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

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

April 30, 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 **April 16, 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
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 04/16/2024

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 The Division of Licensing and Protection conducted an unannounced, onsite complaint investigation, including reports #22919 and #22873, on 4/16/24 to determine compliance with 42 CFR Part 483 requirements for Long Term Care Facilities. Deficiencies were cited as a result of this survey.	F 000	I This plan of correction was written to follow state and federal guideines. It is not an admission of noncompliance. However, it is the facility's commitment to demonstrat and maintain compliance.	
F 691 SS=E	Colostomy, Urostomy, or Ileostomy Care CFR(s): 483.25(f) §483.25(f) Colostomy, urostomy,, or ileostomy care. The facility must ensure that residents who require colostomy, urostomy, or ileostomy services, receive such care consistent with professional standards of practice, the comprehensive person-centered care plan, and the resident's goals and preferences. This REQUIREMENT is not met as evidenced by: Based on interview, and record review, the facility failed to ensure that Residents with colostomies receive care and services consistent with professional standards of practice and the comprehensive care plan for 2 of 2 sampled residents (Residents #1 and #2). Findings include: 1. Per record review, Resident #1 was admitted to the facility on 4/3/24 with a diagnosis of Diverticulitis (a chronic condition of the intestines), Failure to Thrive, and Colostomy Status (a colostomy is when the intestines are surgically diverted to exit out of an incision in the abdomen). Per review of a provider admission note entered on 4/5/24, the note states, "Patient had recent colon resection for bowel obstruction	F 691	F691 Specific Corrective Action 1. Resident #1 was discharged on 04/10/24 Resident #2 has active orders for the care of the colostomy 2. An audit of resident records was completed to validate that residents with colostomy have active orders for care of the colostomy including care and changing of the appliance/bag. 3. The facility obtains orders for the care of the colostomy/ileostomy. This includes orders for the change of the appliance, emptying and changing of the colostomy/ileostomy bag. Licensed staff will be re-educated to this process. 4. DNS/Designee will complete audits of resident records to validate residents with colostomy/ileostomy have orders for the care of the ostomy. 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 5/29/2024.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE MOA — (X6) DATE 4/29/24

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 04/16/2024

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 691	Continued From page 1	F 691	**Tag F 691 POC accepted on 4/30/24 by K. Ruffe/P. Cota**	

approximately 2 and half weeks ago. [They were] sent back to the ER after having acute abdominal pain and having inability to care for [themselves]." Resident #1 was discharged to the hospital on 4/10/24 and did not return.

Per further record review, Resident #1 was never ordered for any colostomy care, including emptying of the colostomy bag and changing of the colostomy bag. Resident #1's care plan did not contain any focus for colostomy care and assessment.

Per review of the facility's Clinical Competency Evaluation checklist for "Colostomy and Ileostomy Care", the first step in the checklist instructs the staff member performing the care to verify the order for care. The last step in the checklist instructs the staff member performing the care to document the procedure.

Per interview on 4/16/24 at approximately 3:45 PM the Market Clinical Lead confirmed that the record contains no evidence that regular colostomy care or evaluation was ordered or performed for Resident #1 during their admission.

2. Per record review, Resident #2 was admitted to the facility on 2/23/24 with a diagnosis of Diverticulitis and Colostomy Status. Resident #2 was ordered to have colostomy bag changes every Monday, Wednesday, and Friday. These orders ran from admission to the facility through 3/12/24, then 3/18/24 through 4/12/24, and then from 4/15/24 to the present. There is no active order for colostomy changes every Monday, Wednesday, and Friday from 3/12/24 through 3/18/24.

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 04/16/2024

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 691	Continued From page 2 Per review of Resident #2's Treatment Administration Record, ordered colostomy care was not marked as administered on 3/6/24, 3/11/24, 3/18/24, 3/22/24, 4/1/24, and 4/12/24. Per interview on 4/16/24 at approximately 11:00 AM, the Director of Nursing confirmed that there are many missing administrations of the ordered colostomy care in Resident #2's record.	F 691		
F 725 SS=F	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge	F 725	F725 Specific Corrective Action 1. The facility currently has staffing patterns in place, based on census and acuity, that are sufficient to assure patient safety and attain or maintain the highest practicable physical,mental, and psychosocial well-being of each patient. This includes a PPD of 2.0 for LNA and an overall nursing PPD of 3.0 at a minimum. 2. All residents have the potential to be affected 3. The facility ensures they have sufficient nursing staff, including nurse aides in accordance with state and federal regulations, with the appropriate competencies and skills sets to provide nursing and related services to assure patient safety and attain or maintain the highest practicable physical,mental, and psychosocial well-being of each patient. Facility NHA, Scheduling and Payroll Manager, and Nursing Leadership will be re-educated to this process. 4. NHA/Designee will validate that the facility has sufficient nursing staff to meet the needs of the facility this includes at a minimum of a PPD of 2.0 for nurses aides and an overall nursing PPD of 3.0. These audits will be daily x 30 days, weekly x 4 weeks, then bi weekly x 2 months. Results of these audits will be brought to the monthly QAPI Committee for further review and recommendations. Date of Compliance 5/29/2024	

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 04/16/2024

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 725	Continued From page 3	F 725	Tag F 725 POC accepted on 4/30/24 by K. Ruffe/P. Cota	

Continued From page 3
nurse on each tour of duty.
This REQUIREMENT is not met as evidenced by:
Based on resident interview, staff interview, and record review, the facility failed to ensure that there are a sufficient number of skilled nurse aides to provide care and services to attain the highest practicable well-being for each resident and in accordance with each resident's plan of care. Findings include:

1. Per record review, Resident #2 was admitted to the facility on 2/23/24 following surgical intervention for diverticulitis (a chronic issue with the intestines) that resulted in a colostomy (when the intestines exit through a hole in the abdomen). As a result of this, Resident #2 receives all their care in bed. Per review of the care plan, Resident #2 requires substantial to total assist in bed for toileting, incontinence care, bathing, and grooming/hygiene. The care plan also states that Resident #2 is incontinent of urine.

Per interview on 4/16/24 at approximately 9:30 AM, Resident #2 stated that they have had to wait hours on several occasions in order to have their urine-soaked brief changed by staff. They also stated that they only occasionally receive bed baths from staff and they would like to get bed baths more frequently. They attribute this to the facility not having enough staff.

Per review of LNA task documentation, Resident #2 has only received 7 bed baths (on 3/23/24, 3/24/24, 4/1/24, 4/3/24, 4/4/24, 4/9/24, and 4/16/24) in the last 30 days.

2. Per record review, Resident #3's care plan

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 04/16/2024

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 725 Continued From page 4 F 725

states that they need assistance of 1 staff member for transfers, toileting, and hygiene.

Per interview on 4/16/24 at approximately 1:00 PM, Resident #3 stated that it takes the facility a long time to answer the call bell, and that there have been occasions where they have had to wait over an hour to be toileted. One of these times, Resident #3 states that they had an accident before they could get to the toilet.

3. Per record review, Resident #4's care plan states that they are incontinent and require assistance of one staff member for transfers, hygiene, and toileting.

Per interview on 4/16/24 at approximately 1:00 PM, Resident #4's representative stated that it often takes 30 minutes or more for Resident #4 to be toileted/cleaned up from the time that they put the call bell on. They stated that they visit the facility frequently and have seen it take over an hour for staff to answer residents' call lights on many occasions. They also stated that when they receive a call from a staff member asking them to get in touch for updates about Resident #4, it can take as many as 4-6 separate calls back before anyone at the facility even picks up the phone.

4. Per record review, Resident #5's care plan states that they require the limited assistance of 1-2 staff members for toileting and the full assistance of 1 staff member for transferring.

Per interview on 4/16/24 at approximately 1:00 PM, Resident #5 stated that their call light is usually on for a half an hour before staff can come and answer it to see what they need. Resident #5 also stated that they often have to

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 04/16/2024

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 725 Continued From page 5 F 725

wait 10 minutes after using the toilet before a staff member is able to assist them off of the toilet.

5. Per record review, Resident #6's care plan states that they are occasionally incontinent of urine and require limited assistance of 1 for toileting and require the use of a Hoyer lift and 2 staff members for transfers.

Per interview on 4/16/24 at approximately 1:00 PM, Resident #6 stated that they have to wait an average of 30 minutes to get their needs met using the call light system. Resident #6's spouse, who was there at the time of the interview, agreed with this estimate.

6. Per interview on 4/16/24 at approximately 1:30 PM, LNA (licensed nursing assistant) 1 stated that LNA staffing is not sufficient. LNA 1 is sometimes scheduled to work with only 2 other LNAs for an entire floor. Residents complain to LNA 1 frequently that their call lights are not being answered in a timely manner. LNA 1 stated that Residents are "always wet" and they regularly have to skip giving Residents showers because there isn't enough time or help to get them done. Call lights also take a very long time to get to. LNA 1 stated that they do not see administrative nurses helping with LNA assignments on any regular basis, and usually it's only a call light or two.

Per interview on 4/16/24 at approximately 1:30 PM, LNA 2 stated that call bells are "impossible" to stay on top of with current LNA staffing. Having 5 LNAs scheduled for the floor is ideal and allows one LNA to address call lights while the other 4 complete their daily care for their assigned Residents. There are rarely 5 LNAs working on

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 04/16/2024

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 725 Continued From page 6 F 725

the floor, sometimes as few as 3 on days. Nursing administration does not take a full LNA assignment or stay for full/half shifts if they do come to assist.

Per interview on 4/16/24 at approximately 1:30 PM, LNA 3 stated that LNA staffing is usually not efficient. Having 5 LNAs on the floor is ideal, but usually only 4 are scheduled and then there are often call outs that don't get replaced. Working with only 3 LNAs to a floor is very difficult and resident care does not always get completed in those situations. LNA 3 stated that it is very difficult to answer call lights and make sure residents are dry and well hydrated when staffing is short. Administrative nurses will check in occasionally when the floor is short LNA help and may answer a few call lights, but they don't take an LNA assignment. LNA 3 stated they have never seen administrative nurses work as an LNA for a full or even half shift.

8. Review of facility direct care staff schedules and PPD (direct care staff to resident ratios) for February and March 2024 reveals that the facility failed to maintain Vermont State required minimum staffing levels to allow for 2.0 hours of direct care per resident per day on a weekly average by LNAs (licensed nursing assistants) for 7 of 8 sampled weeks.

Per interview on 4/16/24 at approximately 2:00 PM, the Administrator and Clinical Market Lead stated that the facility is short LNA staff, but that nursing administration does go to the floors on occasion when a unit is short LNAs. However, they confirmed that the person performing the support, nor the length of time, are thoroughly tracked or documented in a way that would

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 04/16/2024

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 725 Continued From page 7

impact the PPD. They also confirmed that nursing administration is not taking a full assignment when they are assisting on the floors.

Per interview on 4/16/24 at approximately 4:00 PM, the Administrator and Clinical Market Lead confirmed that LNA staffing is not sufficient to provide residents with the highest practicable level of well-being.

F 726 Competent Nursing Staff
SS=F CFR(s): 483.35(a)(3)(4)(c)

§483.35 Nursing Services
The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e).

§483.35(a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care.

§483.35(a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs.

§483.35(c) Proficiency of nurse aides.
The facility must ensure that nurse aides are able

F 725

F 726

F726 Specific Corrective Action

1. Licensed staff have been provided education and validation of clinical competencies for the care of the colostomy /ileostomy.

2. An audit of licensed nurses and licensed nursing assistance was completed to validate that the nursing staff have specific competencies necessary to care for residents needs as identified through resident assessment, facility assessment, and plan of care.

3. The facility ensures nursing staff have appropriate competencies and skill sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well being of each resident. Administrative nursing staff, licensed nurses, and licensed nursing assistance will be re-educated and validation of competencies completed for this process.

4.DNS/Designee will complete audits of employee education and competencies to validate the staff have appropriate skill sets to care for the resident population at the facility. These audits will be weekly x 4 weeks, bi-weekly x 4 weeks, then monthly x 3 months. Results of these audits will brought to the monthly QAPI Committee for further review and recommendations.

Date of compliance 5/29/2024

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 04/16/2024

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 726	Continued From page 8	F 726	Tag F 726 POC accepted on 4/30/24 by K. Ruffe/P. Cota	

Continued From page 8

to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care.
This REQUIREMENT is not met as evidenced by:

Based on interview and record review, the facility failed to ensure that licensed nurses have the specific competencies necessary to care for Residents' needs as identified through resident assessments and the plan of care. Findings include:

Per record review, Residents #1 and #2 both had colostomies while admitted to the facility. A colostomy is when the intestines are surgically diverted to exit out of an incision in the abdomen. Stool is then collected In a bag that must be emptied periodically. The bag must also be changed periodically.

Per interview on 4/16/24 at approximately 11:00 AM, the facility Nurse Educator stated that they were not sure if ostomy care was part of the annual competencies that nurses have to complete, or if the competencies are completed as needed based on the current patient population. The facility Wound Nurse stated that they have shown some of the nurses who provided ostomy care to Residents #1 and #2 how to do it, but that they have not completed a competency checklist for each nurse for ostomy care that outlines the facility's procedure for ostomy care and ostomy bag changes.

Per review of the facility's checklists for clinical competency validation, there is a checklist for "Colostomy and Ileostomy Care" which outlines all the procedural steps for providing such care

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 04/16/2024

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 726	Continued From page 9	F 726		

and has a section for staff competency validation in which a "met" or "not met" box must be checked.

Per interview on 4/16/24 at approximately 12:30 PM, the Clinical Market Lead confirmed that they found evidence of ostomy care as being on the list of annual competencies for nurses, but that they can find no evidence that the competency validation checlists were completed for each nurse in the last year.

Division of Licensing and Protection

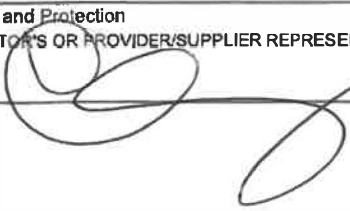
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	475025	A. BUILDING: ______ B. WING ______	C 04/16/2024

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
S320 SS=F	7.13 (d)(1) QUALITY OF CARE - STAFFING LEVELS 7.13 (d)(1) The facility shall maintain staffing levels adequate to meet resident needs. 1. At a minimum, nursing homes must provide: i. no fewer than three (3) hours of direct care per resident per day, on a weekly average, including nursing care, personal care and restorative nursing care, but not including administration or supervision of staff; and ii. of the three hours of direct care, no fewer than two (2) hours per resident per day must be assigned to provide standard LNA care (such as personal care, assistance with ambulation, feeding, etc.) performed by LNAs or equivalent staff and not including meal preparation, physical therapy or the activities program. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility failed to maintain required minimum staffing levels to allow for 2.0 hours of direct care per resident per day (PPD) on a weekly average by Licensed Nursing Assistants (LNAs) for 7 of the 8 sampled weeks. Findings include: Per review of the daily nursing PPD hours, the average direct care PPD by LNA staff was below the required 2 hours per day minimum during the following weeks in February and March 2024: 2/12/24 - 2/18/2024 = 1.97 2/10/24 - 2/25/24 = 1.93 2/26/24 - 3/3/24 = 1.87	S320	S320 Specific Corrective Action 1. The facility is currently staffing to, at a minimum, of 2.0 LNA PPD and 1.0 Nurse PPD for a total PPD of 3.0 at a minimum. 2. All resident have the potential to be affected 3. The facility ensures they have sufficient nursing staff, including nurse aides in accordance with state regulations, to ensure patient needs are met in regards to daily personal care, assistance with ambulation,feeding etc. Facility NHA, Scheduling and Payroll Manager, and Nursing Leadership will be re-educated to this process. 4.NHA/Designee will validate that the facility has sufficient nursing staff to meet the needs of the facility this includes at a minimum of a PPD of 2.0 for nurses aides and an overall nursing PPD of 3.0. These audits will be daily x 30 days, weekly x 4 weeks, then bi weekly x 2 months. Results of these audits will be brought to the monthly QAPI Committee for further review and recommendations. Date of compliance 5/29/2024	

Division of Licensing and Protection

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE



TITLE: mOA

(X6) DATE: 4/29/24

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 04/16/2024

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
S320	Continued From page 1 3/4/24 - 3/10/24 = 1.81 3/11/24 - 3/17/24 = 1.94 3/18/24 - 3/24/24 = 1.94 3/25/24 - 3/31/24 = 1.87 Per interview on 4/16/24 at approximately 2:00 PM, the Administrator and Clinical Market Lead stated that the facility is short LNA staff, but that nursing administration does go to the floors on occasion when a unit is short LNAs. However, they confirmed that the person performing the support, nor the length of time, are thoroughly tracked or documented in a way that would impact the PPD. They also confirmed that nursing administration is not taking a full assignment when they are assisting on the floors.	S320	Tag S320 POC accepted on 4/30/24 by K. Ruffe/P. Cota	