STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395690	A. Building B. Wing	07/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Springfield Rehabilitation and Healthcare Center	463 West Sproul Road Springfield, PA 19064

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate foot care. (continued on next page)

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.

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record reviews, interviews with residents and staff and reviews of policies and procedures, it was determined that the facility failed to provide foot care and treatment for one of eight residents reviewed. (Resident R1)Findings include: A review of the policy and procedures titled medication and treatment orders dated July 2016 revealed that orders for medications and treatments will be consistent with the principles of safe and effective writing. The policy indicated that only authorized licensed practitioners, or individuals authorized to take verbal orders from practitioners shall be allowed to write orders in the clinical record. The policy also said that verbal orders must be recorded immediately in the resident's clinical record. The order must include prescriber's last name, credentials and date and time of the order. A review of the policy and procedure titled consultant physician services dated February 2023 revealed that the consultant physician services must be inwriting and signed by the attending physician. After completion of the consult, the consultant physician was to provide the facility with a consultation report which was to include any orders, recommendations or follow-up actions. The policy indicated that consultation reports were filed in the resident's clinical record. The policy said that the orders from the consultant physician were to be entered into the resident's clinical record by the nursing staff Clinical record review revealed that Resident R1 was admitted to the facility on [DATE]. The resident was admitted to the facility for rehabilitation and nursing care post-surgical TMA traumatic amputation of left foot and left tendon Achilles lengthening. Clinical record review revealed that the consulting podiatrist (a physician that specializes in the diagnosis, treatment and surgical care of the foot, ankle and related structures of the leg) evaluated Resident R1 on July 10, 2025. The podiatrist removed the staples from the surgical site, advised the facility staff to work with Resident R1 and the physical therapy department to work at encouraging weight bearing, as tolerated to the left foot. The podiatrist report also indicated that Resident R1 required a diabetic shoe with filler, as adaptive equipment to meet her foot care needs for eventual ambulation. The podiatrist requested that the nursing staff assist Resident R1 in obtaining a diabetic shoe that would be custom fitted to meet her foot care needs for returning to ambulation status. Clinical record review revealed no documented evidence that an appointment and transportation was made for Resident R1 to be fitted for the adaptive equipment (diabetic shoe with filler) as assessed by the podiatrist on July 10, 2025. The podiatrist again evaluated Resident R1 on July 24, 2025, and requested that the resident be fitted for a diabetic shoe with filler. Observations of Resident R1 at 1:00 p. m., on July 28, 2025, revealed that the resident was not wearing any adaptive equipment for the left foot. Resident R1 was observed seated in a wheelchair and using it to ambulate on July 28, 2025. Clinical record review revealed a physical therapy progress note dated July 15, 2025, indicating Resident R1 was demonstrating hopping on her right foot with a roller walker and staff supervision. During an interview with Resident R1 at 1:30 p.m., on July 28, 2025, the resident reported that the physical therapy department trialed her with a boot that was painful to wear. Clinical record documentation by the occupational therapist on July 18, 2025, indicated that the resident was complaining of aching, throbbing, discomfort of her left foot, while wearing the trialed boot. Interview with Resident R1 at 1:45 p.m., on July 28, 2025, confirmed that she was not afforded the opportunity to use the custom-made diabetic shoe with filler that the podiatrist recommended on July 10, 2025. Interview with the physical therapist assistant, Employee E3, registered nurse, Employee E4 and social worker, Employee E5 at 11:00 a.m., on July 28, 2025 confirmed that Resident R1 was not afforded the opportunity to obtain the adaptive equipment (custom fitted diabetic shoe with filler) as recommended by the consulting podiatrist on July 10, 2025 to meet the foot care needs of this resident, for walking and ambulation. Interview with the social worker, Employee E5 at 10:30 a. m., on July 28, 2025, revealed that Resident R1 was formerly living in an assisted living and that the resident wished to return to living in the community at that home. The assisted living building had stairs/steps that Resident R1 would have to use for safe evacuation in an emergency. Interview with the physical therapist assistant on July 28, 2025 revealed that Resident R1 required the custom fitted diabetic shoe with filler, as requested by the podiatrist to be trialed with ambulation, steps and stairs before discharge into the community assisted home where she had resided. 28 PA. Code 211.10(c)(d) Resident care policies 28 PA. Code 211.12 (d)(1)(3)(5) Nursing services