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	11/19/2025

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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. Based on interview and record review the facility failed to inform in advance of the risks and benefits of the proposed care, the treatment alternatives or other options for 1 of 5 sampled residents (Resident #1). This is a repeat deficiency for this facility, with the violation cited during a recertification survey dated 3/27/25. Findings include:Per record review Resident #1 was admitted with physician's orders for an antidepressant, Protriptyline (Vivactil) 10 mg twice daily, and an antipsychotic medication, Aripiprazole (Abilify) 15 mg daily. A consent form for antipsychotic medications was completed on and signed by the Resident's Guardian on 8/15/2025 listing the Aripiprazole as a prescribed medication. Further record review revealed a Consent for Antidepressant Medication form which was blank, it did not list the Protriptyline, and it was not signed by the Guardian. There was no documented evidence that the facility obtained informed consent for the Protriptyline. A physician's order dated 9/13/2025 for Quetiapine (Seroquel, an antipsychotic) 600 mg daily was initiated. A Psychotropic Medication Administration Disclosure form that includes the Abilify, Seroquel, and Protriptyline was completed by the Unit Manager on and states that the guardian gave verbal consent for the psychotropic medications on 9/16/2025 however, this was one month after the Protriptyline was initiated and three days after the Seroquel was initiated. Review of Resident #1's care plan revealed a focus initiated on 8/16/2025 of [Resident] is at risk for complications related to the use of psychotropic drugs with an intervention of Provide informed consent to resident or healthcare decision maker Date Initiated: 08/16/2025. Per interview with the facility Administrator on 11/6/2025 at 3:30 PM the consent for antipsychotic form in the Resident's chart dated 8/15/2025 did not reflect the Protriptyline. The Administrator also confirmed that the Psychotropic Medication Administration Disclosure form had not been completed until 9/16/2025, after the initiation of the Protriptyline and Seroquel.

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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	11/19/2025

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 - Minimal harm or potential for actual harm Residents Affected - Few	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 interview and record review the facility failed to notify the resident representative of a change in condition related to laboratory results and treatment options for one of three residents in the sample (Resident #1). This is a repeat deficiency for this facility, with the violation cited during a partial survey dated 3/3/25. Findings include:Based on record review Resident #1 had a court appointed guardian with the guardian's spouse listed as emergency contact #2 on their information sheet. A progress note dated 10/8/2025 states The nurse received a fax from the [NAME] lab of a urine culture. The nurse sent the culture results to the [Nurse Practitioner]. The Resident was evaluated by OT [occupational therapy] and determined the resident is not safe to take anything orally other than a [tablespoon] of water every so often for comfort. Based on OTs evaluation the nurse attempted to call the [guardian] to talk about the results of the culture and talk about options regarding [antibiotic] treatment. The nurse left a voicemail for the [guardian] to call the nurse back. Another progress note dated 10/8/1025 states The nurse tried calling the [guardian's] phone but was not home just [spouse]. [Spouse] had questions regarding the resident being sent out to a different [facility] or hospital. The nurse did not talk with the [spouse] about the urine as [they] are not the resident's legal guardian. Per phone interview with Resident #1's guardian and their spouse on 11/4/2025 at 2:00 PM communication with the facility was not good and they did not return her/his calls even after s/he was told that someone will call back. The facility did not consistently share information regarding the Resident's condition. S/he stated that one nurse had hung up on her/him when s/he had called to ask questions about the Resident's condition. Review of the facility policy titled Notification of change in condition or status states 1. The nurse will notify the resident's attending Physician or physician on call when there has been a (an) . d. significant change in the resident's physical/emotional/mental condition; e. need to alter the resident's medical treatment significantly; Per interview on 11/4/2015 at 3:15 PM the facility Administrator confirmed that Resident #1's guardian's spouse was emergency contact #2 and should have been updated regarding the positive results and treatment. The Administrator also confirmed that the nursing progress note reflected that the Nurse had not notified the Guardian's spouse of the results of the Resident's urine as she should have.

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	11/19/2025

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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. (continued on next page)

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	11/19/2025

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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed protect a resident's right to be free from neglect by failing to provide services to the resident that are necessary to avoid physical harm, pain, mental anguish and emotional distress for 1 of 5 residents in the applicable sample (Resident #1).This deficient practice rose to the immediate jeopardy level due to the facility's failure to provide necessary services, which resulted in antipsychotic medication withdrawal, repeated falls with major head injury, and death. This is a repeat deficiency for this facility, with the violation cited at immediate jeopardy during a partial survey dated 3/3/25. Findings include:Per record review Resident #1 was admitted to the facility for short term rehab after a fall at their home resulting in a distal radius fracture and multiple fractured ribs. Additional diagnoses included left third finger fracture, urinary tract infection (UTI), osteoporosis, frequent falls, schizophrenia, major depressive disorder, narcolepsy with cataplexy (sudden weakness or limping of the muscles) recurrent UTIs, and hypertension.Review of the hospital discharge orders dated 8/15/2025 revealed physicians' orders for Keflex 500 mg every 12 hours for 4 days, then resume nitrofurantoin (Macrobid) 100mg daily. Guaifenesin 600mg twice daily, sliding scale insulin lispro with blood sugars 4 times daily, lidocaine patch 2 patches daily, and Quetiapine (Seroquel) 600mg at bedtime. None of these orders were implemented on admission to the facility. Not identifying and ordering the medications listed resulted in Resident #1 not receiving antibiotic therapy needed to prevent infection, not being monitored for effective diabetic management, and not receiving an antipsychotic necessary to treat schizophrenia causing exacerbation of symptoms increasing the risks of falls and other safety risks.Per interview on 11/4/2025 at 3:19 PM with the facility Administrator after the facility became aware that Resident #1 did not have their long-term order of Seroquel 600 mg daily on 9/12/2025, the facility had identified that the information that had arrived at the facility with the Resident had been scanned into the electronic health record excluding every other page. It was at this time that the facility realized that the hospital discharge orders had not been appropriately reconciled. The Administrator confirmed that the missed order Seroquel was a medication error however, the facility did not review the entire discharge summary to ensure there were no other orders that should have been implement that were not.Per interview with a Licensed Practical Nurse on 11/13/2025 at 5:10 PM she is typically the nurse who does the second check on admission orders and finishes the admission process because she works evenings. When asked about the process of obtaining and reconciling admission orders she stated that she compares the medication list to what has been entered in the electronic health record by another nurse. When asked if she reviews the rest of the information that comes from the hospital, she stated that she does try to read through it but does not always get to it.Per interview with the facility Administrator on 11/12/2025 at 11:30 AM she confirmed that once the facility identified there were missing pages to the discharge paperwork from the hospital and there was a medication error as a result, they did not further review it to ensure there were no additional orders that had been missed. Therefore, the sliding scale with insulin, the antibiotics for treatment of UTI and prophylaxis, and the lidocaine patches were not identified until the surveyor identified the errors.Per interview on 11/13/2025 at 5:30 PM the Regional Assistant Director of Nursing ([NAME]) stated that the process for admission medication reconciliation involves review of the medication list that comes from the hospital. The [NAME] confirmed that it is not practice to review all of the information that comes from the hospital stating, sometimes we get a packet this thick holding up fingers about an inch apart we can't possibly read all of that. The [NAME] stated again we just review the medication list.Per interview with Resident #1's Primary Physician on 11/14/25 at 2:30 PM she had been made aware that the Resident's Seroquel had not been ordered on admission when it was identified on 9/13/2025, but she was not aware that the other medications had been missed in the admission process. The Physician confirmed that the discharge summary that was used to admit Resident #1 only included every other page of information, and that the expectation is that the Unit Manager and/or admissions person review the complete discharge summary.The Food and Drug Administration's (FDA's) Boxed Warning states that some commonly reported Seroquel withdrawal symptoms can occur include nausea, vomiting, anxiety, irritability, agitation or restlessness, panic-like symptoms, and rebound mood swings. Rebound symptoms include mania or hypomania, depression, Psychotic symptoms, and severe insomnia. When it is stopped abruptly -especially at higher doses such as 300-800 mg the sudden loss of receptor blockade can cause the body to rebound and over-respond until it readjusts. Acute withdrawal symptoms such as insomnia, nausea, and vomiting

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	11/19/2025

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 0635 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Provide doctor's orders for the resident's immediate care at the time the resident was admitted. (continued on next page)

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	11/19/2025

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 0635 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to accurately reconcile physician orders needed to provide necessary care and services on admission, once the facility identified an issue with the admission orders, they failed to review the rest of the discharge summary for other potential missed orders for 1 of 3 residents in the sample (Resident #1). All residents admitting or readmitting to the facility are at risk for serious injury or death as a result of noncompliance. This deficient practice rose to the immediate jeopardy level due to the facility's failure to provide accurate admission orders, which resulted in Resident #1 experiencing antipsychotic withdrawal and worsening psychiatric symptoms including refusal of medications and care, unmonitored and untreated blood sugars, increased risk for developing a urinary tract infection, falls resulting in a subdural hematoma that worsened over time resulting in death. This is a repeat deficiency for this facility, with the violation cited during a recertification survey dated 3/27/25. Findings include:Per record review Resident #1 was admitted to the facility for short term rehab after a fall at their home resulting in a distal radius fracture and multiple fractured ribs. Additional diagnoses included left third finger fracture, urinary tract infection (UTI), osteoporosis, frequent falls, schizophrenia, narcolepsy with cataplexy (sudden weakness or limping of the muscles), recurrent UTIs, and hypertension.Review of the hospital discharge orders dated 8/15/2025 revealed physicians' orders for Keflex 500 mg every 12 hours for 4 days, then resume nitrofurantoin (Macrobid) 100mg daily. Guaifenesin 600mg twice daily, sliding scale insulin lispro with blood sugars 4 times daily, lidocaine patch 2 patches daily, and Quetiapine (Seroquel) 600mg at bedtime. None of these orders were implemented on admission to the facility. The Food and Drug Administration's (FDA's) Boxed Warning states that some commonly reported Seroquel withdrawal symptoms can occur include nausea, vomiting, anxiety, irritability, agitation or restlessness, panic-like symptoms, and rebound mood swings. Rebound symptoms include mania or hypomania, depression, Psychotic symptoms, and severe insomnia. When it is stopped abruptly -especially at higher doses such as 300-800 mg the sudden loss of receptor blockade can cause the body to rebound and over-respond until it readjusts. Acute withdrawal symptoms such as insomnia, nausea, and vomiting have been reported following abrupt cessation of quetiapine (Seroquel). It is recommended that, where possible, the dose be tapered gradually. On 8/18/2025 three days after admission and three days of the missing Seroquel administration, Resident #1 began experiencing hallucinations and then began exhibiting anxious, angry, and combative behaviors which were not her/his baseline. A Skilled Note dated 8/18/2025 states Hallucinations (perceptual experiences in the absence of real external sensory stimuli). Comments: resident observed talking to internal stimuli at times while at nursing station. A Psychiatry Note dated 8/19/2025 states Resident is pleasant, with occasional non distressful hallucinations with talking to others not there. An Administration Note dated 8/22/2025 states Resident refused to take [her/his] meds, stating that [s/he] does not take meds. Various approaches were used without success. Provider on call [name omitted] was informed who also tried without success. Resident refused dinner, drink and [vital signs]. [S/he] was hallucinating. An Administration Note dated 8/23/2025 states refused care and [vital signs].A Progress note date 9/9/2025 reveals that Resident #1 was anxious, hallucinating, and wandering. The progress note also states Safety concerns: resident often observed self-transferring without calling for assistance from staff. A Progress Note dated 9/10/2025 states resident observed multiple times by staff throughout [evening] wandering and responding to internal stimuli. resident observed stating dad she wont let me do it, and bill is not going to let me sleep. resident easily redirected by staff. resident assisted with toileting and clothing.A Skilled Note dated 9/10/2025 states Mental Status: Anxious, Pleasant, Delusions (misconceptions or beliefs that are firmly held, contrary to reality). Wandering. Comments: [s/he] has auditory hallucinations that [s/he] is talking to '[her/his] father', he tells [her/him] what to do and what not to do . Concerns: gets mad at staff, swings [her/his] cast trying to hit us . Per Progress Note dated 9/11/2025 Resident #1 was found at 12:45 AM lying in bed with a cut and swelling on the left side of their forehead. The Resident stated that s/he got up, froze, and fell flat, then got up and layed on her/his bed. The incident report identifies predisposing factors as ambulation without assist, wanderer, and history of falls. A progress note dated 9/11/2025 reflects that at 12:30 PM the Resident was sent to the hospital emergency department for evaluation of the head wound and complaints of left foot pain. The Resident returned to the facility on 9/12/2025 with diagnoses of subdural hematoma and fracture of the foot with a walking boot in place. A Progress Note dated 9/12/2025 states resident's [guardian and spouse]

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	11/19/2025

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 0656 Level of Harm - Immediate jeopardy to resident health or safety 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. (continued on next page)

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	11/19/2025

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 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility failed to develop a care plan or implement interventions specific to the safety risks associated with narcolepsy with cataplexy (sudden weakness or limping of the muscles), risk factors for the use of antipsychotic medications, implement care plan interventions to monitor blood glucose 4 times daily and administer insulin on a sliding scale for a diabetic who was admitted with physician orders to do so, identify safety/fall risk related to complications of the diagnosis of a subdural hematoma for 1 of 3 residents in the sample (Resident #1). This deficient practice rose to the immediate jeopardy level due to the facility's failure to ensure care plans are developed and implemented, which resulted in Resident #1 experiencing a fall that resulted in a head injury with a subdural hematoma that worsened over time and resulted in death. This is a repeat deficiency for this facility, with the violation cited during a partial survey dated 3/3/25. Findings include:Per record review Resident #1 was admitted to the facility for short term rehab after a fall at their home resulting in a distal radius fracture and multiple fractured ribs. Additional diagnoses included left third finger fracture, urinary tract infection (UTI), osteoporosis, frequent falls, schizophrenia, narcolepsy with cataplexy (sudden weakness or limping of the muscles), recurrent UTIs, and hypertension. Review of the hospital Discharge summary dated [DATE] revealed physicians' orders for Keflex 500 mg every 12 hours for 4 days, then resume nitrofurantoin (Macrobid) 100mg daily. Guaifenesin 600mg twice daily, sliding scale insulin lispro with blood sugars 4 times daily implemented due to elevated blood sugar readings, lidocaine patch 2 patches daily, and Quetiapine (Seroquel, an antipsychotic) 600mg at bedtime. Review of the facility admission provider orders and the August 2025 medication administration record revealed that these orders were not implemented on admission to the facility. Review of Resident #1's care plan revealed a focus initiated on 8/16/2025 of at risk for MDRO [Multi Drug Resistant Organism] colonization/infection due to history of MRSA and at risk for infection/sepsis, Limited mobility, HX of UTI's, history of MRSA initiated on 8/16/2025. The care plan does not reflect the actual urinary tract infection that the resident was admitted with, or interventions related to the treatment of an actual UTI.Review of Resident #1s physicians orders after admission to the facility revealed that an order for finger sticks (a method used to obtain blood sugars) once in the AM was entered on 8/17/2025. The Resident's plan of care does not address the use of sliding scale insulin or finger sticks 4 times per day. Review of Resident #1's daily blood sugars revealed that between 8/17/25- 10/9/25 the resident experienced 13 documented episodes of hyperglycemia (blood glucose above which would have required the administration of the sliding scale insulin). There is no way to determine if the Resident was experiencing hyper or hypoglycemia (high or low blood sugars) or would have required sliding scale coverage the other three times per day because the blood sugars were not ordered or obtained. Further review of hospital discharge orders included Quetiapine (Seroquel, an antipsychotic) 600mg at bedtime for schizophrenia. According to the hospital records Resident #1 has been on Seroquel 600 mg since 9/1/2023. Review of the facility documentation including physician's orders and the August medication administration record (MAR) revealed that the Seroquel 600 mg was not ordered on admission. Review of the Resident's care plan reveals that the plan of care did not identified risks associated with or management of withdrawal symptoms caused by abrupt cessation of Seroquel. The Food and Drug Administration's (FDA's) Boxed Warning states that some commonly reported Seroquel withdrawal symptoms can occur include nausea, vomiting, anxiety, irritability, agitation or restlessness, panic-like symptoms, and rebound mood swings. Rebound symptoms include mania or hypomania, depression, Psychotic symptoms, and severe insomnia. When it is stopped abruptly -especially at higher doses such as 300-800 mg the sudden loss of receptor blockade can cause the body to rebound and over-respond until it readjusts. Acute withdrawal symptoms such as insomnia, nausea, and vomiting have been reported following abrupt cessation of quetiapine (Seroquel). It is recommended that, where possible, the dose be tapered gradually. An admission Fall Risk Assessment completed on 8/15/2025 was noted to have several inaccuracies and reflected that Resident #1 had a diminished safety awareness, impaired mobility with continence, required the use of an assistive device, 1-2 falls in the past 3 months, takes 1-2 high risk medications, no change in medication and/or change in dosage in the past five days 1-2 predisposing diseases/conditions. The Fall Risk care planning section of the assessment was not completed. The Resident was actually prescribed 4 of the high-risk medications which included antihypertensives, antiseizure, hypoglycemics, and psychotropics. Although unbeknownst to the facility, the Resident did have a

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	11/19/2025

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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (continued on next page)

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	11/19/2025

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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to effectively assess a resident's risks, implement, monitor, and modify interventions when necessary to prevent falls with major injury resulting in death. The facility also failed to provide necessary treatment of clinical conditions which put the resident at an increased risk of safety and accidents. The facility also failed identify and address potential accident hazards related to the resident's clinical condition. As a result, the resident experienced a recuring UTI, a decline in behavioral health, hyperglycemic episodes, medication withdrawal, and increased fall risk for 1 of 3 Residents in the sample (Resident #1). This deficient practice rose to the immediate jeopardy level due to the facility's failure to prevent falls, which resulted in Resident #1 sustaining two falls resulting in a subdural hematoma that worsened over time resulting in death. This is a repeat deficiency for this facility, with the violation cited during partial surveys, dated 6/12/24, 10/18/24, 3/3/25 (at immediate jeopardy), and 5/28/25. Findings include: Per record review Resident #1 was admitted to the facility for short term rehab after a fall at their home resulting in a distal radius fracture and multiple fractured ribs. Additional diagnoses included left third finger fracture, urinary tract infection (UTI), osteoporosis, frequent falls, schizophrenia, major depressive disorder, narcolepsy with cataplexy (sudden weakness or limping of the muscles) recurrent UTIs, and hypertension. Review of the hospital discharge orders dated 8/15/2025 revealed physicians' orders for Keflex 500 mg every 12 hours for 4 days, then resume nitrofurantoin (Macrobid) 100mg daily. Guaifenesin 600mg twice daily, sliding scale insulin lispro with blood sugars 4 times daily, lidocaine patch 2 patches daily, and Quetiapine (Seroquel) 600mg at bedtime. None of these orders were implemented on admission to the facility. Review of physician's orders revealed that on 8/17/25 a Registered Nurse entered an order for fingerstick (a method for testing blood sugars) once daily. Review of Resident #1's blood sugars between 8/17- 10/9 revealed that the resident experienced 10 episodes of hyperglycemia (High blood sugar) which would have required the administration of the sliding scale insulin. There is no way to determine if the Resident had other episodes of hyperglycemia because the blood sugars were not completed as directed in the discharge orders. Per the National Library of Medicine Diabetes increases the risk of cardiovascular and microvascular complications but also increases the risk of common geriatric syndromes, including cognitive impairment, depression, falls, polypharmacy, persistent pain, and urinary incontinence.Per interview with Resident #1's Primary Physician on 11/14/25 at 2:30 PM she had been made aware that the Resident's Seroquel had not been ordered on admission when it was identified, but she was not aware that the other medications had been missed in the admission process. The Physician stated that it is not best practice to be checking blood sugars four times daily on an elderly person, however she did not address that because she had missed it. The Physician confirmed that the discharge summary that was used to admit Resident #1 only included every other page of information, and that the expectation is that the Unit Manager and/or admissions person review all of the discharge summary. During an interview on 11/6/2025 at 1:17 PM the Regional Assistant Director of Nursing when asked if the diagnosis or narcolepsy with cataplexy should be identified on the care plan as a safety or fall concern, she stated that the Resident had an at risk for falls care plan that addressed fall risks, and not all diagnoses are on the care plan. The [NAME] confirmed that the care plan did not address fall or safety concern related to the diagnosis of narcolepsy with cataplexy. An admission Fall Risk Assessment completed on 8/15/2025 was noted to have several inaccuracies and reflected that Resident #1 had a diminished safety awareness, impaired mobility with continence, required the use of an assistive device, 1-2 falls in the past 3 months, takes 1-2 high risk medications, no change in medication and/or change in dosage in the past five days 1-2 predisposing diseases/conditions. The Fall Risk care planning section of the assessment was not completed. The Resident was actually prescribed 4 of the high-risk medications which included antihypertensives, antiseizure, hypoglycemics, and psychotropics. Although unbeknownst to the facility, the Resident did have a change in medications as they were not receiving their long-term dose of Seroquel 600 mg (antipsychotic), sliding scale insulin, and the antibiotic that was prescribed during their hospital stay. The Resident also had 4 predisposing diseases/condition rather than 1-2 which included hypertension, osteoporosis, fractures, and dementia. Review of Resident #1's care plan reflects a care plan focus of risk for falls due to cognitive loss, lack of safety awareness, history of falls. The care plan interventions implemented on the baseline care plan included provide Resident with opportunities for choice, assist to organize belongings for a clutter-free environment in the resident's room

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	11/19/2025

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 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. Based on interview and record review the facility failed to ensure that one of five nurses, an agency nurse in the applicable sample had received training and competencies needed to provide care for the residents who reside in the facility. This is a repeat deficiency for this facility, with the violation cited during a recertification survey dated 3/27/25. Findings include: Per review of 5 nurse's education and training files to determine if they had the training and skill set to perform an admission the facility was unable to locate the employee training and competency files of an agency staff nurse. Per interview with the facility Administrator on 11/4/2025 at approximately 4:00 PM the agency nurse no longer works there, and they had a recent change in the education department. The Administrator confirmed that they were not able to find the agency nurses file that consists of training and competencies required to provide care to the residents who live there.

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	11/19/2025

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 0760 Level of Harm - Actual harm Residents Affected - Some	Ensure that residents are free from significant medication errors. (continued on next page)

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	11/19/2025

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 0760 Level of Harm - Actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure residents were free from significant medication errors for 1 of 3 sampled residents (Resident #1). This deficient practice resulted in harm; Resident #1 had antipsychotic medication withdrawal, increased behavior health distress exhibited by hallucinations, resistive and combativeness with care, and medication refusals; unmonitored and untreated blood sugars; increased risk of urinary tract infection resulting in a hemolytic Strep Group B urinary tract infection, and increased risk for and repeated falls with major head injury, and death. This is a repeat deficiency for this facility, with the violation cited during two recent partial surveys dated 3/3/25 and 5/28/25. Findings include:Per record review Resident #1 was admitted to the facility on [DATE] for short term rehab after a fall at their home resulting in a distal radius fracture and multiple fractured ribs. Hospital diagnoses included a urinary tract infection (UTI). Per review of hospital documentation, while in the hospital s/he had a change in mental status that was attributed to acute metabolic encephalopathy likely caused by the UTI and was started on an antibiotic to be continue for 4 days after discharge and then another antibiotic prophylactically thereafter. Prior diagnoses include osteoporosis, frequent falls, schizophrenia, narcolepsy with cataplexy (a chronic neurological disorder characterized by excessive daytime sleepiness and sudden, involuntary muscle weakness), and recurrent UTIs. Hospital discharge orders included Quetiapine (Seroquel, an antipsychotic) 600mg at bedtime for schizophrenia. According to the hospital records Resident #1 has been on Seroquel 600 mg since 9/1/2023. Review of the facility documentation including physician's orders and the August Medication Administration Record (MAR) revealed that the Seroquel 600 mg was not ordered on admission. The Food and Drug Administration's (FDA's) Boxed Warning states that some commonly reported Seroquel withdrawal symptoms can occur include nausea, vomiting, anxiety, irritability, agitation or restlessness, panic-like symptoms, and rebound mood swings. Rebound symptoms include mania or hypomania, depression, Psychotic symptoms, and severe insomnia. When it is stopped abruptly -especially at higher doses such as 300-800 mg the sudden loss of receptor blockade can cause the body to rebound and over-respond until it readjusts. Acute withdrawal symptoms such as insomnia, nausea, and vomiting have been reported following abrupt cessation of quetiapine (Seroquel). It is recommended that, where possible, the dose be tapered gradually. Review of progress notes written since admission reveal that on 8/18/2025 Resident #1 began experiencing hallucinations which increased over time and also began exhibiting behaviors. A Skilled Note dated 8/18/2025 states Hallucinations (perceptual experiences in the absence of real external sensory stimuli). Comments: resident observed talking to internal stimuli at times while at nursing station. A Psychiatry Note dated 8/19/2025 states Resident is pleasant, with occasional non distressful hallucinations with talking to others not there. An Administration Note dated 8/22/2025 states Resident refused to take [her/his] meds, stating that [s/he] does not take meds. Various approaches were used without success. Provider on call [name omitted] was informed who also tried without success. Resident refused dinner, drink and [vital signs]. [S/he] was hallucinating. An Administration Note dated 8/23/2025 states refused care and [vital signs].A Skilled Note dated 9/8/2025 states Disorganized Thinking, Oriented to: Person .Mental Status: Anxious, Depressed, Angry, Hallucinations (perceptual experiences in the absence of real external sensory stimuli). Delusions (misconceptions or beliefs that are firmly held, contrary to reality). Physical Behaviors (Hitting, Kicking, ect.) Verbal Behaviors (Screaming, Cursing, etc.) Wandering. Resident/ Care Giver Education: a cast should not be used to hit people Comments: when [s/he] is hallucinating or attempting to hit, stay away from [her/him] until [s/he] calms down .A Skilled Note dated 9/10/2025 states Mental Status: Anxious, Pleasant, Delusions (misconceptions or beliefs that are firmly held, contrary to reality) Wandering. Comments: [s/he] has auditory hallucinations that [s/he] is talking to '[her/his] father', he tells [her/him] what to do and what not to do. today [s/he] took [her/his] pills without difficulty. pleasant and cooperative. Therapy: Physical Therapy, while outside of physical therapy functionality has improved. Safety Concerns: gets mad at staff, swings [her/his] cast trying to hit us Comments: no [complaint of] pain or discomfort.An Administration Note dated 9/10/2025 states resident observed multiple times by staff throughout [hour of sleep] wandering and responding to internal stimuli. resident observed stating dad she wont let me do it, and bill is not going to let me sleep. resident easily redirected by staff. resident assisted with toileting and clothing. A Nursing Progress Note dated 9/12/2025 states resident refused all medications at the present time. On-call NP notified, no new orders from NP at this time, resident allowed blood glucose to be checked, and insulin was