesis (muscle weakness or partial paralysis on one side of the body). Resident #1's care plan reads, "[Resident #1] has acute pain/chronic pain Diabetic neuropathy [nerve damage]," revised on 2/3/2023, with the goal "The resident should voice a satisfactory level of comfort through the review date," revised on 7/30/24, and has the following interventions: "Monitor/record/report to Nurse resident	F 697	F697 – Specific Corrective Action Resident #1 is currently on scheduled pain medication. Resident #1 has a care plan for pain with non-pharmaceutical intervention identified and staff are assessing the resident for pain every shift utilizing the PAINAD Scale. Resident #3 care plan was updated to include the location of the resident's pain. Resident #3 has a care plan for pain with non-pharmaceutical intervention identified and staff are assessing the resident for pain every shift utilizing the PAINAD Scale. Resident #5 care plan was updated to include the underlying cause of the resident's pain. Resident #5 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 _____	C 10/18/2024

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 697	Continued From page 16 complaints of pain or requests for pain treatment," created on 3/18/22, and "Tylenol prn [as need] for pain as ordered," created on 3/18/22. Resident #1's care plan reveals, "[Resident #1] has impaired communication as evidenced by: difficulty making self understood (expressive); aphasia secondary to CVA," initiated on 7/26/2024. Staff failed to recognize Resident #1's increase of pain following a fall. A pain assessment interview dated 7/26/24 reads, "Ask resident: 'Have you had pain or hurting at any time in the last 5 days?'" The answer "unable to answer" is marked off. The assessment indicates that when the resident is unable to complete the pain assessment interview, "A Staff Assessment for Pain must be manually scheduled and completed since the interview is considered incomplete." This is the last pain assessment interview in Resident #1's record. Per interview on 9/9/2024 at 1:49 PM, the Registered Nurse (RN) who filled out this assessment was asked where the staff interview was that this tool referred to. S/He explained that there are no additional pain interviews completed by staff. The RN explained that after Resident #1's stroke in July, s/he was unable to communicate verbally. S/He explained that staff would be expected to use a PAINAD scale (a pain assessment tool to assess people with cognitive impairment that consists of five categories: breathing, negative vocalization, facial expression, body language, and consolability on a 1-10 scale) when evaluating Resident #1's pain. S/He confirmed that this was not an intervention in his/her care plan and should have been.	F 697	having NPI recorded in the EMAR. Resident #6 is getting a lidocaine patch to the back. Resident #6 has a care plan for pain with non-pharmaceutical intervention identified and staff are assessing the resident for pain every shift. An audit of resident records was completed to validate the following: residents with pain have orders for non-pharmaceutical interventions, the resident is being assessed for pain every shift utilizing the appropriate pain scale depending on cognitively status, the care plans are updated to include the source of the resident's pain and non-pharmaceutical interventions. The facility ensures that patients/residents will be evaluated as part of the nursing	

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 10/18/2024

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 697	Continued From page 17 A facility incident report dated 8/1/24 reveals that Resident #1 suffered an unwitnessed fall on 8/1/24 at approximately 7:30 PM and the resident was unable to give a description of the incident. The note reads, "pt [patient] was anxious and was noted to be trying to get [his/her] legs out of the bed. pt was found on the floor beside [his/her] bed. [s/he] was transferred by hoyer lift [equipment to lift and transfer a person] back to bed assessed for injuries no injuries noted." An 8/1/24 fall evaluation note completed by a Physician Assistant after a virtual visit reads, "[Resident #1] was in bed tonight, kicked [his/her] legs out of the sheets, and rolled out of bed and onto the floor. [S/He] was not injured per nursing report. I did ask the patient if [s/he] had any pain and [s/he] was not verbal at all with me. Per nurse this is [his/her] baseline." Per review of the vital section of the electronic medical record, documented pain assessments reveal that Resident #1 had pain levels of 0 for all days between 8/1/24 and 8/20/24, except for one day on 8/10/24, where it is documented to be a 3 out of 10. When pain value entries are entered into the electronic medical record they are categorized as either using a numerical scale or a PAINAD scale. None of the entries between 8/1/24 and 8/20/24 are categorized as using the PAINAD scale to evaluate Resident #1's pain. (Licensed Nursing Assistant) LNA staff witnessed an increase in pain after Resident #1 fell out of bed on 8/1/24. This was not communicated to a provider. Per interview on 9/9/24 at 2:14 PM, a LNA that	F 697	assessment process for the presence of pain upon admission/readmission, quarterly, with change in condition or change in pain status. Staff will continually observe and monitor patients for comfort and presence of pain and will implement strategies in accordance with professional standards of practice, the patient-centered plan of care, and the patient's choices related to pain management. The facility uses the appropriate pain scale to assess pain based on the resident's cognitive status. Licensed Nurses will be re-educated to this process. DON/Designee will complete audits of resident records to validate the following: that staff are assessing residents for pain utilizing the appropriate pain scale, care plan for pain include the location of the resident's pain, non- pharmaceutical interventions are being offered, recorded and are updated in the	

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 10/18/2024

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 697	Continued From page 18	F 697		

worked with Resident #1 explained that when s/he helped with Resident #1 with his/her ADL care after his/her fall, s/he was in significant pain. S/He explained that s/he had worked at the facility for a while and had a good relationship and knowledge of Resident #1. This LNA explained that when s/he had to move him/her to do his/her care Resident #1 was screaming in pain, grabbing, and biting the air. S/He stated that s/he had made nursing staff aware of this.

Per phone interview on 9/23/24 at 12:55 PM, the Licensed Nursing Assistant (LNA) that found Resident #1 on the floor on 8/1/24 explained that Resident #1 was unable to speak after his/her stroke but was able to communicate with facial expressions, sounds, and small body movements and occasionally s/he could answer yes or no. The LNA stated that Resident #1 did not show signs of pain immediately after the fall while Resident #1 was on the floor, but s/he did have progressively increased pain the days following the fall, sometimes screaming in pain when helping with his/her care. S/He explained that s/he reported to nursing staff that Resident #1 was having increased pain multiple times and was told by nursing staff that they were already aware or that the pain was Resident #1's baseline. S/He reiterated that prior to the fall Resident #1 had signs of discomfort and the pain s/he had post fall was a significant change from his/her baseline.

Per phone interview on 9/11/24 at 2:27 PM, the Nurse Practitioner (NP) who had visits with Resident #1 on 8/7/24 and 8/14/24, was asked about his/her concern for injury post fall. S/He explained that s/he was unaware that Resident #1 was in pain. S/He revealed that nursing staff did

plan of care. These audits will be weekly x 4 weeks, bi-weekly x 4 weeks, then monthly x 3 months. Results of this audit will be brought to the monthly QAPI Committee for further review and recommendations.

Date of Compliance: 12/3/2024

Tag F 697 POC accepted on 11/13/24 by S. Stem/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 10/18/2024

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 697	Continued From page 19	F 697		

not alert him/her to an increase of pain. S/He did not see evidence of Resident #1 having pain per his/her pain assessments in his/her vitals, except for one report of 3 out of 10 pain, which on its own was not concerning. S/He confirmed that Resident #1 was non-verbal and would require staff to use the PAINAD to evaluate his/her pain.

An 8/20/24 nursing note states that Resident #1 was transferred to the Emergency Department (ED) for immediate evaluation and treatment for altered mental status. An 8/20/24 ED Registered Nurse (RN) note states that on admission to the ED Resident #1, "does respond to painful stimuli and slightly moves arms when transferring from EMS stretcher to ED stretcher." Per interview on 9/9/24 at approximately 12:30 PM with this RN, s/he explained that Resident #1 appeared to be in pain anytime they moved his/her legs. An 8/21/24 ED Physician Assistant note reveals that a CT scan was preformed to rule out pneumonia. An 8/20/24 radiology report, signed at 11:34 PM reveals that Resident #1 has an "Acute right femoral neck fracture [fracture in the hip joint]. Unexpected finding."
A 9/16/24 Nurse Practitioner note reveals that Resident #1 was seen for a follow up visit "related to [his/her] recent CVA, a fall with a right femur fracture with resulting physical deconditioning." Nursing evaluations up through 9/25/24 reveal that Resident #1 is still experiencing significant hip pain, some days reporting and/or displaying up to 10 out of 10 pain.

Staff failed to evaluate existing pain for Resident #1.

Resident #1 has the following physician order "Tylenol Oral Tablet 325 MG (Acetaminophen)

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 10/18/2024

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 697	Continued From page 20	F 697		

Give 2 tablet by mouth every 4 hours as needed for pain," with a start date of 9/21/22. Resident #1's Medication Administration Record (MAR) reveals that the PRN Tylenol was administered 6 times between 8/1/24 and 8/20/24, on 8/7/24, 8/10/24, 8/11/24, 8/12/24, 8/13/24, and 8/14/24. Of the 6 times the Tylenol was administer, the only time a pain evaluation was completed was on 8/10/24, where Resident #1 is documented to have 3 out of 10 pain.

Facility policy titled "NSG227 Pain Management," revised on 11/1/23 reads, "5. At a minimum of daily, patients will be evaluated for the presence of pain by making an inquiry of the patient or by observing for signs of pain. 6. PRN pain medications will: 6.1 Be documented in the Medication Administration Record (MAR), 6.2 Have defined parameters for use, 6.3 Have reasons for PRN medication requests documented, and effectiveness and/or side effects/adverse drug reactions will be assessed and documented."

Per a phone interview on 9/23/24 at 4:44 PM, the Market Clinical Advisor confirmed that there was not a documented evaluation of Resident #1's pain each time s/he was administered PRN pain medications and should have been.

Staff failed to revise Resident #1's care plan to address and manage pain after a change in condition to meet the resident's goals for pain management.

An 8/27/24 NP follow up visit note reveals that Resident was readmitted to the facility on 8/26/24 following a hospitalization where Resident #1 was found to have a displaced fracture of his/her right

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 10/18/2024

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 697	Continued From page 21 hip. The note references hospital records documenting pain with repositioning and the NP's exam revealed Resident #1 "grimacing when lifting right leg off bed." The NP's assessments included an order for norco (hydrocodone-acetaminophen, opioid pain medication) for pain management related to his/her hip fracture. Facility policy titled "NSG227 Pain Management," revised on 11/1/23 reads, "3. An individualize, interdisciplinary, person-centered care plan will be developed and include: 31. Addressing/Treating underlying cause of pain to the extent possible; 3.2 Non-pharmacological and pharmacological approaches; 3.3 Using specific strategies for preventing or minimizing sources of pain or pain related symptoms." Per review of Resident #1's care plan, related to pain was not updated to reflect pain related to his/her recent fracture or the use of the PAINAD scale until 9/9/24. 2. Per record review, Resident #6 has diagnoses that include right sided lumbago with sciatica (lower back pain that radiates down the right leg), polyneuropathy (nerve damage that can cause pain), stage 4 kidney disease, morbid obesity, and Alzheimer's disease. Resident #6 has the following physician orders, "Lidocaine External Patch 4 % Apply to affected area topically in the evening for pain." This order does not indicate where his/her body s/he is having pain. S/He also has an order for "Diclofenac Sodium External Gel 1 % (Diclofenac Sodium (Topical)) Apply to knees topically two times a day for pain relief."	F 697		

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 10/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 697	Continued From page 22 Recorded pain levels reviewed between 9/1/24 and 10/18/24 show that Resident #6 reported his/her pain to be an 8 or 9 (on a 1-10 pain scale) multiple times. A 9/24/24 nursing note reveals that Resident #6 has right lower back pain described as a 9, aching, and worse with movement. Resident #6's care plan reads, "[Resident #6] exhibits or is at risk for alterations in comfort related to eye pain," revised on 5/19/23. His/her care plan does not include a pain focus related to his/her pain in his/her back or knees and does not include interventions to provide non-pharmacological pain interventions. Per Resident #6's Medication Administration Record, there is an area to document non-pharmacological pain interventions (NPI) every shift when pain is identified. This area is documented under NPI as "n" (no) or "N/A" from 9/1/24 through 10/18/24. Nursing notes show that non- pharmacological interventions were only documented twice during this time. Per interview on 10/18/24 at 2:51 PM, the Market Clinical Lead confirmed that residents experiencing pain should have care plans that identify the cause of pain and include non-pharmacological pain interventions and Resident #6 did not. 3. Per record review, Resident #3 has diagnoses that include dementia, legal blindness, and acute kidney failure. A 9/10/24 nurse note reveals that Resident #3 sustained a that morning fall with complaints of pain to his/her hip and went sent to the emergency department (ED). A 9/13/24 Nurse	F 697		

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 10/18/2024

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 697	Continued From page 23 Practitioner note states that s/he had a hip fracture and underwent hip surgery. Records show Resident #3 was transferred back to the facility on 9/12/24. A 9/27/24 NP note states that Resident #3 had sustained two more falls since his/her surgery and was guarding hip and grimacing with movement. Recorded pain levels reviewed between 9/10/24 and 10/18/24 show that Resident #3 reported to be in pain multiple times, the highest being a 10 (on a 1-10 pain scale). Resident #3's care plan reads, "[Resident #3] exhibits or is at risk for alterations in comfort related to chronic pain," revised 10/26/23. After returning to the facility following his/her hip surgery, Resident #3's care plan was not updated to reflect the underlying cause of his/her pain. Per interview on 10/18/24 at 2:51 PM, the Market Clinical Lead confirmed that residents experiencing pain should have care plans that identify the cause of pain and Resident #3 did not. 4. Per record review, Resident #5 has diagnoses that include dementia, spinal stenosis (narrowing of the spinal canal that puts pressure on the spinal cord and nerves), and osteoarthritis. Per Resident #5's care plan, s/he "requires assistance/is dependent for ADL care in ADLs related to limited mobility," revised on 4/11/24. Per a 9/30/24 nursing note, Resident #5 suffered a fall resulting in a protrusion to the anterior part of his/her left arm and severe pain. S/He was transferred to the emergency department. A hospital Advanced Registered Nurse Practitioner	F 697		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 697	Continued From page 24	F 697		

note dated 9/30/24 reveals that Resident #5 had a closed nondisplaced fracture of the left humerus. Discharge instructions included a left upper extremity splint and sling and Percocet as needed for pain.

Per Resident #5's care plan, s/he "exhibits or is at risk for alterations in comfort related to pain," revised on 9/21/23. After returning to the facility following his/her 9/30/34 emergency department visit, Resident #5's care plan was not updated to reflect the underlying cause of his/her pain related to his/her fracture and was not updated to include the use of a splint and sling.

Recorded pain levels reviewed between 9/30/24 and 10/18/24 show that Resident #5 reported to be in pain multiple times, the highest being a 10 (on a 1-10 pain scale).

Per Resident #5's Medication Administration Record, there is an area to document non-pharmacological pain interventions (NPI) every shift when pain is identified. This area is documented under NPI as "n" (no) or "N/A" from 9/30/24 through 10/18/24 for 15 of the 19 pain level reports.

Per interview on 10/18/24 at 2:51 PM, the Market Clinical Lead confirmed that residents experiencing pain should have care plans that identify the cause of pain and Resident #5 did not.