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	03/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Springfield Health & Rehab	105 Chester Road Springfield, VT 05156

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 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure consultation with the attending physician during a COVID-19 outbreak, and failed to notify the physician of positive COVID-19 results for 3 of 11 residents who tested positive for COVID-19 (Residents #6, #7, and #12). The facility also failed to notify the physician after a resident physically assaulted another resident causing injury (Resident #1 and #4), and at the time of significant changes in condition regarding development of pressure ulcers (Resident #9). This citation is at the immediate jeopardy level due to the lack of notification and consultation with the physician during a COVID-19 outbreak and with significant changes in resident statuses puts all residents at risk for serious injury or death because of the noncompliance. Findings include: 1. Per record review, Resident #7 was admitted to the facility with the primary diagnosis of a non-ST segment elevation myocardial infarction (NSTEMI, a type of heart attack), and was no longer able to care for her/himself at home due to advancing dementia. A COLST (Clinicians orders for life sustaining treatment) dated [DATE] reflects that Resident #7 was a full code in the event of cardiac arrest. Per review of the facility documented COVID-19 line list, Resident #7 tested positive for COVID-19 on [DATE] and was experiencing symptoms of lethargy (a general state of fatigue that involves a lack of energy and motivation for physical and mental tasks). See F880 for more information. Per record review there is no documented evidence in the Resident's record or facility reports that the Physician was notified on [DATE] that Resident #7 had tested positive for COVID-19 or that s/he was experiencing lethargy. There is also no documented evidence that the Physician was consulted regarding the treatment and care needs of Resident #7 related to COVID-19, and no documented evidence that the Resident was closely monitored after [DATE] or received any treatment specifically related to the COVID-19 infection. From 1/7-[DATE] the resident was being monitored for a previous dental infection, using a standardized sepsis questionnaire but the last vital signs were taken on [DATE]. See F710 for more information. The facility policy titled Change in Resident Condition or Status states: 1. Purpose of Policy Our facility shall promptly notify the resident, his or her attending physician, and responsible party of changes in the residents' condition and/or status. (continued on next page)

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

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	IV. Policy Statement A. The Nurse Supervisor, Manager, or Charge Nurse will notify the resident's attending physician when 1. The resident is involved in any accident or incident that results in an injury including injuries of an unknown source. 2. There is a significant change in the resident's physical, mental, or psychological status. 3. There is a need to alter the resident's treatment significantly . Per record review, a Progress Note written by a Licensed Practical Nurse (LPN) on [DATE] reveals that the Resident was found in bed unresponsive and gurgling the physician was notified, s/he was sent to the hospital, and subsequently died. Per review of the Resident's Death Certificate the cause of death was cardiopulmonary arrest due to COVID, hypertension (high blood pressure), diabetes, coronary artery disease (disease in the heart's major blood vessels). During an interview on [DATE] at 4:15 PM the Medical Director, who is also the attending physician, stated that she was not sure if she had been notified of Resident #7's COVID-19 positive results. The Medical Director confirmed that she was not notified that the Resident was experiencing lethargy, and that the nurse should have notified her. The Medical Director also stated the nurse should have completed a change of condition notification. 2. Further review of the facility documented COVID-19 outbreak line list revealed that in addition to Resident #7, 10 other Residents and 15 staff members tested positive for COVID-19 between [DATE] and [DATE]. Per review of resident and facility records, 2 of the other Residents who tested positive (Residents #6, #12) had no documented evidence of physician notification in their medical records. During an interview on [DATE] at 4:15 PM the Medical Director, who is also the attending physician, stated that she was not sure if she had been notified of each resident who tested positive during the outbreak. The Medical Director confirmed that she had not been consulted with regarding the facility policies, mitigation plan, or COVID-19 guidance from [NAME] Department of Health (VDH). 3. Per record review Resident #1 was admitted to the facility with diagnoses that include cognitive communication deficit, and dementia with mood and behavioral disturbance. A Nurse Progress Note dated [DATE] revealed that Resident #1 entered Resident #4's room while s/he was in bed. Resident #1 knocked over the bedside table and threw a can or cans of soda at Resident #4's face resulting in bruising to his/her forehead, left eye, and a skin tear to the left forearm. There is no documented evidence in the record that Resident #4 received any additional monitoring related to being struck in the head immediately following the incident. During an interview on [DATE] at 3:06 PM Resident #4 stated that [s/he] is afraid to fall asleep because [Resident #1] will come in the room again. (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	During an interview on [DATE] at approximately 2:00 PM a Licensed Practical Nurse (LPN) confirmed that Resident #1 had hit Resident #2 in the head with a 12 pack of soda on [DATE]. Review of the facility incident report dated [DATE] reveals that the nurse had documented that the Medical Director had been notified of the incident. However, during an interview with the Medical Director on [DATE] at 5:14 PM they stated that they had not been notified of the incident that occurred on [DATE]. The Medical Director stated that they would have had Resident #1 sent out to the hospital for evaluation due to aggression and Resident #4 would be sent out for evaluation for the need for an x-ray or scans had they been notified. The Medical Director also said that s/he would expect to be notified of incidents such as this. 4. Per record review a Skin Wound Evaluation dated [DATE] reveals that Resident #9 had a newly developed an in house acquired moisture associated skin damage (MASD) related to incontinence associated dermatitis (IAD) on their sacrum that measured 0.9 cm in length and 0.5 cm in width. The notification section of the form is blank indicating that there were no required notifications made. Assessments dated [DATE] documented the skin was intact. Per record review an Integrated Wound Care (IWC) Progress Note dated [DATE] states that Resident #9 is being seen for the evaluation and treatment of deep tissue injury (DTI), [a pressure-related injury to subcutaneous tissues under intact skin. Initially, these lesions have the appearance of a deep bruise. These lesions may herald the subsequent development of a Stage III-IV pressure ulcer even with optimal treatment. (NPAUP, 2005)] to the right trochanter (near the hip). Further record review revealed that there was no documented evidence that the physician was notified of the development of the DTI. An IWC Progress Note dated [DATE] reveals that the DTI had progressed to a stage 2 pressure ulcer (partial thickness loss of dermis presenting as a shallow open ulcer with a red or pink wound bed, without slough or bruising. May also present as an intact or open/ruptured blister). There is no evidence in the Resident's record that the physician was notified that the DTI had progressed to a stage 2 pressure ulcer. Per interview on [DATE] at 2:23 PM the Director of Nursing and the Regional Director of Nursing confirmed that there was no documented evidence that the physician was notified of Resident #9's recently developed pressure ulcers. During a dressing change observation on [DATE] at 3:10 PM the Licensed Practical Nurse (LPN) was observed changing dressings on Resident #9's sacrum, hip, and right outer ankle. There was a large dry wound noted on the outer aspect of the Resident's left foot. This surveyor asked the LPN and the Director of Nursing (DON) who was assisting with the treatment, if there was a treatment ordered for that area. Both the LPN and DON were not aware of the wound. The DON recommended that the LPN leave the wound open to air. There was no previous documentation of the wound on the outer aspect of the left foot and no documented physician notification. Review of the Resident's Treatment Administration Record revealed that there was no physician's order for treatment of the wound until [DATE]. Per interview on [DATE] at 5:14 PM the Medical Director stated that she had not been informed that Resident #9 had developed the pressure ulcers on his/her trochanter (hip), right ankle, and out aspect of the left foot. The physician confirmed that she should have been notified of the new pressure ulcers. Reference: (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	http://www.npuap.org/resources/educational-and-clinical-resources/npuap-pressure-ulcer-stagescategories/

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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 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. Based on observation, interviews, and record review, the facility failed to protect the resident's right to be free from physical abuse by a resident for 1 of 3 residents in the sample (Resident #4). As a result, Resident #4 suffered injury and persistent fear that s/he would be physically assaulted again. Findings include: A review of a facility reported incident submitted to the State Agency on 1/9/25 of an allegation of physical abuse related to a resident-to-resident altercation that occurred on 1/8/25 at approximately 5:12 PM, revealed that Resident #1 entered the room of Resident #4 and threw a can of soda at Resident #4's arm causing a skin tear to the left forearm. Resident #4 also suffered a bruise to his/her forehead. A review of the nursing documentation and risk management notes reveals no evidence of how the bruise occurred to Resident #4's forehead. See F689 for more information. Per interview on 1/22/25 at approximately 10:00 AM, Resident #4 stated that Resident #1 came into his/her room while s/he was asleep and threw a 12 pack of soda at his/her face. Per observation, Resident #4 had evidence of bruising around his/her left eye, mid forehead and left side of forehead. There was a dressing on his/her left forearm dated 1/17/25. Per further interview s/he stated that s/he is afraid to sleep because [s/he] is worried that [Resident #1] will come back in [his/her] room. Per review of Resident #4's care plan dated 2/6/24 [S/he] requires assistance/dependent for movement related to weakness and due to bilateral ankle fractures s/he is unable to stand on her own, s/he requires a mechanical lift. The care plan also reveals that [Resident #4] is blind in the left eye . has a history of adjustment disorder and depression. [Interventions include] provide a calm environment, and assess for fear, and anxiety. Per the facility investigation, staff interviews dated 1/8/25, revealed staff were passing dinner trays, when one staff member noticed Resident #1 was exiting Resident #4's room. When the Licensed Nursing Assistant (LNA) serving drinks entered Resident #4s room she noted the nightstand was knocked over and Resident #4 reported being assaulted by Resident #1. During an interview on 1/23/25 at approximately 2:00 PM, a Licensed Practical Nurse (LPN #1) confirmed that Resident #1 had hit Resident #4 in the head with a 12 pack of soda on 1/8/25 and that staff were not aware that Resident #1 was in the room until the event occurred . Per review of Resident #1's care plan dated 1/19/24 [Resident #1] exhibits or has the potential to exhibit physical and verbal behaviors. [Interventions include] listen to [Resident #1] and help [him/her] calm down . [12/20/24] remove [Resident #1] from public area when behavior is disruptive/unacceptable, offer [Resident #1] to lay down, and assist to room. Per further review of Resident #1's care plan dated 12/10/24 s/he is identified as risk for wandering and has an intervention to offer resident schedule time for appropriate walks/appropriate activity. Residents #1's care plan fails to address behaviors of entering other residents' rooms, or the need for supervision after multiple resident to resident incidents. Per interview with an LNA #1 on 1/22/25 at 2:00 PM, he stated that there has been no education provided to staff related to how to manage Resident #1 behavior. He states that when Resident #1 is agitated it is difficult to redirect him/her. He stated that when he cares for other residents, Resident #1 goes into other resident rooms and is hard to get him/her out. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Per interview of a LPN #3 on 1/23/25 at approximately 10:50 AM, she stated she was concerned that all residents would be at risk from Resident #1, on the second floor unit because she feels there are not enough staff to keep Resident #1 from going into other resident rooms. Per interview with LPN #2 on 1/23/25 at 10:55 AM, She stated that she is concerned that all residents on the second floor are at risk from Resident #1 because once s/he is in wheelchair, s/he is independent with mobility. The LPN stated Resident #1 has been found in multiple resident's rooms and is difficult to redirect due to his/her aggression. Per facility investigation reports, Resident #1 had a recent history of aggressive physical behaviors toward other residents, including an altercation on 12/23/25, when Resident #1 was witnessed pushing and punching Resident #3, and threatening to kill him/her. Then again on 12/29/24 when staff witnessed Resident #1 go down the hallway, go past Resident #2, turn around, get behind him/her and hit him/her in the back of the head. Per interview with Regional Director of Nursing on 1/23/25 at approximately 6:00 PM, she stated that per Resident #1's task list s/he should have been on 15-minute checks starting 12/21/24 prior to the above incidents occurring on 12/23/24, 12/29/24 and on 1/8/25. However, according to her, there is no documented evidence that staff completed 15-minute checks at any point since initiated on 12/21/24. She stated there was no evidence on Resident #1's care plan of the intervention and there should have been. She also stated there was no documented evidence of 15 minute checks in the record, which would have been done on paper then scanned into medical record. Review of Resident #1's medical record did not contain any evidence that 15 minute checks were performed. Per interview with an LPN on the second-floor unit on 1/23/25 at 6:30 PM, she stated she was unaware of any residents on the unit who were receiving 15 minutes checks including Resident #1.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based on record review and interview, the facility failed to ensure that an allegation of resident to resident abuse was reported to the State Licensing Agency for 1 of 3 sampled residents (Resident #4) within 2 hours of the incident and failed to submit an investigation of the findings to the State Agency within 5 days. Findings include: A facility investigation submitted to the State Agency on 1/9/25 of an allegation of physical abuse related to a resident-to-resident altercation that occurred on 1/8/25 at approximately 5:12 PM, revealed that Resident #1 entered the room of Resident #4 and threw a can of soda at his/her arm causing a skin tear to the left forearm, and a bruise to his/her forehead Per nursing documentation and risk management notes there is no evidence of how the bruise occurred to Resident #4's forehead. The facility failed to report the incident to the State Agency within 2 hours of the occurrence. According to the State Agency the facility filed the report on 1/9/25 at 4:30 PM, over 23 hours after the facility was aware of the allegation, and the 5 day investigation was not submitted until 1/24/25, 15 days after the investigation began. Per facility titled Abuse Neglect and Exploitation last revised 1/2024 reads For any actual or suspicious act or signs of abuse, neglect or exploitation it is the responsibility of every employee and volunteer to make sure the resident is safe first .upon receipt of a report from a resident or family member of actual abuse neglect or exploitation employee or volunteer is to proceed with the reporting process immediately . Director of Nursing or designees will report incident within 2 hours after the allegation is made, if the events that cause the allegation do not involve abuse and do not result in serious bodily injury or no later than 24 hours if the allegation do not involve abuse. Per interview on 1/23/25 at approximately 3:00 PM with the facility Administrator, she stated she was unaware that Resident #4 had been hit in the forehead with a can or possibly a 12 pack of soda. She stated she did not realize the incident should have been reported to the Stage Agency within 2 hours. Per further interview the Administrator stated the 5 day investigation was also submitted late, and not sent to State Agency until 1/24/25.

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F 0656 Level of Harm - Actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on interview and record review the facility failed to implement care plan interventions related to skin and wound assessments for 1 of 15 residents in the sample (Resident #9). As a result of the failure to follow care plan interventions Resident #9's pressure ulcers worsened. Findings include. 1. Per observation on 1/22/2025 at 3:10 PM a Licensed Practical Nurse (LPN) and Director of Nursing (DON) were observed performing wound care to Resident #9's pressure ulcers. The Resident was noted to have an excoriated sacrum with two open areas that were cleansed and a new dressing was applied. The pressure ulcer on his/her right hip was also cleansed and a new dressing was applied. The pressure ulcer on his/her right malleolus (ankle) was noted to be open with slough around the edges of the wound. This area was also cleansed and a new dressing was applied. There were 2 open area on the Resident's left distal foot that were cleansed and a new dressing applied. This surveyor noted a large dry wound on Resident #9's left lateral foot and asked the LPN and DON if there was a treatment ordered for that area. Both the LPN and DON were not aware of the wound. The DON recommended that the LPN leave the wound open to air. Per record review there was no documentation of the wound on the left lateral foot, no documented physician notification, and there was no treatment ordered for the wound until 1/30/2025, 8 days after it was identified. Review of Resident #9's Care Plan focus dated 3/8/2024 for at risk for skin breakdown reveals that it was not updated to include the stage 2 pressure ulcer on his/her left lateral foot until 1/29/2025. Per record review Resident #9 has a Care Plan focus dated 3/8/2024 that indicates s/he is at risk for skin breakdown related to: foley catheter use and fragile skin. On 1/10/2025 the Care Plan focus was revised to include MASD (moisture associated skin damage) to the sacrum and a deep tissue injury (DTI), (a pressure-related injury to subcutaneous tissues under intact skin. Initially, these lesions have the appearance of a deep bruise. These lesions may herald the subsequent development of a Stage [three and stage four] pressure ulcer even with optimal treatment. [NPAUP, 2005]) on his/her right hip. Interventions include weekly skin checks by licensed nurse (initiated on 11/7/22), and weekly wound assessment to include measurements and description of the wound (initiated on 5/12/2023). Review of the weekly checks titled Skin Observation/Check reveals that skin checks were documented on 12/31/2024 identifying moisture associated skin damage (MASD) related to incontinence associated dermatitis (denuded, excoriation), there are no documented wound measurements or description, 1/12/2025 identifying a right trochanter (hip) open area-tx in place, and sacrum, scattered open areas to bilateral buttocks-tx in place, there are no wound measurements or description, 1/20/2025 identified a coccyx ulcer and was updated on 1/29/25 to include right trochanter (hip), right ankle (outer), and left ankle (outer) no wound measurements or description, and on 1/31/2025 no wound measurements or description and only mentions that there is a coccyx wound, not documenting the presence of the four additional pressure ulcers that included an unstageable pressure ulcer to the right trochanter, an unstageable pressure ulcer on the right medial malleolus (ankle), a stage 2 pressure ulcer of the left proximal foot, a stage 2 pressure ulcer on the left distal foot. (continued on next page)

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F 0656 Level of Harm - Actual harm Residents Affected - Few	Per record review an Integrated Wound Care (IWC) Progress Note dated 1/7/2025 states that Resident #9 is being seen for the evaluation and treatment of deep tissue injury to the right trochanter (near the hip) measuring 4 cm length x 2. 1 cm width. The wound notes state Non-blanching discoloration, no open areas and no bogginess. An IWC Progress Note dated 1/14/2025 reveals that the DTI had progressed to a stage 2 pressure ulcer (partial thickness loss of dermis presenting as a shallow open ulcer with a red or pink wound bed, without slough or bruising. May also present as an intact or open/ruptured blister) measuring 4 cm length, 2 cm width, and 0.18 cm depth. There is no evidence in the Resident's record that the physician was notified that the DTI had progressed to a stage 2 pressure ulcer. Further record review reveals that Resident #9's wounds were not assessed or measured weekly between 1/14/25 - 1/28/25. An IWC Follow-up Progress Note dated 1/28/2025 reveals that Resident #9 was seen for follow-up for the pressure ulcer to the right trochanter that was now unstageable (Pressure ulcers that are known but not stageable due to coverage of the wound bed by slough [dead tissue within a wound], and/or eschar [dead tissue])with 10% slough and 90% eschar and measures 3.5 cm length, 1.5 cm width, and 0.1 cm depth. The wound on Resident #9 sacrum is also documented as unstageable with 30% slough and 70% eschar measuring 10 cm length, 11 cm width, and 0.1 cm depth. A note states that there are 3 areas separated by skin bridge with periwounds intact and blanching. Three additional pressure ulcers had developed since the last consultation . An unstageable pressure ulcer on the right medial malleolus (ankle) was noted as 10% granulation (tissue is new connective tissue and blood vessels that form on wound surfaces during healing), 70% eschar, and 20% slough and measure 9.5 cm length x 2.5 cm width x 0.1 depth. A stage 2 pressure ulcer of the left proximal foot that measures 2.5 cm length, 0.3 cm width, and 0.1 cm depth. A stage 2 pressure ulcer developed on the left distal foot that measured 1.5 cm length, 1.5 cm width, and 0.1 cm depth. Per interview with the facility Administrator on 1/22/25 at 9:45 AM the IWC Consultant had been asked to reschedule the 1/22/25 visit. 2. Further record review reveals that Resident #9 has a care plan focus initiated on 4/25/2024 that states requires the use of enhanced barrier precautions (EBP) related to Indwelling device: Foley Catheter. An intervention initiated on 4/25/24 states Use of face mask or eye protection if there is a risk of splash or spray and Use of gloves and gown for high-contact care activities (personal protective equipment, PPE). Per observations on 1/22/2025 at 2:55 PM a Licensed Practical Nurse (LPN) and Director of Nursing (DON) were observed entering Resident # 9's room with supplies to flush his/her foley catheter. There was a sign on the Resident's door that indicated that EBP should be used. Both the LPN and DON were observed in the room without face mask and eye protection. Once the foley care was complete, the LPN and DON exited the room and gathered supplies for the scheduled wound care. The LPN and DON were then observed performing wound care on the 5 pressure ulcers without wearing the required PPE. (continued on next page)

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F 0656 Level of Harm - Actual harm Residents Affected - Few	Immediately after the wound care this surveyor asked the DON why Resident #9 was on EBP and he stated that he would be on EBP due to his/her foley and open wounds. The DON confirmed that he and the LPN should have worn PPE during the catheter flush and the wound care per care plan and facility protocol. On 1/23/2025 at 1:45 PM the LPN was again observed in Resident #9's room performing wound care without the indicated PPE. After exiting the room, the LPN was interviewed and stated that she should have donned PPE and she did not. Reference: http://www.npuap.org/resources/educational-and-clinical-resources/npuap-pressure-ulcer-stagescategories/

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. Based on observation, interview, and record review the facility failed to revise the care plan for 1 of 15 residents in the sample (Resident #4) related to resident to resident physical abuse and wounds. Findings include: A facility investigation submitted to the State Agency on 1/9/25 of an allegation of physical abuse related to a resident-to-resident altercation that occurred on 1/8/25 revealed that Resident #1 entered the room of Resident #4 and threw a can of soda at his/her arm causing a skin tear to the left forearm and a bruise to his/her forehead. Review of Resident #4's care plan reveals there is no documented evidence that the facility revised the care plan to add interventions to monitor Resident #4 for complications related to resident to resident physical abuse resulting in injury. See F689 for more information. Per interview on 1/22/25 at approximately 10:00 AM with Resident #4 stated that s/he is afraid to sleep because [s/he] is worried that [Resident #1] will come back in [his/her] room. Per Resident #4's care plan dated on 6/27/24 [Resident #4] is at risk for skin breakdown related to advance age, frail, fragile skin, [and] limited mobility. The facility did not revise Resident #4's care plan to include new skin impairments (skin tear and bruise) or any interventions to assess, monitor, or treat the new wound. Per interview with the Director of Nursing on 1/23/25 at approximately 11:00 AM, he confirmed there had been no updates to Resident #4's care plan related to new skin wounds or the resident to resident altercation.

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Springfield Health & Rehab	105 Chester Road Springfield, VT 05156

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. Based on observation, interview and record review the facility failed to provide quality care to 1 out of 15 residents in the sample (Resident #4) related to wound care that is not pressure. Findings include: Per observation on 1/23/25 at approximately 10:00 AM, Resident #4 had a dressing on his/her left forearm dated 1/17/25. Per interview with Resident #4 at that time s/he stated that s/he had an injury to his/her left arm and that the nurses had placed a dressing to the area. Resident #4 further stated that a nurse had not changed the dressing in several days and pointed to the date on the bandage which was dated on 1/17/25. Review of the facility policy titled Wound Care last reviewed/revised in 1/2024 states the following information should be recorded in the resident's medical record 1. The type of wound care given. 2. The date and time the wound care was given. 3. The position in which the resident was placed. 4. The name and title of the individual performing the wound care. 5. Any changes in the resident's condition. 6. All assessment date (i.e., wound bed color, size drainage, ect.) obtained when inspecting the wound. Per record review, Resident #4 had the following dressing orders dated 1/9/25 Cleanse left forearm with normal saline, apply xeroform to skin tear and wrap with kerlix, and change daily. Although the dressing was documented as being changed per the Treatment Administration Record, the dressing was observed to have not been changed for 5 days, since 1/17/25, and there was no documentation of a wound assessment. Per interview of the Licence Practical Nurse (LPN #3) working with the Resident #4 on 1/23/25 at 10:30 AM, she confirmed the dressing on Resident #4's left forearm was dated 1/17/25 and appeared old. The LPN confirmed that Resident #4 had orders for daily dressing changes in his/her medical record starting 1/9/25.

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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 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. Based on observations, interviews, and record review, the facility failed to ensure that 1 of 3 residents in the applicable sample (Resident #9) received necessary treatment and services consistent with professional standards of practice to promote healing by not obtaining physician's orders for treatment, not following care plan interventions, and not performing accurate skin and wound assessments. This deficient practice caused Resident #9's wounds to deteriorate, and caused him/her to develop additional pressure ulcers. This is a repeat deficiency for this facility, with violations cited during the previous recertification survey, dated 1/10/25. Findings include: Per observation on 1/22/2025 at 3:10 PM a Licensed Practical Nurse (LPN) and Director of Nursing (DON) were observed performing wound care to Resident #9's pressure ulcers. The Resident was noted to have an excoriated sacrum with two open areas that were cleansed and a new dressing was applied. The pressure ulcer on his/her right hip was also cleansed and a new dressing was applied. The pressure ulcer on his/her right malleolus (ankle) was noted to be open with slough around the edges of the wound. This area was also cleansed and a new dressing was applied. There were 2 open area on the Resident's left distal foot that were cleansed and a new dressing applied. This surveyor noted a large dry wound on Resident #9's left lateral foot and asked the LPN and DON if there was a treatment ordered for that area. Both the LPN and DON were not aware of the wound. The DON recommended that the LPN leave the wound open to air. Per record review there was no previous documentation of the wound on the left lateral foot, no documented physician notification, and there was no treatment ordered for the wound until 1/30/2025. An Integrated Wound Care (IWC) Progress Note dated 1/7/2025 states that Resident #9 is being seen for the evaluation and treatment of deep tissue injury to the right trochanter (near the hip) measuring 4 cm length x 2. 1 cm width. The wound notes state Non-blanching discoloration, no open areas and no bogginess. Keep clean and dry, apply skin prep and protective DPD (dry protective dressing) daily and PRN (as needed). There is no documented evidence that this treatment recommendation was initiated. Review of Resident #9's January 2025 Treatment Administration Record (TAR) reveals a wound treatment initiated on 1/11/2025 that states cleanse right hip with wound cleanser or normal saline. Pat dry. Apply sureprep (used to create a barrier film on peri-wound skin). Cover with optifoam (a foam wound dressing) dressing daily. There is no documented evidence that the newly developed pressure ulcer was treated when it was identified on 1/7/2025 until 1/11/2025, four days after it was identified. During an interview on 1/22/2025 at 2:23 PM the Director of Nursing (DON) and the Regional DON confirmed that although the pressure ulcer was identified and assessed by the IWC Consultant on 1/7/2025, there was no documented evidence that the IWC Consultant's recommendations for treatment were implemented, and no treatment orders were in place for the DTI until 1/10/2025. An IWC Progress Note dated 1/14/2025 reveals that the DTI had progressed to a stage 2 pressure ulcer (partial thickness loss of dermis presenting as a shallow open ulcer with a red or pink wound bed, without slough or bruising. May also be presented as an intact or open/ruptured blister) measuring 4 cm length, 2 cm width, and 0.18 cm depth. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Resident #9 has a Care Plan focus that indicates s/he is at risk for skin breakdown related to: foley catheter use and fragile skin. On 1/10/2025 the focus was revised to include MASD (moisture associated skin damage) to the sacrum and a deep tissue injury (DTI; a pressure-related injury to subcutaneous tissues under intact skin. Initially, these lesions have the appearance of a deep bruise. These lesions may herald the subsequent development of a stage [three and stage four] pressure ulcer even with optimal treatment. [NPAUP, 2005]) on his/her right hip. Interventions include weekly skin checks by licensed nurse (initiated on 11/7/22), and weekly wound assessment to include measurements and description of the wound (initiated on 5/12/2023). The Care Plan was not updated to reflect the unstageable pressure ulcer to the left distal foot, stage 2 pressure ulcer to the left lateral proximal foot, and the unstageable pressure ulcer to the right medial malleolus until 1/29/2025. Review of the weekly checks titled Skin Observation/Check reveals that skin checks were documented on 12/31/2024 with no wound measurements or description, 1/12/2025 with no wound measurements or description, 1/20/2025 no wound measurements or description, and on 1/31/2025 no wound measurements or description and only indicates that there is a coccyx wound, there is no documentation regarding the four additional pressure ulcers that included an unstageable pressure ulcer to the right trochanter, an unstageable pressure ulcer on the right medial malleolus (ankle), a stage 2 pressure ulcer of the left proximal foot, a stage 2 pressure ulcer on the left distal foot. Further record review reveals that there is no documented evidence that Resident #9's wounds were assessed or measured weekly between 1/15/25 - 1/27/25. An IWC Follow-up Progress Note dated 1/28/2025 reveals that Resident #9 was seen for follow-up for the pressure ulcer to the right trochanter that was now unstageable (Pressure ulcers that are known but not stageable due to coverage of the wound bed by slough [dead tissue within a wound], and/or eschar [dry dead tissue]) with 10% slough and 90% eschar and measures 3.5 cm length, 1.5 cm width, and 0.1 cm depth. The wound on Resident #9 sacrum was also documented as unstageable with 30% slough and 70% eschar measuring 10 cm length, 11 cm width, and 0.1 cm depth. A note states that there are 3 areas separated by skin bridge with periwounds intact and blanching. The IWC Follow-up Progress Note dated 1/28/2025 also reflects three additional pressure ulcers had developed since the last consultation on 1/14/2025. An unstageable pressure ulcer on the right medial malleolus (ankle) was noted as 10% granulation (tissue is new connective tissue and blood vessels that form on wound surfaces during healing), 70% eschar, and 20% slough and measure 9.5 cm length x 2.5 cm width x 0.1 depth. A stage 2 pressure ulcer of the left proximal foot that measures 2.5 cm length, 0.3 cm width, and 0.1 cm depth. A stage 2 pressure ulcer developed on the left distal foot that measured 1.5 cm length, 1.5 cm width, and 0.1 cm depth. Per interview with the Director of Nursing (DON) and the Regional DON on 1/22/25 at 2:23 PM, Resident #9 was being followed by the IWC Consultant in the past for a DTI on her/his right trochanter that had resolved. On 1/7/2025 when the Resident returned from an appointment it was brought to the DON's attention by the Resident's family member that a new wound had developed on the Resident's hip. The DON confirmed that there was no documentation regarding the development of the DTI and no new orders for wound care were received until 1/10/2025. The DON also stated that a Skin Observation/Check was completed on 1/12/2025 however, there is no description or measurements of the wound, and he did not know why it fell through the cracks. The Regional DON also confirmed that the Skin Observation/Check completed on 1/12/2025 was the first documentation of the DTI . (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Per interview with the facility Administrator on 1/23/25 at 5:48 PM the IWC Consultant had been asked to reschedule the 1/22/25 visit. On 2/5/2025 at 12:30 PM the Administrator confirmed that the Wound Care Consultant had not provided consultation during the week of 1/20/25- 1/24/2025. Reference: http://www.npuap.org/resources/educational-and-clinical-resources/npuap-pressure-ulcer-stagescategories/

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide adequate supervision to prevent 1 of 3 sampled residents (Resident #6) from gaining access to an alarmed stairwell and falling down a flight of 8 stairs, sustaining a head injury. The facility failed to ensure resident safety by not responding timely to a door alarm that is used to alert staff of potential resident elopement. The facility also failed to provide adequate supervision of 2 residents in the applicable sample (Resident #1 and Resident #4) to prevent a resident-to-resident assault that resulted in fear and injury to Resident #4. This citation is at the immediate jeopardy level due to the lack of adequate supervision to prevent mobile residents from entering secured, dangerous areas within the facility, prevent residents from leaving the unit or building, and prevent resident assault, putting all residents at risk for serious injury or death because of the noncompliance. This is a repeat deficiency for this facility, with violations cited during two partial surveys, dated 10/18/24 and 6/12/24. Findings include: 1. Per record review, Resident #6 has medical diagnoses that include dementia, Alzheimer's Disease, history of falling, and cognitive communication deficit. A care plan focus initiated on 6/16/23 indicates that s/he is at risk for elopement related to exit seeking behavior. Interventions implemented on 6/16/23 include door alarms on at all times, answer alarms promptly, redirect if near exits or doorways, and utilization of a Wander Guard device. A Nursing Progress Note dated 10/23/24 revealed that on 10/22/24 at approximately 7:00 PM Nurse #1 was giving medications out. There were TV's blaring, bathroom bells ringing on both sides of the hall, certain resident's screaming instead of using their call bell, and [residents] at the nurses station needing attention. This [Nurse #1] r ealized a door alarm was going off and went to answer the alarm. The Resident was already on the other side of the East Stairway exit door when this nurse opened the door to the sounding alarm. This nurse observed [the resident] at the top of the stairs at which point the resident was in [her/his] wheelchair rolling forward and heard the resident scream and start to fall down the stairs, tumbling in somersaults-head over heels down the stairs with [her/his] wheelchair. The ground floor stopped [Resident #6's] fall and [her/his] head was resting on the floor while [her/his] body was still on the stairs with [her/his] wheelchair on top of [her/him]. This nurse lifted the wheelchair off the resident, checked for breathing, resident was unconscious, I ran up the stairs, screamed for 911 and help, and ran back down to the resident and held [the Resident's] neck in position until [s/he] regained consciousness again and was moving [her/his] head on [her/his] own, arm and legs, but c/o hip pain. [On call physician] assessed the patient and agreed [s/he] needed to be sent to the [emergency room] ER. Paramedics arrived and transported resident to [NAME] ER. A provider Encounter Note written on 10/22/23 states that Resident #6 was observed by nurse falling down one flight of stairs. Nurse states prior to the fall, multiple bathroom alarms were ringing and [s/he] could not differentiate those alarms from the stairway alarm. [S/he] reports going down the hall with [his/her] med cart and finally recognizing that the stairway alarm was alerting [her/him] and the door to the stairway was unlocked. When [s/he] checked the door, [s/he] saw [patient] standing at the top of the stairway starting to fall . States the patient has two lacerations to bilateral temporal areas of scalp and a possible left hip fracture. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	Review of the facility Incident Report dated 10/22/2024 states The resident went to the door was able to read the egress sign and pushed on the door until it released (as it is intended to do). According to the Incident Report, predisposing factors were noise and alarm on and sounding, and predisposing situation factors include active exit seeker, wanderer, and history of falls. Review of the facility incident folder revealed staff statements describing what they were doing at the time of Resident #6's fall and the nursing schedule for 10/22/24 reveals that there was one Licensed Practical Nurse (LPN, Nurse #2), who was off the floor at the time of the incident, and two Licensed Nursing Assistants (LNAs #1 and #2) one of which was on break (LNA #2), and one who was at the nurse's station documenting care (LNA #1), assigned to the east hall. The west hall had one LPN (Nurse #1) who was at the nurse's station administering medications, and three LNAs (#3, #4, and #5), one who was off the unit (LNA #3) and two who were in Resident rooms providing care (LNA #4,and LNA #5). Leaving two staff members on the floor to respond to the alarm (Nurse #1 and LNA #1). Nurse #1 was the first to respond to the alarm finding Resident #6 in the stairwell. Per observation on 1/22/25 at 2:10 PM, the east stairway exit door was noted to have a cloth stop sign door banner across the doorway at approximately waist height. This banner was connected to a magnetic fixture that was connected to an alarm on the door by a string that was attached through a hole in the banner. This surveyor was able to disconnect the string easily without sounding the alarm. Per interview with the Administrator on 1/24/25 at 10:45 AM the incident occurred prior to her employment. She only had access to what information is in the Incident Report and incident file. When asked if there was access to the video from the hall surveillance camera film she stated that it does not save for that long of a period of time. 2. On entrance to the facility on 1/22/25 at 9:05 AM, the Wander Guard System had been activated and the alarm at the front door was sounding. There were no staff present, and the front lobby was empty. One staff member was observed getting into the elevator without concern for the alarm. Another staff member approached the elevator and asked the team if they had been helped. This surveyor asked them if the administrator was available. She went down the hall to get the Administrator, leaving the alarm on. When the Administrator approached s/he introduced herself and was informed why the team was there. While standing there, the alarm continued to sound. At this time she confirmed that it was the Wander Guard and stated it was alarming because at mealtimes, when residents get too close to the windows in the dining room upstairs, they set off the alarm. Approximately 10 minutes had elapsed between arrival and when the alarm was turned off. There was no investigation to determine if a resident had left the building. A list of 15 residents who have been identified as at risk for elopement was provided by the facility Administration. Per observations made on the second floor on 1/23/25 at approximately 1:15 PM, the Wander Guard alarm was sounding. There were two LNAs and one nurse in the nursing station area, none of whom responded to the alarm to ensure that a resident had not left the building. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	During an interview with the facility Administrator on 2/3/25 at 10:15 AM, she stated that the Wander Guard System had been repaired to make the distance between the Wander Guards and the alarm further apart. Although staff had received training regarding elopement and the Wander Guard alarm, they did not follow the facility policy/procedure. The Administrator confirmed that staff had been desensitized due to the frequency of it being set off . 3. A facility investigation report of an allegation of physical abuse in a resident-to-resident altercation submitted to the State Agency on 1/9/25 stated that on 1/8/25 Resident #1 entered the room of Resident #4 and threw a can of soda at his/her arm causing a skin tear to the left forearm and a bruise to the forehead. This was Resident #1's third resident-to-resident altercation investigated by the facility since 12/23/24. The facility did not revise Resident #1's care plan to include effective interventions for supervision to keep other residents safe. Per review of facility risk management report (RMS) documented on 1/8/25 by nursing staff [Resident #4] c/o (complained of) [Resident #1] coming into [his/her] room, [s/he] pushed the bedside table over, picked up a can of ginger ale, and [hit him/her] in the left arm with it causing a skin tear 1 cm x 1 cm. [S/he] received a bruise to [his/her] forehead. See F600 and F689 for more information. Per interview on 1/22/25 at approximately 10:00 AM, Resident #4 stated that Resident #1 came into his/her room while s/he was asleep and threw a 12 pack of soda at his/her face. Per observation Resident #4 had evidence of bruising around his/her left eye, mid forehead and left side of forehead. There was a dressing on his/her left forearm dated 1/17/25. Per further interview the s/he stated that s/he is afraid to sleep because [s/he] is worried that [Resident #1] will come back in [his/her] room. Per interview with an LNA #1 on 1/22/25 at 2:00 PM, he stated that there has been no education provided to staff related to how to manage Resident #1 behavior. He stated that when Resident #1 is agitated it is difficult to redirect him/her. He stated that when he cares for other residents, Resident #1 goes into other resident rooms and is hard to get him/her out. During an interview on 1/23/25 at approximately 2:00 PM, a Licensed Practical Nurse (LPN #1) confirmed that Resident #1 had hit Resident #4 in the head with a 12 pack of soda on 1/8/25 and that staff were not aware that Resident #1 was in the room until the event occurred. Per interview of a LPN #3 on 1/23/25 at approximately 10:50 AM, she stated she was concerned that all residents would be at risk from Resident #1, on the second floor unit because she feels there are not enough staff to keep Resident #1 from going into to other resident rooms. Per interview with LPN #2 on 1/23/25 at 10:55 AM, She stated that she is concerned that all residents on the second floor are at risk from Resident #1 because once s/he is in wheelchair, s/he is independent with mobility. The LPN stated Resident #1 has been found in multiple resident's rooms and is difficult to redirect due to his/her aggression. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	Per a nursing note dated 1/15/25 [Resident #1] entered [Resident #5's and Resident #14] room [Resident #1] had the following behavior note dated 1/15/25 Resident was found in another resident's room [Resident #5 and #14] . [the] resident was screaming and yelling at [him/her] to get out of [his/her] room, but the resident refused to leave. [Resident #1] threw motor to low loss air mattress on the floor. [S/he] started swinging at staff and grabbing other resident's bed and wall so [s/he] wouldn't leave. Resident finally returned to [his/her] room and laid down in bed. Per interview with the Medical Director on 1/23/2025 at 5:14 PM stated she was unaware that Resident #1 had been violent toward the other residents. She stated that she had not been notified of the incident that occurred on 1/8/2025. The Medical Director stated that she would have had Resident #1 sent out to the hospital for evaluation due to aggression and Resident #4 would have been sent out for evaluation for the need for an x-ray or scans had s/he been notified. See F580 and F710 for further information. The Medical Director also said that she would expect to be notified of incidents such as this. Per record review of Resident #4's medical chart there is no documented evidence that the facility assessed resident neurological status or reported to the provider that Resident #4 had an apparent head injury. The facility is unable to provide any documented evidence of how the bruise occurred to Resident #4's forehead, left eye and left side of face or that the bruising had been investigated. Per facility reported incidents Resident #1 had two other incidents in the last 30 days with other residents. Including an altercation on resident-to-resident altercation on 12/23/25, when Resident #1 pushed and punched Resident #3. Per facility investigation staff reported hearing Resident #1 threatening to kill Resident #3. Another facility incident was submitted on 12/29/24 stated that an unsolicited event occurred between Resident #1 and Resident #2 on 12/29/24 in which an Activity Aide .Witnessed [Resident #1] go down the hallway, go past [Resident #2], turn around, get behind [him/her] and hit [her/him] on the left side of back of head. Per a nursing behavior note dated 12/29/24 [Resident #1] had an incident with another resident today. [Resident #1] slapped [Resident #2] behind the head. This incident was witnessed and reported to this nurse. Per review of Resident #1's care plan dated 1/19/24 [Resident #1] exhibits or has the potential to exhibit physical and verbal behaviors. [Interventions include] listen to [Resident #1] and help [him/her] calm down . [12/20/24] remove [Resident #1] from public area when behavior is disruptive/unacceptable, offer [Resident #1] to lay down, and assist to room. Per further review of Resident #1's care plan dated 12/10/24 s/he is identified as risk for wandering and has an intervention include offer resident schedule time for appropriate walks/appropriate activity. Residents #1's care plan fails to address behaviors of entering into other residents rooms, or supervision after multiple resident to resident incidents. Per interview with the Director of Nursing on 1/23/25 at approximately 11:00 AM stated that he was aware of Resident #1's behaviors toward other residents on the unit and had discussed with the staff redirecting the resident. He stated the facility had not discussed a referral for a psychiatric evaluation or placement related after recent escalation in behaviors. he stated that he was unaware of the bruising to Resident #4 forehead and did not know if Resident #4 had been hit with a can or a 12 pack of soda. The DON confirmed that Resident #4 did have a small red area on his/her forehead after the incident. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	Per interview with the Regional Director of Nursing on 1/23/25 at approximately 6:00 PM stated that per Resident #1's task list s/he should have been on 15-minute checks starting 12/21/24 prior to the above incidents occurred. However, according to clinical lead there is no documented evidence that staff completed 15-minute checks or documented in the medical record. She also confirmed that this was not added to his/her care plan. Per interview of nursing staff on the second-floor unit on 1/23/25 at 6:30 PM they stated they were unaware of any residents on the unit who were receiving 15 minutes checks.

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Springfield Health & Rehab	105 Chester Road Springfield, VT 05156

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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 0710 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Obtain a doctor's order to admit a resident and ensure the resident is under a doctor's care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure that the medical care of each resident is supervised by a physician for 3 of 15 sampled residents (Resident #7, #1, #4). As a result Resident #7 who was positive for COVID, did not receive specific monitoring or treatment for the COVID infection, and died of COVID, Resident #1's violent behaviors continued to put other residents at risk, and Resident #4 suffered injury that was not immediately assessed or treated. This citation is at the immediate jeopardy level due to medical care not being supervised by the physician resulting in residents not being treated for COVID, aggressive behaviors, and failure to assess resident with suspected injury to his/her head. Findings include: 1. Per review of the facility documented COVID-19 line list, Resident #7 tested positive for COVID-19 on [DATE] and was experiencing symptoms of lethargy (a general state of fatigue that involves a lack of energy and motivation for physical and mental tasks). Per record review there is no documented evidence in the Resident's record or facility reports that the Physician was notified on [DATE] that Resident #7 had tested positive for COVID-19 or that s/he was experiencing lethargy. There is also no documented evidence that the Physician was consulted regarding the treatment and care needs of Resident #7 related to COVID-19, and no documented evidence that the Resident was closely monitored after [DATE] or received any treatment specifically related to the COVID-19 infection. From 1/7-[DATE] the resident was being monitored for a previous dental infection, using a standardized sepsis questionnaire but the last vital signs were taken on [DATE]. Per record review, a Progress Note written by a Licensed Practical Nurse on [DATE] reveals that the Resident #7 was found in bed unresponsive and gurgling the physician was notified, s/he was sent to the hospital, and subsequently died. Per review of the Resident's Death Certificate the cause of death was cardiopulmonary arrest due to COVID, hypertension (high blood pressure), diabetes, coronary artery disease (disease in the heart's major blood vessels). Per further record review of the record there were no notes from a physician that they had supervised the change in condition for Resident #7 or that she was assessed or treated for COVID. Per CDC recommendations for high risk individuals Per the Centers for Disease Control individuals at high risk related to COVID include those with cardiovascular disease and diabetes. This includes heart failure, coronary artery disease, cardiomyopathies, and possibly high blood pressure (hypertension). People with diabetes are more likely to have serious complications from COVID-19. [The CDC recommends] Anyone that is [AGE] years of age, especially 65 and older, OR have certain underlying medical conditions, such as a weakened immune system, heart disease, obesity, diabetes, or chronic lung disease, regardless of age be treated with antivirals. During an interview on [DATE] at 4:15 PM the Medical Director, who is also the attending physician, stated that they were not sure if they had been notified of Resident #7's COVID-19 positive results. The Medical Director confirmed that she was not notified that Resident #7 was experiencing lethargy, and that the nurse should have notified her. See F710 for more information. (continued on next page)

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F 0710 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	2. Per record review, a Nurse Progress note dated [DATE] revealed that Resident #1 entered into Resident #4's room while s/he was in bed. Resident #1 knocked over the bedside table and threw a can or cans of soda at Resident #4's in a skin tear to the left forearm and bruise on his/her forehead. There is no documented evidence in the record that Resident #4 received any additional monitoring related to being struck in the head. See F600 and F689 for more information. Per observation on [DATE] at approximately 10:00 AM, Resident #4 had evidence of bruising around his/her left eye, mid forehead and left side of forehead. There was a dressing on his/her left forearm dated [DATE]. During an interview on [DATE] at approximately 2:00 PM a Licensed Practical Nurse (LPN) confirmed that Resident #1 had hit Resident #4 in the head with a 12 pack of soda on [DATE]. Per record review, Resident #1 did not receive care from a physician related to his/her aggressive behavior or the event that occurred on [DATE] and Resident #4 did not receive immediate care after a head injury, including an assessment, from a physician related to injuries to their head and face. Review of the facility risk management report dated [DATE] reveals that the nurse had documented that the Physician had been notified of the incident. However, during an interview with the Physician, who is also the Medical Director, on [DATE] at 5:14 PM she stated that she had not been notified of the incident that occurred on [DATE]. The Physician stated that if she had been notified Resident #1 would have been sent out for evaluation for aggressive behavior and Resident #4 would have been sent to the emergency department for evaluation and a possible x-ray or scans. The Physician, also said that s/he would expect to be notified of incidents such as this. Per further interview with the Medical Director on [DATE] she stated she was unaware that Resident #1 had been violent toward the other residents. S/he stated that s/he had not been notified of the incident that occurred on [DATE].

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. Based on interview and record review, the facility failed to ensure that there was sufficient staff 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. This deficient practice had the potential to impact all residents who reside in the facility. This is a repeat deficiency for this facility, with violations cited during a partial survey, dated 4/16/24. Findings include: 1. During an interview with the Director of Nursing on 1/22/2025 at 12:03 PM, he stated that he is often working the medication cart due to short staff. Per interview with the designated Infection Preventionist, she was not able to complete training or follow up with the COVID-19 outbreak mitigation plan due to being out with COVID-19 and also working as a staff nurse. See F882 for more information. During an interview on 1/23/25 at 5:48 PM with the facility Administrator, the Integrated Wound Care (IWC)Consultant had been asked to reschedule the 1/22/25 visit due to lack of available staff to assist with wound rounds because they were working as a staff nurse passing medications. 2. Per record review of the daily nursing hours provided by the Administrator, the hours of direct care per resident per day by LNA staff fell below the State Licensing Agency requirment of 2 hours per day minimum for 4 of 8 weeks sampled. See S-320 for more information.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are free from significant medication errors. Based on interview and record review the facility failed to ensure that residents were free from significant medication errors for 2 of 3 residents in the applicable sample (Resident #10 and #11). Findings include: 1. Per record review, Resident #10 tested positive for COVID-19 on 1/10/2025. A Physician's order dated 1/10/2025 states Paxlovid (300/100) Oral Tablet Therapy Pack 20 x 150 MG & 10 x 100 MG (Nirmatrelvir-Ritonavir) Give 3 tablet by mouth two times a day for COVID-19 treatment for 5 Days until finished . Review of Resident #10's Medication Administration Record (MAR) revealed that the start date was to be 1/10/2025 at 9:00 PM and end date on 1/15/2025 for a total of 10 doses. The MAR reflects that the first dose of Paxlovid was not administered until 1/13/2025 at 9:00 PM. The MAR revealed that Resident #10 only received 4 doses of the Paxlovid between 1/13/2025 - 1/15/2025. Review of the Order Audit Report confirms that the Paxlovid was not dispensed by the pharmacy until 1/13/2025. Further review of Resident #10's revealed a Physician's order with a start date of 1/11/2025 for Azithromycin Oral Tablet 250 mg give 2 tablets by mouth in the morning for infection- covid and sacral wound for 1 day and Azithromycin Oral Tablet 250 mg give 1 tablet by mouth in the morning for infection- covid and sacral wound for 4 days with a start date of 1/12/2025. The MAR indicates that Resident #10 did not receive the 2 tablets of 250 mg on 1/11/2025 or the 1 tablet of 250 mg twice daily on 1/12/25 or 1/13/2025. According to the MAR Resident #10 only received two doses of Azithromycin. Review of the Order Audit Report confirms that the Azithromycin was not dispensed by the pharmacy until 1/13/2025. Per interview on 2/5/24 at 12:30 PM a Registered Nurse (RN) confirmed that there was a delay in the Paxlovid and Azithromycin and that the resident did not receive full doses. She also confirmed that the medications had not been administered per Physician's order, the MD had not been aware of the missed doses, and that they were not rescheduled to include the full duration of treatment. 2. Per record review Resident #11 tested positive for COVID-19 on 1/9/2025. A Physician's Order dated 1/10/2025 states Paxlovid (150/100) Oral Tablet Therapy Pack 10 x 150 MG & 10 x 100 MG give 2 tablets orally two times a day for COVID-19 treatment for 5 Days until finished . An Order Audit Report reflects that the Paxlovid was not dispensed by the pharmacy on 1/14/2025. During an interview on 2/5/2025 at 6:06 PM, the DON and a Registered Nurse confirmed that the Paxlovid was not administered per Physician's order.

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many Note: The nursing home is disputing this citation.	Administer the facility in a manner that enables it to use its resources effectively and efficiently. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility was not administered in a manner that enables it to maintain the physical well-being of each resident, whereby actions and decisions by the facility's leadership team directly contributed to multiple deficiencies that resulted in harm and immediate jeopardy by failing to ensure that the physician was notified of changes, residents were free from abuse, care plans were implemented, pressure ulcer care and prevention was provided, adequate supervision of residents, residents' care is supervised by a physician, the responsibilities of the Medical Director were met, implement an effective infection prevention program, and have a qualified infection preventionist. Findings include: During an investigation of 3 facility reported incidents and 3 complaints, the facility was found to have deficient practices that resulted in 5 citations at Immediate Jeopardy level, 5 harm level citations, and 7 potential for more than minimal harm citations. On [DATE], the survey team identified and notified the facility of deficiencies at the immediate jeopardy (IJ) level for F689 related to violations around accidents, hazards, and supervision. This IJ determination also results in substandard quality of care. On [DATE], during an onsite extended survey, the survey team identified and notified the facility of deficiencies at the immediate jeopardy (IJ) level for violations around F-580 related to physician notification, and F-880 infection control. During off-site review on [DATE] additional immediate jeopardy was identified at F710 and F835. The identified failures by the lack of administrative oversight put all residents at risk for serious harm, injury, or death. 1. Per interview with the Medical Director (MD) on [DATE] at 1:42 PM the facility has had a lot of changes. The MD stated we lost the Director of Nursing (DNS) and critical access nurses. It had been a bad transition between owners. There are a lot of new people and travelers right now. Per interview on [DATE] at 3:20 PM, a resident's responsible party stated the lack of consistent administration has caused issues with resident care and follow through of issues and concerns. Per review of the facility's license to operate issued by the Division of Licensing and Protection since [DATE] reveals the following changes to administration: -There was a change in the Administrator twice within the past year; on [DATE] and [DATE]. -There was a change in the Medical Director three times within the past year; on [DATE], [DATE], and [DATE]. -There was a change in the Director of Nursing six times within the past year; on [DATE], [DATE], [DATE], [DATE], [DATE], and [DATE]. (continued on next page)

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many Note: The nursing home is disputing this citation.	2. As a result of the facility failing to ensure notification and consultation with the attending physician, a resident was physically assaulted by another resident and was not evaluated for potential significant injury that may have been caused by the assault, a resident did not receive treatment orders for a developed pressure ulcer, and residents did not receive treatment related to COVID, including a resident who suffered a COVID related death. This citation is at the immediate jeopardy level due to the lack of notification and consultation with the physician during a COVID-19 outbreak and with significant changes in resident statuses, putting all residents at risk for serious injury and/or death because of the noncompliance. See F580 for more information. 3. As a result of the facility's failure to provide adequate supervision, a resident gained access to an alarmed stairwell and fell down a flight of 8 stairs and sustained a head injury, a resident sustained a head injury when s/he was assaulted by another resident, and a security system to prevent wandering was observed to be ineffective. This citation is at the immediate jeopardy level due to the lack of adequate supervision to prevent mobile residents from entering secured, dangerous areas within the facility, prevent residents from leaving the unit or building, and prevent resident assault, putting all residents at risk for serious injury and/or death because of the noncompliance. This is a repeat deficiency for this facility, with violations cited during two partial surveys, dated [DATE] and [DATE]. See F689 for additional information. 4. As a result of the facility's failure to ensure that the medical care of each resident is supervised by a physician, a resident who was positive for COVID did not receive antiviral's and died of COVID, and a resident's violent behaviors caused a resident to suffer injury that was not assessed or treated by the physician and continued to put other residents at risk. This citation is at the immediate jeopardy level due to medical care not being supervised by the physician resulting in residents not being treated for COVID, aggressive behaviors, and failure to assess resident with suspected injury to his/her head. See F710 for additional information. 5. As a result of the facility's failure to implement an infection prevention and control program that follows the accepted national standards regarding preventing, identifying, and controlling communicable diseases and failing to follow the CDC (Centers of Disease Control) and state health department recommendations for outbreak management, related to testing and other mitigation strategies including containment and personal protective equipment (PPE) use, a resident died of COVID and the residents in the facility were in immediate jeopardy of serious harm and/or death. See F880 for additional information. 6. As a result of the facility failing to protect the resident's right to be free from physical abuse, a resident suffered injury and remained in persistent fear that s/he would be physically assaulted again. This deficient practice resulted in harm. See F600 for more information. (continued on next page)

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many Note: The nursing home is disputing this citation.	7. As a result of the facility's failure to implement care plan interventions related to skin and wound assessments, a resident's pressure ulcers worsened. This deficient practice resulted in harm. See F656 for more information. 8. As a result of the facility's failure to ensure that a resident received necessary treatment and services for pressure ulcers consistent with professional standards of practice to promote healing, by not obtaining physician's orders for treatment, not following care plan interventions, and not performing accurate skin and wound assessments, the resident's wounds deteriorated and caused him/her to develop additional pressure ulcers. This deficient practice resulted in harm. This is a repeat deficiency for this facility, with violations cited during the previous recertification survey, dated [DATE]. See F686 for additional information. 9. As a result of the facility's failure to ensure that a staff member with specialized Infection Prevention and Control training beyond initial professional training was designated as the facility's Infection Preventions (IP), the facility failed to prevent spread of COVID-19 through mitigation strategies that would be directed by an infection preventionist, and 1 resident died from COVID-19. The failure to designate a qualified infection preventionist caused harm and has the potential to impact all residents who reside in the facility. This is a repeat deficiency for this facility, with violations cited during the previous two recertification surveys, dated [DATE] and [DATE]. See F882 for additional information.

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F 0841 Level of Harm - Actual harm Residents Affected - Few	Designate a physician to serve as medical director responsible for implementation of resident care policies and coordination of medical care in the facility. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure that the medical director fulfilled her responsibilities to effectively implement resident care policies and coordinate medical care for residents in the facility regarding the surveillance of, and development of policies that reflect current professional standards of practice to prevent the spread of potential COVID-19 infection, and coordinate care of residents. This deficient practice resulted in ineffective COVID-19 mitigation, death of a resident from COVID-19, and resident abuse with injury. 1. Per review of the facility documented COVID-19 outbreak line list revealed that 11 Residents and 15 staff members tested positive for COVID-19 between [DATE] and [DATE]. Resident #7 tested positive for COVID-19 on [DATE] and was experiencing symptoms of lethargy (a general state of fatigue that involves a lack of energy and motivation for physical and mental tasks). Per record review, a Progress Note written by a Licensed Practical Nurse on [DATE], 6 days after being diagnosed with COVID-19, reveals that the Resident was found in bed unresponsive and gurgling the physician was notified, s/he was sent to the hospital, and subsequently died. Per review of the Resident's Death Certificate the cause of death was cardiopulmonary arrest due to COVID, hypertension (high blood pressure), diabetes, coronary artery disease (disease in the heart's major blood vessels). Per record review there is no documented evidence in Resident #7's record or facility reports that the Medical Director was notified that Resident #7 had tested positive for COVID-19 or that s/he was experiencing lethargy. There is also no documented evidence that the Physician was consulted regarding the treatment and care needs of Resident #7 related to COVID-19, and no documented evidence that the Resident was monitored or received any treatment related to the COVID-19 infection. During an interview on [DATE] at 4:30 PM the Medical Director stated that she had only been acting as the facility's medical Director since December and had not had a chance to review facility policies and procedures. She also had not reviewed the infection control policies related specifically to the COVID-19 outbreak. The Medical Director confirmed that she had no knowledge of what the facility was doing regarding surveillance and prevention of COVID-19 cases during the outbreak. The Medical Director stated the COVID-19 cases at the facility to her knowledge had been mild and that she had no formal conversations with the facility about mitigation strategies. Further review of the facility documented COVID-19 outbreak line list revealed that in addition to Resident #7, 10 other Residents and 15 staff members tested positive for COVID-19 between [DATE] and [DATE]. Per review of resident and facility records, 4 other Residents who tested positive (Residents #6, #12, #13, and #14) had no documented evidence of physician notification or consultation in their medical records. During an interview on [DATE] at 4:15 PM the Medical Director stated that she was not sure if she had been notified of each resident who tested positive during the outbreak. The Medical Director confirmed that they had not been consulted with regarding the facility policies, mitigation plan, or COVID-19 guidance from [NAME] Department of Health (VDH). (continued on next page)

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F 0841 Level of Harm - Actual harm Residents Affected - Few	2. Per record review Resident #1 has a history of aggressive behavior towards others. There is no documented evidence in Resident #1's medical record that the Medical Director was aware of or consulted with regarding a violent incident toward another Resident. Per review of facility risk management report (RMS) documented on [DATE], [Resident #4] c/o (complained of) [Resident #1] coming into [his/her] room, [s/he] pushed the bedside table over, picked up a can of ginger ale, and [hit him/her] in the left arm with it causing a skin tear 1 cm x 1 cm. [S/he] received a bruise to [his/her] forehead. Per interview on [DATE] at approximately 10:00 AM, Resident #4 stated that Resident #1 came into his/her room while s/he was asleep and threw a 12 pack of soda at his/her face. Per observation Resident #4 had evidence of bruising around his/her left eye, mid forehead and left side of forehead. There was a dressing on his/her left forearm dated [DATE]. Per further interview the s/he stated that s/he is afraid to sleep because [s/he] is worried that [Resident #1] will come back in [his/her] room. Per interview with the Medical Director on [DATE] at 5:14 PM stated she was unaware that Resident #1 had been violent toward the other residents. She stated that she had not been notified of the incident that occurred on [DATE]. The Medical Director stated that if she had been consulted she would have had Resident #1 sent out to the hospital for evaluation due to aggression and Resident #4 would be sent out for evaluation for the need for an x-ray or scans had s/he been notified. The Medical Director also said that she would expect to be notified of incidents such as this. Per record review of Resident #4's medical chart there is no documented evidence that the facility assessed resident neurological status or reported to the provider that Resident #4 had an apparent head injury.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Based on interview and record review the facility failed to ensure that resident's medical records contained nurse progress notes, complete and accurate assessments, and wound care consultant notes to provide a picture of the resident's progress, including his/her response to treatments and/or services, and changes in his/her condition for 2 of 15 sampled residents (Resident #9 and #7). This is a repeat deficiency for this facility, with violations cited during a partial survey, dated 6/12/24, and the previous recertification surveys, dated 1/10/24. Findings include: 1. Review of the facility policy titled Charting and Documentation, The Policy Statement says All services provided to the residents, progress toward the care plan goals, or any changes in the resident's medical, physical. functional or psychological condition, shall be documented in the resident's medical record. The medical record should facilitate communication between the interdisciplinary team regarding the resident's condition and response to care. Review of the facility policy titled Wound Care last reviewed/revised in 1/2024 states the following information should be recorded in the resident's medical record 1. The type of wound care given. 2. The date and time the wound care was given. 3. The position in which the resident was placed. 4. The name and title of the individual performing wound care. 5. Any changes in the residents' condition. 6. All assessment date (i.e., wound bed color, size drainage, etc) obtained when inspecting the wound . Per record review a Skin Wound Evaluation dated 12/10/24 reveals that Resident #9 had a newly developed in-house acquired moisture associated skin damage (MASD) related to incontinence associated dermatitis (IAD) on their sacrum that measured 0.9 cm in length and 0.5 cm in width. This is documented as a new wound; however, the form states continue with same treatment. Several areas of the evaluation are blank and there is no other description of the wound documented. A Skin Observation/Check dated 1/12/2025 reveals that Resident #9 had an existing open area to his/her right trochanter (hip) open area with a treatment in place and scattered open areas to the sacrum, bilateral buttocks treatment place, Sections C. Other skin conditions, D. Feet and toes, and E, Heels are blank. There are also no wound measurements documented. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of a Skin Wound Evaluation on 1/23/25 revealed that on 1/20/2025 a Licensed Practical Nurse (LPN) completed the form indicating that Resident #9 had an existing area on his/her coccyx. There were no other areas documented. Further review of the form on 2/4/2025 revealed that the form had been updated on 1/29/2025, six days later, and now reflected an existing right trochanter (hip) ulcer, right ankle (outer) ulcer, and a left ankle (outer) ulcer. Under Section A. Body Audit part 2. it asks if there is a new skin alteration identified? The answer marked is no. There is no other information regarding the wounds or skin condition documented on the form. Sections C. Other skin conditions, D. Feet and toes, and E, Heels are blank. 1/23/25 there were no Nurse Progress Notes related to the development of new skin areas. No progress notes at all since 1/15/25 A Skin Observation/Check dated 1/312025 states that Resident #9 has an existing area on his/her coccyx. There is no description or details regarding the condition of the wound and the wounds to his/her right trochanter (hip), right ankle (outer), and a left ankle (outer) are not documented. Further record review revealed a physician's order dated 1/10/25 to cleanse wound location Right hip with wound cleanser or normal saline. Pat dry. Apply sureprep (used to create a barrier film on peri-wound skin). Cover with optifoam dressing (a foam wound dressing). as needed for removal or soilage. There was no evidence in the record that the physician was notified that Resident #9 had developed a new pressure ulcer. Per interview with the Director of Nursing (DON) and the Regional DON on 1/22/25 at 2:23 PM, Resident #9 was being followed by the IWC Consultant in the past for a DTI on her/his right trochanter that had resolved. On 1/7/2025 when the Resident returned from an appointment it was brought to the DON's attention by the Resident's family member that a new wound had developed on the Resident's hip. The DON confirmed that there was no documentation regarding the development of the DTI and no new orders for wound care were received until 1/10/2025. The DON also stated that a Skin Observation/Check was completed on 1/12/2025 however, there is no description or measurements of the wound, and he did not know why it fell through the cracks. The Regional DON confirmed that the Integrated Wound Care Progress Notes for 1/7/2025 and 1/14/2025 were just upload into the Resident's record on 1/22/2025. The RN also confirmed that the Skin Observation/Check completed on 1/13/2025 was the first documentation of the DTI. 2). Per review of Resident #7's medical record there was no documented evidence that s/he tested positive for COVID on 1/7/25. Per review of a COVID-19 line list, Resident #7 tested positive for COVID-19 on 1/7/2025 and was experiencing symptoms of lethargy (a general state of fatigue that involves a lack of energy and motivation for physical and mental tasks). Per review of the medical record there was no documentation that Resident #7 was positive for COVID, no documented nursing assessment related to being positive for COVID. The facility was unable to provide any documentation that the provider was notified of his/her positive test. There was no evidence that the Physician was consulted regarding the treatment and care needs of Resident #7. The facility was unable to provide documentation that Resident #7 received any treatment related to the COVID-19 infection or that s/he was assessed related to his/her high risk for complications related to co-morbities. Per Resident #7's care plan s/he had no evidence of interventions related to monitoring and assessing for complications related to COVID-19. (continued on next page)

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	475025	A. Building B. Wing	03/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Springfield Health & Rehab	105 Chester Road Springfield, VT 05156

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 2/4/2025 at 4:30 PM the Medical Director stated that she had only been acting as the facility's medical Director since December and had not had a chance to review facility policies and procedures. She also had not reviewed the infection control policies related specifically to the COVID-19 outbreak. The Medical Director confirmed that she had no knowledge of what the facility was doing regarding surveillance and prevention of COVID-19 cases during the outbreak. The Medical Director stated the COVID-19 cases at the facility to her knowledge had been mild and that she had no formal conversations with the facility about mitigation strategies. See F841 for more information.

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many Note: The nursing home is disputing this citation.	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 3. Per record review Resident #9 has a urinary catheter and open pressure ulcers that require dressing changes. A care plan focus initiated on [DATE] reflects that the Resident requires the use of enhanced barrier precautions (EBP) related to indwelling device: Foley Catheter. Interventions initiated on [DATE] state use of face mask or eye protection if there is a risk of splash or spray and use of gloves and gown for high-contact care activities. A facility policy titled Enhanced Barrier Precautions states the Enhanced barrier Precautions require staff to wear a gown and gloves while performing high-contact care activities with all residents who are at higher risk of acquiring or spreading an MDRO [Multi-drug resistance organism]. 1. Enhanced barrier precautions will be applied to: . b. Residents with an indwelling medical device including central venous catheter, urinary catheter, feeding tube .regardless of their MDRO status. c. Residents with a chronic wound, regardless of their MDRO status. Chronic wounds include pressure ulcers, diabetic foot ulcers . High-contact resident care activities include: . g. Caring for or using an indwelling medical device (for example, central venous catheter, urinary catheter .) h. performing wound care (for example any skin opening requiring a dressing) Per observations on [DATE] at 2:55 PM a Licensed Practical Nurse (LPN) and Director of Nursing (DON) were observed entering Resident # 9's room with supplies to flush his/her foley catheter, which carries a moderate risk of splashing. They were both observed in the room over the bed without face mask and eye protection. When the LPN and DON exited the room they both went to the treatment cart and retrieved the supplies needed for Resident #9's treatments. Both the LPN and DON reentered the Resident's room and were observed performing wound care without wearing the proper personal protective equipment. Immediately after the wound care was performed this surveyor asked the DON why Resident #9 was on EBP and he stated that s/he would be on EBP due to his/her foley and open wounds. The DON confirmed that he and the LPN should have worn PPE during the catheter flush and the wound care per care plan and facility protocol. On [DATE] at 1:45 PM the LPN was again observed in Resident #9's room performing wound care without the indicated PPE. After exiting the room, the LPN was interviewed and stated that she should have donned PPE and she did not. (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many Note: The nursing home is disputing this citation.	Based on observations, interviews, and record review, the facility failed to implement an infection prevention and control program that follows the accepted national standards regarding preventing, identifying and controlling communicable diseases. Specifically, the facility failed to follow the CDC (Centers of Disease Control) and state health department recommendations for outbreak management, related to testing and other mitigation strategies including containment and personal protective equipment (PPE) use. The deficient practices associated with the lack of infection control measures led to the determination that the residents in the facility were in immediate jeopardy of serious harm and/or death. At the time that the facility was notified of the immediate jeopardy on [DATE] at 12:00 PM, 11 residents and 15 staff members had tested positive for COVID-19 since the beginning of the facility outbreak that began on [DATE]. 5 residents (Residents #1, # 3, #13, and #12 and #14) were positive for COVID-19 at the time of survey entrance. Of the 11 residents that tested positive for COVID-19 during this outbreak, 2 residents (Resident #7 and #8) were sent to the hospital with respiratory distress. Resident #7 died shortly after being transferred to the hospital on [DATE]. According to Resident's #7 Death Certificate dated [DATE], his/her cause of death included cardiopulmonary arrest due to COVID. Findings include: 1). The facility failed to follow facility policy and state health department recommendations for outbreak management related to contact tracing and testing strategies. Facility policy titled Coronavirus, Prevention and Control, dated 1/2024, reads, The Infection Preventionist maintains close communication and collaboration with local and state health authorities. Per policy, in the event of an outbreak, testing guidance reads, the facility will initiate contact tracing to identify residents or staff who may have had close contact . When close contacts can be identified, all HCP with higher risk exposure to the positive individual and all residents who had close contact with the positive individual will be tested on Day 1 following the exposure, and again on Day 3, and Day 5 following exposure .When close contacts cannot be identified, broad based (unit- based or facility - wide) will be conducted for staff and residents. Testing will be conducted for all residents and staff on the affected unit(s), who have not previously been positive in the past 30 days, immediately, and if negative again 48 hours later, and if negative 48 hours later (Day 1, 3 and 5). If additional cases are identified, testing should continue every 3-7 days until there are no new cases for 14 days. Policy also states that The facility will maintain records of all testing performed for surveillance, symptoms, or outbreak purposes. Records will include the names of the individuals tested, dates of testing, and results. Resident testing information will be recorded in the individual resident's electronic health record. Per an email dated [DATE], the [NAME] Department of Health (VDH) Epidemiologist revealed that the facility originally reported 1 positive on [DATE]. They did not report additional positives to VDH until [DATE] and did not indicate the number of positive cases, whether they were staff or residents, or include a line list. Guidance that was provided to the facility on [DATE] included A person's infectious period begins 2 days before symptom onset date or positive test date, whichever comes first. If a staff person worked during their infectious period and close contacts are identified, we recommend the close contacts are tested on Days 1, 3, and 5 post exposure. If a resident ends up testing positive, we recommend they isolate for 10 days (and come out of isolation on Day 11). (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many Note: The nursing home is disputing this citation.	Per the VDH Epidemiologist the last day they were contacted by the facility was on [DATE] when they sent an updated line list and they answered the following question. How are you currently managing masking, testing, isolation of residents, exclusion of staff? And they responded ., We are managing ok with testing and masking. The facility was unable to provide any contact tracing logs, or testing logs for residents or staff since the outbreak began. There was no one at the facility that was aware of the outbreak management plan, or the status of the COVID outbreak. Per an interview with the Director of Nursing (DON) on [DATE] at approximately 11:00 AM, he revealed that the facility did not have an Infection Control Nurse (ICN) since [DATE]. See F882 for more information. The DON was unable to provide evidence that the facility followed their policy or recommendation by VDH related to contact tracing, testing, or use of PPE . Per further interview he had not been in contact with VDH for any further guidance related to the outbreak and that they were not familiar with the current CDC or VDH guidance related to COVID-19. DON confirmed he was not aware of how many residents at the facility are positive for COVID and has no documented evidence of current outbreak status. During an interview on [DATE] at approximately 2:55 PM with the new Infection Control Nurse (ICN) she stated she had just been designated to the ICN role and had not been trained, did not possess the qualifications, and had not been provided with information related to the facility's current outbreak status or mitigation strategies. Per [NAME] Department of Health (VDH) on [DATE] via email stated the facility did not report the death of Resident #7 or seek additional guidance related to the COVID outbreak. Per VDH during emails the line list submitted by the facility was incomplete or not attached and did not always identify resident or staff member. 2. The facility was not observed implementing mitigation strategies, including proper PPE use while working with COVID-19 positive residents, and isolation. Staff were unaware of mitigation strategies and timelines for COVID-19 positive residents. Per observation on [DATE] at 11:00 AM on the second-floor unit, Residents #3, #12, #14, and #1 all have a personal protective equipment caddy outside the room and precaution signs posted on each door stating, stop isolation in addition to standard precautions staff and provider must: clean hands when entering and exiting, gown to be changed between residents, N95 respirator (facemask acceptable if N95 not available), eye protection (goggles or face shields) and gloves (changed between each resident). Facility policy titled Coronavirus, Prevention and Control, dated 1/2024, reads, COVID-19 transmission based precautions include: For staff entering the resident's room/provide care: use of N95 mask or equivalent, eye protection, gown and gloves. Per record review, Resident #15 tested positive for COVID-19 on [DATE], Resident #3 on [DATE], Resident #12 on [DATE], Resident #14 on [DATE] and Resident #1 on [DATE]. Based on the guidance provided to the facility by VDH, Resident #15 would bi in isolation, requiring transmission based precautions, through [DATE], Resident #3 through [DATE], Resident #12 through [DATE], and Resident #1 through [DATE]. (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many Note: The nursing home is disputing this citation.	Per observation on the unit on [DATE] at 11:20 AM, 1:20 PM, 2:00 PM and at 5:15 PM three different staff members were observed entering in and out of the precaution rooms wearing only a mask, without eye protection, gown, or gloves. The staff were not observed completing hand hygiene when entering or exiting the rooms. Per observation on the second-floor unit on [DATE] at 11:20 LNA #1 entered room of Resident #12 wearing only a mask, without eye protection, gown, or gloves. Resident # 12 tested positive for COVID on [DATE]. Per interview of LNA #1 who was observed entering Resident room [ROOM NUMBER] [DATE] at 2:00 PM room with only a mask and without gown and gloves (and without eye protection stated, at 2:05 PM I thought the residents were not on precautions anymore, and that the signs may be old. Per interview on [DATE] at 3:30 PM, the License Practical Nurse #2 (LPN) caring for Residents #14, #12, and #1 on the second floor stated that she was unsure if the precautions were still active and stated, the residents were positive a few weeks ago, I am pretty sure it's all cleared up. Per observation on [DATE] at approximately 1:00 PM, Resident #3 who tested positive for COVID on [DATE], was sitting in the activity dining area on the second-floor unit with another resident. Per interview on [DATE] at 5:10 PM, the LPN #2 caring for COVID positive residents on the (second floor unit stated that s/he was unaware if the residents should still be on precautions, then stated that s/he thinks the precautions signs are old and just have not been taking down. Per interview on [DATE] at 1:15 PM, the License Practical Nurse #3 caring for residents on the second-floor unit stated that she was not aware of the facility policy related to COVID-19 or the guidelines given by VDH. She confirmed that the residents did not maintain precautions and that they do not make residents stay in their room when COVID-19 positive. She stated that since the infection preventionist left on [DATE] there has not been guidance or education related to the current outbreak. Per interview on [DATE] at 4:15 PM, the Medical Director, who is also the attending physician at the facility, confirmed that she was not aware of the facility's COVID-19 policies or COVID-19 guidance from [NAME] Department of Health (VDH), including when to discontinue mitigation strategies. Per further interview she stated she was not made aware of all COVID positive residents and that she was not notified of Resident #7 lethargy.

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F 0882 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Designate a qualified infection preventionist to be responsible for the infection prevent and control program in the nursing home. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the staff member designated as the facility's Infection Preventions (IP) had obtained specialized Infection Prevention and Control training beyond initial professional training. This is a repeat deficiency for this facility, with violations cited during the previous two recertification surveys, dated [DATE] and [DATE]. As a result the facility failed to prevent spread of COVID-19 through mitigation strategies that would be directed by an infection preventionist, and 1 resident died from COVID-19 (Resident #7). The failure to designate a qualified infection preventionist has the potential to impact all residents who reside in the facility. Findings include: Record review reveals that 11 residents and 15 staff members had tested positive for COVID-19 during a facility outbreak that began on [DATE]. 5 residents (Residents #1, #3, #13, and #12 and #14) were positive for COVID-19 at the time of survey entrance on [DATE]. Of the 11 residents that tested positive for COVID-19 during this outbreak, 2 residents (Resident #7 and #8) were sent to the hospital with respiratory distress. Resident #7 died shortly after being transferred to the hospital on [DATE]. According to Resident's #7 Death Certificate dated [DATE], his/her cause of death included cardiopulmonary arrest due to COVID. See F880 for more information. During an interview with the Director of Nursing (DON) on [DATE] at approximately 11:00 AM, he stated that the facility did not have a qualified designated infection prevent (IP) since [DATE]. The DON also confirmed that the current designated staff member did not have the required specialized training to act as the Infection Preventionist. Per interview on [DATE] at 2:55 PM the staff member who was designated as the facility's Infection Preventionist did not have the required specialized training as of [DATE]. She stated that she had no specialized training in infection prevention and control. Per interview with the Administrator and Director of Nursing (DON) on [DATE] at approximately 10:00 AM the facility did not have a qualified designated infection preventionist from [DATE] until the new DON completed a CDC (Center for Disease Control and Prevention) Nursing Home Infection Preventionist Training Course on [DATE]. The facility went 14 days without a qualified IP during a COVID-19 outbreak.