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	03/27/2025

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

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(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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure that the 1 of 27 residents in the sample (Resident #23) or his/her representative was informed in advance, by the physician or other practitioner or professional, of the risks and benefits of proposed care, of treatment alternatives or treatment options, and to choose the alternative or option he or she prefers. Findings include: Per record review, Resident #23 has a diagnosis of Alzheimer's and is no longer able to make his/her own medical decisions. S/he was recently treated for a fractured hip, that was surgically repaired on 3/6/25. Resident #23 was readmitted to the facility on [DATE]. Resident #23 has a Power of Attorney (POA) who makes his/her medical decisions. The following orders were written by the Physician on 3/14/25 Morphine Sulfate (concentrate) oral solution 20 mg/ml, give 0.5 milliliters (mls) by mouth every 2 hours as needed for hip fracture, post op pain; Comfort measures. Per interview with Resident #23's Representative on 3/24/25 at 4:20 PM, s/he stated s/he had not been informed of that Resident #23 had been prescribed morphine for pain control and or comfort measures. S/he stated s/he met with the Physician on 3/14/25, and that s/he asked not to have morphine or comfort measures started. S/he stated that S/he told the provider that Resident #23 needed time to recover from his/her hip fracture and surgery. Per further interview, the POA stated that when s/he visited Resident #23 on 3/15/25, Resident #23 was not able to stay awake or participate in any care during the visit. S/he stated that when s/he inquired about what medications Resident #23 had been given s/he learned that s/he was given morphine for pain. Per review of Resident #23's Medication Administration Record (MAR) dated 3/15/25, Resident #23 received 0.5 mls (10 milligrams) of morphine by mouth at 7:02 AM for a pain scale level of 0. Per further review of the MAR, the resident's assessment for pain had been documented as 0 on all three shift on 3/15/25. There was no documented evidence in the medication administration record or the progress notes as to why Resident #23 received the Morphine with a pain level of 0. Per a Physician note dated 3/14/25, visit titled comfort measures, the Physician stated [His/Her] daughter is ambivalent about using anything stronger than Tylenol .We discussed very low dose of morphine which would be easier to give. [Resident #23 's POA] is considering options. (continued on next page)

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

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Per interview with the Physician on 3/25/25 at approximately 3:00 PM, she stated she knew Resident #23's Power of Attorney did not want to start the morphine and wanted only Tylenol for pain. However, she stated she was concerned that Resident #23 may need orders for comfort care after returning to the facility. The Physician stated it's hard to get medications to the facility in a timely manner and she wanted to have it available. She stated therefore she left the order in place in case it was needed for Resident #23. Per review of Resident #23 care plan dated 6/16/23 s/he had the following interventions Inform [Resident #23] and/or healthcare decision maker of any change in status or care needs [and] . Promote opportunities for [Resident #23] Health Care Decision Maker to participate in decisions regarding care. Per interview with the Unit Manager (UM) on 3/26/25 at approximately 2:00 PM, she stated that she knew that Resident #23's POA goals for him/her was to have Tylenol for pain and s/he had refused morphine in the past. The UM confirmed that there had not been communication between her and the Provider about starting the morphine or ordering comfort measures for Resident #23.

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. Based on observation, interview, and record review of facility policy, the facility failed to establish a grievance policy that contains the correct information to support the residents' rights to file a grievance for seven of the seven residents in the sample (Resident #62, #15, #51, #19, #30, #46, and #35). This has the potential to affect all residents in the facility. Findings include: A review of the Grievance /Concerns Policy & Procedure, posted in the lobby of the facility, contained information pertaining to the previous owners and named the current Administrator as the Grievance Officer, providing the wrong email address for the Administrator. A review of document Patient Concern/Grievance Policy, revised on 1/2024, reads: 1) The grievance officer is the Director of Social Services, and her name, extension, and location are posted throughout the facility. 2) If a resident/family member has a concern, they can approach /contact any facility staff member, or a resident concern form can be filled out . 6) There will be a follow-up with the residents and/or family member regarding the concern, which will be noted on the concern form and concern log. 7) Concern forms are available at the reception desk upon request. Once completed, all forms should be brought to the receptionist, who will deliver them to the Director of Social Services. Forms can also be placed in a secure box at the reception desk. A third document titled Resident Grievance/Complaint Procedures, reviewed/revised 12/2024 reads A resident representative, family member, visitor or advocate may file a verbal or written grievance or complaint concerning treatment, abuse, neglect, harassment, medical care, behavior of other resident or staff members, theft of property, etc., with fear of threat or reprisal in any form. Complaints may be filed anonymously. You are requested to follow the procedures outlined below when filing a written grievance or complaint. 1) Obtain a Resident Grievance/Complaint Form from the green nurse's station or from the Business Office 2) Answer all questions on the form as applicable. Be sure that all information is accurate. 3) Sign and date the form. 4) Give the completed form to the Administrator. If the Administrator is not available, you may leave the form with the supervisor on duty. 5) After you have filed the grievance, you will receive a written summary of the results of the investigation within a reasonable timeframe. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	6) Should you disagree with the findings, recommendations, or actions taken, you may meet with the Administrator or file a complaint with any of the advocacy agencies listed on the Resident Resources List on the consumer bulletin board. The documents contain discrepancies regarding the identity of the Grievance Officer and the process for filing a grievance. The policy lacks information about the grievance officer's responsibilities, name, contact information, or a process to remain anonymous. Per observation, a facility tour on 3/26/25 at 2:00 PM did not disclose easily obtainable forms or signage indicating a process for filing a grievance or maintaining anonymity for the residents. A Resident Council meeting with the survey team occurred on 3/26/2025 at 2:00 PM, with seven attendees (Residents #62, #15, #51, #19, #30, #46, and #35). A collaborative conversation with all seven residents revealed they did not know how to file a grievance or where to find the information. Per interview with the Administrator on 3/28/24 at approximately 1:30 PM, she confirmed that the posted grievance document in the lobby contained incorrect information. She stated that the Social Service Director was now the Grievance Officer, and the policy did not include the required information per Federal Regulation. She agreed that the policy and procedures do not support the resident's rights to file grievances and that the supplied information is inconsistent. Per interview with Resident Council on 3/25/25 at 2:00 PM, Resident #51 stated they did not know how to file a grievance. Resident #51 discussed that s/he did not feel the facility responded to grievances promptly, and stated s/he was still waiting for a response for a grievance s/he had filed. Several residents also stated that they were fearful of retaliation if they voiced concerns.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based upon interview and record review, the facility failed to assure that further potential abuse, neglect, exploitation, or mistreatment did not occur after an allegation of abuse for 1 resident [Resident #324] of one sampled resident regarding abuse allegations. Findings include: Per interview with Resident #324 on 3/24/25 at 1:25 PM, Resident #324 stated that Licensed Nurse #1 was withholding his/her pain medication as well as not treating his/her wounds and had inserted a silicone catheter when the resident had a potential allergy to silicone. Resident #324 was interviewed on 3/26/25 at 12:10 PM. Resident #324 stated s/he reported it to other nurses and Licensed Nurse #1 was moved to a different unit. However, the next day the nurse was seen outside his/her door and on the unit. Resident #324 stated s/he felt intimidated. Per interview with the Administrator on 3/24/25 at 2:13 PM, the Administrator stated s/he filed the concerns in a grievance. The Administrator confirmed that Licensed Nurse #1 was working on a different unit of the facility. Per record review of the facility's initial investigation report, the concerns of potential abuse were reported to APS [Adult Protective Services] and [NAME] [Department of Aging and Independent Living] Division of Licensing and Protection on 3/24/25 at 5:00 PM. Per the facility's Abuse, Neglect, and Exploitation policy [no reviewed/revised date] states, It is the responsibility of every employee, volunteer, and supervisor to facilitate the prevention of abuse, neglect, and exploitation of residents/patients . For any actual or suspicious act or sign of abuse, neglect or exploitation it is the responsibility of every employee and volunteer to make sure the resident is safe first . Explain to all parties involved that an internal investigation will occur and as applicable the incident will be reported to Licensing and Protection/Adult Protective Services and there may be an external investigation by them .To ensure [that] alleged victims remain safe, prohibit any contact between alleged perpetrator and alleged victim during this investigation phase. Per record review of the facility's initial investigation report states, If the AP [alleged perpetrator] is facility staff, removal of the alleged perpetrator's access to the alleged victim and other residents and assurance that ongoing safety and protection is provided for the alleged victim and other residents. Per interview with the Administrator on 3/26/25 at 10:43 AM, the Administrator confirmed that Licensed Nurse #1 was still working at the facility while the facility investigation was being conducted.

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review, the facility failed to notify residents and/or their representative in writing of a transfer/discharge for 3 out 3 sampled residents (Residents #14, #22, and #26). Findings include: Per facility Transfer or Discharge Policy reviewed 1/2024, The Resident and/or their representative will be notified in writing of the following information: a. Reason for transfer/discharge. b. Effective date of transfer/discharge. c. The location to which the resident is being transferred/discharged d. A statement of the resident's right to appeal the transfer/discharge e. The facility bed hold policy f. The name, address, and telephone number of the Office of the State Long-term Care Ombudsman Record review shows that Resident #14 was hospitalized on [DATE]. There is no record that a transfer/discharge notice was provided to the resident and/or their representative. Record review shows that Resident #22 was hospitalized on [DATE], 6/24/24, 9/9/24, and 7/25/24. There is no record that a transfer/discharge notice was provided to the resident and/or their representative. Record review shows that Resident #26 was hospitalized on [DATE] and 2/18/25. There is no record that a transfer/discharge notices were provided to the resident and/or their representative. On 3/26/25, at 9:39 AM, the Regional Director of Nursing confirmed that there was evidence that these transfer/discharge notices were given to any of these residents or representative.

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review, the facility failed to notify residents and/or their representative in writing of the bed-hold and returns policy for 3 out 3 sampled residents (Residents #14, #22, and #26). Findings include: Per facility Bed-holds and Returns Policy, reviewed 1/2024, Prior to transfers and therapeutic leaves, residents or resident representatives will be informed in writing of the bed-hold and return policy. 1. Record review shows that Resident #14 was hospitalized on [DATE]. There is no record that a Bed-hold Notice was provided to the resident and/or their representative. On 3/25/25, at 3:34 PM, this was confirmed by the facility Administrator. 2. Record review shows that Resident #22 was hospitalized on [DATE], 9/9/24, and 7/25/24. There is no record that a Bed-hold Notice was provided to the resident and/or their representative. On 3/26/25, at 9:03 AM, this was confirmed by the Regional Director of Nursing. 3. Record review shows that Resident #26 was hospitalized on [DATE] and 2/18/25. There is no record that a Bed-hold Notice was provided to the resident and/or their representative. On 3/26/25, at 9:39 AM, this was confirmed by the Regional Director of Nursing.

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F 0635 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide doctor's orders for the resident's immediate care at the time the resident was admitted. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interview and record review, the facility failed to obtain accurate physician orders to provide necessary care and services on admission for 1 of 27 sampled residents (Resident #322). Findings include: 1). Per record review, Resident #322 was admitted on [DATE] after acute hospitalization, related to a fractured right hip, that was repaired on 3/13/25. Per his/her discharge summary and orders written by the hospital Physician on 3/20/25, Resident #322 was being admitted to rehabilitation for therapy, and pain control. Per further review of the discharge summary, Resident #322 had been receiving oral dilaudid for pain 4 times a day in addition to acetaminophen. Resident #322 was also noted to have swelling in his/her right hip after surgery and was being treated with aspirin 81 mg for prevention of deep vein thrombosis as recommended by a orthopedic surgeon. Per the discharge instructions the aspirin was to continue until 4/13/25. Per review of Resident #322's Discharge summary dated [DATE] s/he had the following orders that should have been continued at the facility upon admission, aspirin 81 mg extended release two times a day prevention deep vein thrombosis, hydromorphone oral tablet 2 mg every 4 hours as needed for pain, acetaminophen 650 mg every four hours as needed for pain, and senna 8.6 two times daily for constipation. There is no evidence that these medications were ordered prior to 3/24/25. Per record review nursing progress note dated 3/24/25 Notified NP that resident has RLE pitting +1 edema. There is no pain, skin intact, just swelling. Per review of the Nurse Practitioner telemed note dated 3/25/25, she stated [His/Her] right leg is still swollen from the calf to the the ankle. I ordered an ultra sound to rule out DVT but it has not been done yet. Assessment and plan per NP perform ultra sound as ordered. Per NP ordered dated 3/24/25 Ultra sound of right leg r/t DVT. However, there was no documented evidence in the medical record of the diagnostic test being completed. Per follow up Physician notes dated 3/26/25 and 3/27/25 titled telemed revealed no evidence of follow up ultra sound or mention of edema in the right lower extremity. There is no evidence that the diagnostic imaging was completed as ordered. Per interview with the Medical Director on 3/27/25 at 1:30 PM, she stated the admission process at the facility had been a problem. She stated that she should see all new admissions within 14 days of admission. She stated for new admissions and readmissions, nursing transcribes orders into the electronic health record and activates the orders before she is able to review them. She stated the process should be that all orders are reviewed by her, or a provider, before they are activated but that does not happen. She stated recently there had been an error when nursing transcribed a progress note as admission orders for one resident. This was later confirmed during interview to be the admission orders for Resident #322 entered on 3/20/25. Per interview on 3/27/25 at approximately 9:30 AM, the Unit Manager (UM) stated the current discharge process is as follows, one nurse will transcribe the orders from the discharge summary and enter them into the electronic health record. Then a second nurse verifies the orders and a message is sent to the provider. She stated that the orders are activated once the second nurse verifies them. The UM stated that she does not always receive notification back from the provider that she received the orders or if they are approved or not. She stated nursing activates all orders including medications unless it is a controlled medication. (continued on next page)

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F 0635 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Per interview with the facility Administrator (Admin.) and the Director of Nursing (DON) on 3/27/25 at approximately 5:19 PM, the Admin. stated that when Resident #322 was admitted to the facility, they did not have the correct discharge summary or admitting orders to care for him/her. Per the Administrator, the orders that were entered into the electronic health record on 3/20/25 by nursing were from the previous hospital stay and not the actual discharge orders. She stated the facility was not made aware that they had the incorrect orders until 4 days after Resident #322's admission and start of care on 3/20/25.

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. Based on interview and record review, the facility failed to ensure pain management was provided for 1 of 27 sampled residents (Resident #28). This is a repeat deficiency for this facility, with violations cited during a previous complaint survey, dated 10/18/24. Findings include: Per the record review, the staff failed to ensure adequate pain control and administer pain medications per provider orders for Resident #28. During the survey, the Resident was observed calling out in pain on multiple occasions. Per record review of Resident #28's care plan, s/he entered hospice care on 3/29/2024 due to end stage diagnosis of chronic obstructive pulmonary disease (COPD; irreversible lung and airway damage that obstructs airways). Per interview with the resident on 3/25/2025 at approximately 12:30 PM, Resident # 28 indicated pain almost every day, particularly in between scheduled pain medications. Per observation on 3/25/2025 at 1:00 PM and on 3/26/2025 at 2:00 PM and 2:29 PM, Resident # 28 was heard from the hall, calling out in pain. A review of the MAR (Medication Administration Record) from March 1- March 26, 2025 shows the resident's pain level is recorded three times daily. During the 26 days reviewed on the MAR, on 10 occasions, Resident #28 reported his/her pain level as greater than 6, with 5 of the those recorded pain levels rated as a 9-10 (pain scale 1-10 with 10 being the worst imaginable). Per an interview with the UM (Unit Manager) on 3/26/2025 at 2:45 PM, she indicated the pain assessment is usually performed at the start of each shift, 7:00 AM, 3:00 PM and 11:00 PM. She stated Resident #28 receives scheduled pain medications but rarely asks for anything in between. A review of Resident #28's care plan dated 4/1/25, including the problem of pain, noted that s/he was on Hospice services with interventions assess pain, restlessness, agitation, constipation, and other symptoms of discomfort . Medicate as ordered and evaluate effectiveness. Review of provider's orders include the following scheduled pain medications: Morphine Sulfate oral solution, give 0.25 ml by mouth three times a day for pain /dyspnea (shortness of breath). Additionally, the following pain medication was ordered to be provided as needed for pain not controlled by the scheduled medication: Acetaminophen oral tablet, give 650 mg by mouth every 6 hours as needed for pain 2-4. There is no evidence Acetaminophen was administered to assist the resident with their pain in between scheduled doses of morphine. Per interview on 3/27/2025 at 11:30 AM, the hospice nurse who was providing care for the resident indicated that a resident on hospice was expected to have increased pain. He stated he would expect a resident to receive additional medications based on reported pain levels and that a resident on hospice would be assessed for pain more frequently than once per shift.

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care or services that was trauma informed and/or culturally competent. Based on interview and record review the facility failed to ensure that residents are effectively assessed for past trauma experiences and address the needs of trauma survivors by identifying and minimizing triggers and/or re-traumatization and developing an idevidualized care plan related to trauma for 4 of 4 residents in the applicable sample (Resident #22, #26, #28, and #51). Findings include: 1. During an interview with Resident #51 on 3/25/25 (date) at 10:31 AM s/he stated that she has had several traumatizing events throughout her/his life. These events include multiple sexual assaults and two fetal abortions, one with and one without consent. Per record review a Psychosocial Evaluation completed by the consultant Licensed Clinical Social Worker (LICSW) on 5/13/2024 Resident #51 has a history of trauma, anxiety, and SI (suicidal ideation). The Resident discussed severadl past traumatic events that occured throughout her/his life and the impact that they have had on them. A Comprehensive Trauma Screening completed as part of the 5/13/2024 Psychosocial Evaluation states: Section I: The following questions should be completed by the Facility Social Worker using information from the Resident's Medical Records. 1. Does the Resident have a previously documented diagnosis of: a. Mental disorder? Yes b. Psychosocial adjustment difficulty? Yes c. History of trauma? Yes 2. Post-Traumatic Stress Disorder? Yes Section II: The following questions should be asked to the Resident verbally when completing the Initial Psycho Social Assessment upon Admission. 1. Have you ever had a: a. Life-threatening illness? No b. Serious accident? Unable or unwilling to answer 2. Have you even been: a. Physically assaulted? Yes b. Physically threatened? Yes c. Sexually threatened? Yes (continued on next page)

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	d. Sexually assaulted? Yes 3. Have you ever been in a situation that was extremely frightening Yes 4. Have you witnessed any extremely frightening situations? Yes 5. Do you have a close relationship with someone who experienced any extremely frightening situations? Unable or unwilling to answer 6. Have you recently felt any of the following due to any of the situations just asked about? a. Decreased social interaction or withdrawn? No b. Angry? No c. Persistent negative mood state? Yes Per record review Resident #51 does not have an identified diagnosis of PTSD (Post-traumatic stress disorder). Further record review reveals that Resident #51's care plan does not identify or address the Resident's past traumatic experiences, or potential trauma triggers. During an interview on 3/26/25 at 12:35 PM with the Regional Director of Nurses (DON) and the facility DON, the Resident's Psychosocial Evaluation and care plan were reviewed. The Regional DON and the facility DON confirmed that Resident #51's Comprehensive Trauma Screening completed as part of the 5/13/2024 Psychosocial Evaluation identified that the Resident did suffer from PTSD and also confirmed that the Resident's care plan did not address past trauma experiences or potential trauma triggers. Per interview with the facility Social Worker (SW) on 3/26/25 at 2:56 PM she stated that the Social Services Assessment and Documentation Trauma History form is the tool that she uses to assess each Resident. When asked if she asks Residents about past traumatic experiences or potential triggers she stated No, that would be talk therapy, and I don't do that. The Comprehensive Trauma Screening that identified PTSD was reviewed with the SW, who confirmed that the screening tool had identified that the Resident does have PTSD. The SW was asked how documentation by the Consulting Social Worker regarding the Resident's condition is communicated. The SW stated that she does not review the Consulting Social Workers notes and there is no process to ensure issues identified by the Consulting Social Worker are communicated. When asked if PTSD should be care planned, the SW stated that Resident #51 was care planned for PTSD. The Resident's care plan was reviewed with the SW at the time of the interview and revealed that it had been updated to include PTSD on 3/26/2025, after the interview with the Regional DON and the facility DON. The SW confimed that the care plan had just been updated 3/26/2025 to include PTSD. 2. Per record review Resident #28 was admitted to the facility with diagnoses of anxiety disorder and post-traumatic stress syndrome. A review of a facility policy titled Trauma Informed Care reads: (continued on next page)

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Springfield Health & Rehab	105 Chester Road Springfield, VT 05156

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1) Upon admission, the facility will assess each resident for a history of trauma in order to ensure they receive appropriate treatment and services. A questionnaire will be utilized for each resident by the social services department. Additional information may be obtained from the medical record, physical and emotional assessments, from the resident, and from family members who have shared this information. 2) Social Service personnel, in coordination with the interdisciplinary care team, will work to develop a plan of care aimed at mitigating/eliminating triggers. Record review shows no evidence that the Resident #28 was assessed for trauma or identification of possible triggers. A review of the Resident's care plan shows no evidence of a care plan to mitigate/eliminate triggers related to past trauma. Per interview on 3/26/25 at approximately 3:10 PM with Social Services, she confirmed the facility did not assess Resident #28 for triggers that may re-traumatize him/her and did not develop a care plan to mitigate potential past triggers. 3. Resident #22 has a diagnosis of post traumatic stress disorder (PTSD), but there are no triggers listed in his/her care plan. He/she has not had a Social Services Assessment discussing or listing triggers. On 3/26/25, at 3:15 PM, the Director of Social Services confirmed that there was no documentation about triggers in Resident #22's care plan and no admission assessment for triggers. 4. Resident #26 has a diagnosis of PTSD. Per a History and Physical Progress note, dated 1/8/2024, he/she has a history of sexual abuse as a child. Per a Regulatory Visit Progress Note, dated 3/8/2024, he/she has a history of sexual abuse as a child. Per a Psychological Services Supportive Care Progress note, dated 7/9/24, Resident #26 stated that [he/she] had to have a catheter recently, which [he/she] stated was triggering due to past sexual trauma. Resident #26 has a care plan for PTSD, but there is no mention of past sexual trauma or sexual trauma triggers. In Resident #26's admission Social Services Assessment, dated 11/25/23, there is no mention of sexual trauma or sexual trauma triggers. On 3/26/25 at 3:15 PM, The Director of Social Services confirmed that Resident #26's care plan does not include triggers for past sexual trauma and that Resident 26's admission Social Services Assessment does not mention past sexual trauma or discuss triggers relating to past sexual trauma.

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F 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure the resident's doctor reviews the resident's care, writes, signs and dates progress notes and orders, at each required visit. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interview, and record review the physician failed to ensure that the onsite review of the resident's total program of care included necessary lab testing, treatment, and medication orders for 3 of 27 residents sampled (Resident #13, #26, and Resident #322). Findings include: 1). Per record review Resident #322 was admitted on [DATE] after an acute hospital stay related to a fractured right hip repaired on 3/13/25. Per his/her discharge summary/orders written by sending Physician on 3/20/25, Resident #322 was being admitted to rehabilitation therapy, and pain control. Per further review of his/her discharge summary, s/he had been receiving oral dilaudid for pain 4 times a day in addition to acetaminophen for pain. S/he was also experiencing constipation and was ordered to continue receiving medications to treat the symptoms. Resident #322 was also noted to have swelling in his/her right hip after surgery and was being treated with aspirin 81 mg for prevention of deep vein thrombosis (DVT) as recommended by orthopedic surgeon which was to continue until 4/13/25. Per review of Resident #322's Discharge summary dated [DATE] s/he had the following orders, aspirin 81 mg extended release two times a day prevention deep vein thrombosis, hydromorphone oral tablet 2 mg every 4 hours as needed for pain, acetaminophen 650 mg every four hours as needed for pain, and senna 8. 6 two times daily for constipation. There was no documented evidence that these medications were ordered until 3/24/25 or administrated to the resident prior to date. Per Interview with the Medical Director on 3/27/25 at 1:30 PM she stated the admission process at the facility had been a problem. She stated that she should see all new admissions within 14 days of admission. She stated for new admissions and readmissions nursing transcribes orders into the electronic health record and activates the orders before she is able to review them. She stated the process should be that all orders are reviewed by her or a provider before they are activated but that does not happen. She stated recently there had been an error when nursing transcribed a progress note as admission orders for one resident. This was later confirmed during interview to be the admission orders for Resident #322 entered on 3/20/25. Per facility policy titled physician visits and initial history and physical [H&P] examinations, last reviewed on 3/27/25 A physician must conduct an initial H&P examination within 14 days of a resident's admission to ensure timely completion of the initial comprehensive assessments. The first physician visit must occur within the first 30 days of admission and must be conducted in person and not telehealth. Per record review of Resident #322 record s/he had a televisit on 3/21/25 titled visit type: follow up; chief complaint: Day 1 admission evaluation, [Resident #322] seen via telemed for a follow up visit to [his/her] day 1 evaluation. [S/he] states [s/he] is feeling okay today. [S/he] did not sleep very well [his/her] first night at the facility, [s/he] states [s/he] had right leg pain. The visit did not include Resident #322 entire discharge summary, orders, or plan of care. There was no evidence of discharge orders being initiated until 3/24/25, four days after admission. (continued on next page)

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F 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Per interview on 3/27/25 at approximately 9:30 AM with the Unit Manager stated the discharge process is as follows, one nurse will transcribe the orders from the discharge summary and enter them into the electronic health record. Then a second nurse verifies the orders, a message is sent to the provider. She stated that the orders are activated once the second nurse verifies them. The UM stated during interview that she does not always receive notification back from the provider that she received the orders or if they are approved or not. She stated nursing activates all orders including medications unless it is a controlled medication. Per interview with the facility Administrator and the Director of Nursing on 3/27/25 at approximately 5:19 PM, the Administrator stated that when the Resident #322 was admitted on [DATE] the facility did not have the correct discharge summary or admitting orders to care for them. Per the Administrator the orders that were entered into the electronic health record on 3/20/25 by nursing were from the previous hospital stay and not Resident #322's actual discharge orders to the facility. 2). Per record review, Resident #13 was readmitted to the facility on [DATE] after a acute hospital admission for COVID, gastrointestinal bleeding and NSTEMI (heart attack). Per further record review s/he was admitted to the hospital with a hemoglobin of 7.0 (low) and required multiple blood transfusions. Per further record review Resident #13 was receiving medications that increase his/her risk for bleeding, including antiplatelet and anticoagulation therapy. Per his/her discharge summary the following recommendations were made to the facility: continue anticoagulation therapy at a lower dose, follow up with provider and have a repeat complete blood count with differential on 1/15/25. Per interview on 3/27/25 at 9:30 AM, the Unit Manager confirmed that there were no orders to have repeat labs done as directed on discharge instructions for Resident #13. Per record review Resident #13 had no evidence of a required physician visit since returning from the hospital on 1/11/25. Per further review Resident #13 had 3 telehealth visits on 1/14/25, 1/15/25 and 1/17/25 all completed via telehealth. Per review of these visits, there was no evidence that the discharge orders were reviewed or acted upon in the medical record. Per interview with the Physician on 3/27/25 at 1:30 PM, she confirmed that the documented evidence shows that she did not complete the required visits with the residents and that she should have. She stated that she should see all residents that have been admitted or readmitted within 14 days of admission. Per interview on 3/27/25 at 10:09 AM with the facility Adminstrator she confirmed that there was no documented evidence of physician visit or accurate admission orders for Resident #13 per his/her discharge summary on 1/11/25. 3) Per record review, Resident #26 has diagnoses of schizoaffective disorder, anxiety and past traumatic brain injury. During an interview on 3/24/25 at 11:38 AM, when asked about a wound on his /her forehead, the resident said, That's from a car accident, a long time ago, but now they think it's cancer. Resident #26 was asked if anything is being done for his/her wound, he/she said They wash it everyday. A Provider's progress note, dated 11/25/24, describes lesions on the resident's face and scalp consistent with basal cell carcinoma (a type of skin cancer) and states referral to Dermatology ASAP. (continued on next page)

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F 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 11/27/24, a Nursing progress note said the Resident was scheduled for a Dermatology appt on 12/17/24 at 1:15 PM. On 12/17/24, at 11:39 AM, Resident #26 was sent to Emergency Department for shortness of breath, nausea and pain in his/her back. The Resident did not return to the facility until 5:05 pm the same day, causing him/her to miss the Dermatology appointment There is no further mention of the skin issue in any Provider documentation. There is no rescheduled dermatology appointment documented. On 3/26/25, at 1:53 PM, The Regional Medical Director confirmed that the Dermatology appointment had not been rescheduled and that no one had followed up on Resident #26's possible basal cell carcinoma.

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	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 the interview and staff education record review, the facility failed to ensure that 2 of 3 sampled licensed nursing assistants (LNAs) were assessed for the competency and skill sets needed to provide care and respond to each resident's individualized needs. This is a repeat deficiency for this facility, with violations cited during a previous complaint survey, dated 4/16/24, and has the potential to affect all residents. Findings include: Per review of 3 LNA education records, 2 of the 3 sampled LNAs currently working at the facility did not have documentation of the competency evaluation required to demonstrate that they had the necessary skills to provide the care needed. Per interview on 3/26/24 at approximately 3:30 PM, the Director of Nursing (DON) indicated that she is responsible for assessing competencies. She is currently developing a system that has not been implemented yet. Per interview with the Regional Director of Nursing on 3/26/2024 at approximately 4:59 PM, she indicated the facility does not have hard copies of employee files that were also employees of the preceding owners. The current company has a system that accesses employee files online through the Human Resource System. The facility could not produce evidence of competencies for 2of 3 of the files sampled

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on the record review and staff interview, the facility failed to ensure that monthly pharmacist drug regimen reviews, recommendations, and attending physician responses were completed and documented in the resident record Medication Regimen Review (MRR) process for 10 of 10 Residents in the applicable sample (Residents #12, #13, #20 #22 #23# 26#29 #54 #61, and #64). This is a repeat deficiency for this facility, with violations cited during the previous recertification survey, dated 1/10/24. Findings include: 1. Per record review Resident #54 has diagnoses that include dementia with mood disturbances. A Care Plan focus initiated on 1/19/2024 states that the Resident exhibits or has the potential to exhibit physical and verbal behaviors toward others. Per review of facility investigation reports, the Resident has had a recent history of aggressive physical behaviors toward other residents on 12/23/2024, 12/29/2024, and 1/8/2025. Review of Resident #54's Physician's orders revealed a physicians order for Lorazepam 0.5 milligrams (mg) every 6 hours as needed for agitation for 90 days was started on 1/24/2025, and an order dated 1/27/2025 for Haloperidol (Haldol, an antipsychotic) 1mg two times a day for terminal agitation, and 1mg every 2 hours as needed (PRN) for terminal agitation. (Terminal agitation, also known as terminal restlessness or terminal delirium, refers to behaviors that occur in the days leading up to death. When a person nears the end of their life, they may become increasingly restless .In some cases, it might seem like their personality changes. They might become uncharacteristically angry or hostile. These are all things that may happen when [their] body begins to shut down .Terminal agitation generally occurs within the last two weeks of a person's life. But it's different for everyone. https://my.clevelandclinic.org/health/symptoms/terminal-agitation). There is no stop date indicated for the PRN Haldol. There is also no documentation that the Resident has been experiencing symptoms of terminal agitation. Review of Medication Administration record (MAR) reflects that starting on 1/28/2025, staff should document Non-Pharmacological Intervention(s) used before PRN anti-depressant, antianxiety, anti-psychotic or sedative/hypnotic medication Document by number:1 Reposition for comfort 2 massage 3 involve in activity/alt. activity to divert 4 provide quiet setting with reduced stimuli as needed 5 relaxation technique 6 music 7 remove from area 8 direction/distraction 9 toilet 10 ambulate 11 provide food/drink 12 educated 13 one:one 14 other -add to PN (progress note) the description. Further review reveals that there is no documentation that any Non-Pharmacological interventions were attempted prior to administration of the PRN administration of the Lorazepam or Haldol. Review of the Medication Regime Reviews (MRR) in Resident #54's record revealed no evidence that a monthly MRR had been completed since 12/3/2025. Review of a paper copy of a MRR dated 2/4/2025, that was provided by the Director of Nursing (DON) on 3/27/2025, that had not been signed by the Medical Director revealed a recommendation related to the order for Haldol as needed (PRN) with no stop date. This MMR did not address the use of Haldol twice daily for terminal agitation over the last two months, nor did it address the lack of documentation of non-pharmacological interventions documented in the MAR prior to administration of the Lorazepam or Haldol. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview with the Regional Pharmacist who oversees the Consultant Pharmacist on 3/27/2025 at 12:43 PM she stated that MRRs are completed on admission and at least monthly. When asked if the Consulting Pharmacist would be expected to identify a resident receiving Haldol for terminal agitation for over two months an irregularity, she stated no, they wouldn't. The Regional Pharmacist also stated that when recommendations are not addressed, they reapproach the facility about it. She stated that they have had to do so with this facility. Per interview with the facility's Medical Director on 3/27/2025 at 1:10 PM she stated that the MRRs go to the Director of Nursing (DON) and then the DON gives them to her to address. The Medical Director stated that she was three months behind with the MRRs. She also stated that she had addressed some of them over the past three months, but she was unsure what happened to them 2. Per record review a physician's order dated 2/7/2025 for Resident #12 to receive Quetiapine (Seroquel, an antipsychotic) 25 milligrams (mg) every 8 hours as needed for terminal agitation with no stop date. Further record review revealed that there was no documented evidence that a pharmacist had completed a monthly Medication Regimen Review (MRR) since 12/3/2024. Review of a paper copy of a MRR dated 3/4/2025, that was provided by the Director of Nursing (DON) on 3/27/2025, and signed by the Physician on 3/27/2025 revealed a recommendation related to the order for Quetiapine as needed (PRN) with no stop date. During an interview on 3/27/2025 at 1:10 PM the facility's Medical Director stated that she was three months behind with the MRRs. She also stated that she had addressed some of them over the past three months, but she was unsure what happened to them. The Medical Director confirmed that the PRN Seroquel did not have a stop date and it should have. 3. Per record review Resident #29 has a Physician's order dated 2/27/2025 for Lorazepam (benzodiazepine) 0.5 milligrams (mg) two times a day. There is no indication for use identified within the order. Further record revealed that there is no documented evidence that the pharmacist conducted a monthly Medication Regime Review since 12/3/2025. During an interview on 3/27/2025 at 1:10 PM the facility's Medical Director confirmed that there was no identified indication for the Lorazepam. She stated that she was three months behind with the MRRs. She also stated that she had addressed some of them over the past three months, but she was unsure what happened to them. Per interview with the Director of Nurses on 3/17/2025 at approximately 2:00 PM, she had requested that the pharmacy email the MRR pharmacy recommendations from January 2025 to present to her. When the MRRs for Resident #29 were requested, the DON stated that she had not received any for Resident #29.4. Per record review, Resident #64 was admitted to the facility on [DATE] and has the diagnoses of dementia, unilateral primary osteoarthritis of the left hip, and unspecified abnormalities of gait and mobility-presence of left artificial hip joint. Resident #64 had the following order Oxycodone HCL oral tablet 5 mg. Give 0.5 tablet by mouth every 4 hours as needed for pain, started on 2/15/2025. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	A facility policy Consultant Pharmacist Reports stated, The consultant pharmacist or designee, e.g., clinical pharmacist at the provider pharmacy, works with the facility personnel and electronic records to gather pertinent information related to the resident's status and/or request for consultation. The findings are faxed or e-mailed within 72 hours to the director of nursing or designee and documented and stored with the other consultant pharmacist recommendations in the resident's chart. A record review indicates a note entered by the Consulting Pharmacist on 2/18/2025 indicating the submission of a new admission Medication Regime Review. With the following recommendations: Currently receiving Oxycodone PRN (as needed) without a stop date. Please evaluate the duration of therapy. Consider adding a stop date of 14 days, if appropriate. Per interview with the DON on 3/27/25 at approximately 1:47 PM, she confirmed the facility had not established a process to ensure monthly pharmacist drug regimen reviews, recommendations, and attending physician responses were completed and documented in the resident record. 5. Per record review, Resident #23 was readmitted to the facility on [DATE] status post fractured hip with surgical repair, and a history of Alzheimer dementia. Resident #23 had the following medication orders written on 3/14/25, Oxycodone 2.5 mg every 4 hours as needed for hip fracture post-op pain, [and] Morphine 0.5 mls every 2 hours as needed for Hip fracture; post -op pain; Comfort measures. Per further review of medication orders there was no evidence of stop dates for as needed medication. A record review indicates a note entered by the Consulting Pharmacist on 3/14/25 indicating the submission of a New admission Medication Regime Review, (MMR). With the following recommendations: Currently receiving Oxycodone PRN (as needed) without a stop date. Please evaluate the duration of therapy. Consider adding a stop date of 14 days, if appropriate. Per MRR signed by the physician on 3/14/25, oxycodone had been discontinued however per the facility MAR oxycodone continued to be prescribed without a end date. 6. Per review of Resident #20's Medication Regimen Review (MRR) dated 1/2/25 the following recommendations were made by the facility pharmacy, Currently receiving Quetiapine (Seroquel) which can increase risk of falls. Per [Resident #20] clinical record, with recent falls. Please evaluate, consider tapering the dose or implementing alternative treatment, if necessary. Per further review of the medical record there was no documented evidence that the provider reviewed or acted upon the pharmacy recommendation. Resident #20 had additional recommendations made on 3/4/25 and as follows Currently there is an active order for Lorazepam PRN without a specific stop date. Please note that CMS guidelines do not allow maintained open-ended orders for PRN psychotropic's on medication profiles, even for Hospice residents. Please evaluate and consider discontinue Lorazepam PRN, if appropriate. Per MMR review dated 3/4/25 signed on 3/27/25 by the physician stated that the Lorazepam was discontinued on 3/7/25. However, per review of Resident #20's MAR, Lorazapam continues to be prescribed as needed without a stop date. Per interview with the Regional Director of Nursing at 3:00 PM on 3/26/25 there was no evidence of pharmacy review being acted on for Resident #20 or #23. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	7. Per record review, Resident #13 was readmitted to the facility on [DATE] after an acute hospital admission for COVID, gastrointestinal bleeding and NSTEMI (heart attack). S/he was admitted to the hospital with a hemoglobin of 7.0 and required multiple blood transfusions. Per further record review Resident #13 was receiving medications that increase his/her risk for bleeding, including antiplatelet and anticoagulation therapy. Per his/her discharge summary the following recommendations were made to the facility on 1/11/25, continue anticoagulation therapy at a lower dose, follow up with provider and have a repeat complete blood count with differential on 1/15/25. Per interview on 3/27/25 at 9:30 AM the Unit Manager confirmed that there were no orders to have repeat lab work done as directed on discharged instructions for Resident #13. Per record review for Resident #13, there was no evidence of a pharmacy admission review on or around 1/11/25 when the resident returned to the facility. There was no evidence that the pharmacy reviewed the discharge summary or recommend the follow up laboratory blood work needed to monitor his/her medications including anticoagulation and antiplatelet therapy. Per consulting pharmacist service agreement The Pharmacy Consultant shall perform Medication Regimen Reviews for all newly admitted and readmitted residents, in accordance with guidance During an interview with the Regional Pharmacist who oversees the Consultant Pharmacist on 3/27/2025 at 12:43 PM, she stated the reviewing pharmacist would not have access to all the discharge information for residents, or access to the entire medical record for the residents. She stated due to limited accessto the medical record the reviewing pharmacist would not be aware of the discharging facilities recommendations for follow up lab work related to medications. Per interview with the Director of Nursing on 3/27/25 at 2:00 PM she confirmed that there was no evidence of pharmacy reviews for Resident #13 and the last completed review, per his/her medical record on was on 11/7/2024. 8. Per record review, Resident #61 has diagnoses of Multiple Sclerosis (an autoimmune disease that destroys the myelin covering around nerve cells) and Major Depressive Disorder. Per Resident #61's care plan, Resident #61 needs assistance for ADL [Activities of Daily living] with bathing, grooming, personal hygiene, dressing, eating, bed mobility, transfers. locomotion, and toileting. Per interview with Resident #61 on 3/24/25 at 11:54 AM Resident #61 reported that s/he was not receiving his/her Risperidone for anxiety. S/he stated that she was sent to the hospital after stating s/he would kill his/herself. Resident #61 discussed that s/he was being prescribed Buspirone [also known as Buspar, a medication used to treat anxiety] and that it was not helpful for reliving his/her anxiety. Per record review of Resident #61's MAR [Medication Administration Record] s/he had an order for Melatonin 5 mg [milligrams] tablet: Take 10 mg [milligrams] by mouth at bedtime for sleep with an order dated for 9/2/24. Resident #1 also had an order for Buspirone [Buspar] 5 mg [milligram] tablet: Take one tablet by mouth three times a day for anxiety with an order start date of 10/2/24. (continued on next page)

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	475025	A. Building B. Wing	03/27/2025

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 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Per psychiatric note dated 2/11/25 at 7:19 PM states, [S/he] takes Sertraline and Trazodone for depression, Sertraline and Buspar [Buspirone] for anxiety, Gabapentin for pain and Melatonin for insomnia. The resident states the Buspar does not help [him/her] anxiety, and Risperidone worked better for controlling [his/her] PTSD. On 1/22/24 resident expressed suicidal ideation, stated I'm going to kill myself. I need Risperidone for my anxiety and was sent to the hospital. No medications changes were made. [S/he] has been cooperative but anxious. [S/he] has a history of attempted suicide . start Risperidone 1mg BID [twice daily], increase Sertraline to 100 mg [milligrams] daily in AM, DC [discontinue] Buspar-ineffective, Trazodone as ordered for now, GDR/DC [gradual dose reduction/discontinue] Buspar and Melatonin. Per a psychiatric progress note dated 3/11/25 at 10:30 AM states, Resident states that Buspar does not help [his/her anxiety], and Risperidone worked better for controlling [his/her] PTSD [Post Traumatic Stress Disorder] and Anxiety. On 1/22/24 resident expressed suicidal ideation, stated I'm going to kill myself, I need Risperidone for my anxiety, and was sent to the hospital. No medications changes were made. [S/he] has been cooperative but anxious. [Resident #61] has a history of attempted suicide . -start Risperidone 0.5mg [milligrams] BID [twice daily]Increase Sertraline to 100mg daily in AM [morning], DC [discontinue] Buspar-ineffective .GDR/DC Buspar and Melatonin-ineffective. Per record review of Resident #61's MAR [Medication Administration Record] from March 2025, Resident #61 never received his/her Risperidone or increase in Sertraline. Resident #61's MAR also shows that the resident continued to be prescribed Melatonin Per record review of a pharmacy medication regimen review dated 1/2/25 states, Currently receiving Buspar for anxiety. Based on available documentation, this medication has been ineffective in treating anxiety for this resident. Please evaluate continued need and consider discontinue if therapy is no longer necessary. The form is signed by the medical director on 1/7/25. On 3/26/25 at 9:30 AM the DON [Director of Nursing] confirmed that the Buspar and Melatonin was not discontinued and there were no orders put in for the increase in the Sertraline and start of Risperidone 1 mg [milligram]. An interview was conducted with the DON [Director of Nursing] on 3/26/25 at 2:11 PM. The DON confirmed the medication changes were not addressed and stated, I can fix this. Per interview with the Medical Director on 3/26/25 at 4:34 PM the Medical Director confirmed that she did not read the progress notes from psychiatry that contained these new orders. On 3/27/25 at 12:37 PM the Medical Director confirmed that Resident #61's Buspirone and Melatonin were not discontinued. 9. On 10/1/24 Resident #22 had a Pharmacy Progress Note indicating potential medication irregularities or other medication concerns. This note should have a corresponding Medication Regiment Review (MRR) with the pharmacy recommendation and the Providers' acknowledgement of those recommendations. The MRR cannot be found in Resident #22's chart. On 03/26/25, at 1:33 PM, the Regional Director of Nursing confirmed that there is no MRR for 10/1/24 in Resident #22's chart. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	10. Resident #26 had Pharmacy Progress Note indicating potential medication irregularities or other medication concerns on 5/1/24, 2/4/25 (two separate recommendations) and 2/24/25 (three separate recommendations). This note should have a corresponding Medication Regiment Review (MRR) with the pharmacy recommendation and the Providers' acknowledgement of those recommendations. These MRRs cannot be found in Resident #26's chart. On 3/27/25, at 4:30 PM, the [NAME] President of Operations confirmed that these MRRs were not in the Residents chart. He/she did produce copies that had been signed on 3/27/24.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure that 2 out of 10 applicable residents (Resident #20, #23) remained free from unnecessary medications. Findings include: 1). Per record review, Resident #23 was readmitted to the facility on [DATE] status post fractured hip with surgical repair, and a history of Alzheimer's dementia. Resident #23 had the following medication orders written by the Provider on 3/14/25: Oxycodone 2.5 mg every 4 hours as needed for hip fracture post-op pain, start 3/14/25 with no evidence of stop date. Morphine 0.5 mls every 2 hours as needed for Hip fracture; post -op pain; Comfort measures, with no evidence of a stop date. A record review indicates a note entered by the Consulting Pharmacist on 3/13/25 indicating the submission of a New admission Medication Regime Review (MMR) with the following recommendations: Currently receiving Oxycodone PRN (as needed) without a stop date. Please evaluate the duration of therapy. Consider adding a stop date of 14 days, if appropriate. Per MRR, signed by the physician on 3/14/25, oxycodone had been discontinued; however, per the facility medication administration record (MAR), oxycodone continued to be prescribed without a end date. 2) Resident #20 had pharmacy recommendations made on 3/4/25 as follows Currently there is an active order for Lorazepam PRN without a specific stop date. Please note that CMS guidelines do not allow maintained open-ended orders for PRN psychotropic's on medication profiles, even for Hospice residents. Please evaluate and consider discontinue Lorazepam PRN, if appropriate. Per MMR review dated 3/4/25, signed on 3/27/25, stated that the Lorazepam was discontinued on 3/7/25. However, per review of Resident #20's MAR there is no evidence of stop date on the PRN medication. Per interview with the Regional Director of Nursing on 3/26/25 at approximately 2:00 PM she confirmed that PRN medications for Resident #20 and #23 did not have a stop dates and should have.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. Based on interview and record review the facility failed to ensure that residents were free from unnecessary psychotropic medications for 5 of 10 Residents in the sample (Resident #12, #20, #29, #54, and #61). The facility also failed to implement 14 day stop dates on prescribed as needed (PRN) psychotropic medications for 3 of the 5 residents in the sample (Residents #12, #20, #54). Findings include: 1. Per record review Resident #54 has diagnoses that include dementia with mood disturbances. Review of the Resident's Care Plan reflects that s/he was admitted to Hospice services on 8/7/2024 due to the diagnosis of congestive heart failure. A Care Plan focus initiated on 1/19/2024 states that the Resident exhibits or has the potential to exhibit physical and verbal behaviors toward others. Per review of facility investigation reports, the Resident has had a recent history of aggressive physical behaviors toward other residents on 12/23/2024, 12/29/2024, and 1/8/2025. During meal observations on 3/24/2025 at 12:40 PM and 3/25/2025 at 12:15 PM, Resident #54 was observed sitting in a wheelchair at a table eating her/his meal independently. S/he appeared calm and there were no signs of distress. Review of Resident #54's Physician's orders revealed that on 1/10/2025 the Resident was prescribed Aripiprazole (an antipsychotic) 5 milligrams (mg) by mouth in the afternoon for sundowning (Sundowning is the name for a group of behaviors, feelings and thoughts people who have Alzheimer's or dementia can experience as the sun sets. The behaviors start or get worse around sunset or sundown . Symptoms include insomnia, anxiety, pacing, hallucinations, paranoia and confusion.) https://my.clevelandclinic.org/health/articles/22840-sundown-syndrome. On 1/27/25 the order for Aripiprazole was increased to 5mg twice daily, and an additional Physician's order also dated 1/27/2025 was added for Haloperidol (Haldol, an antipsychotic) 1mg two times a day for terminal agitation, and 1mg every 2 hours as needed (PRN) for terminal agitation. (Terminal agitation, also known as terminal restlessness or terminal delirium, refers to behaviors that occur in the days leading up to death. When a person nears the end of their life, they may become increasingly restless .In some cases, it might seem like their personality changes. They might become uncharacteristically angry or hostile. These are all things that may happen when [their] body begins to shut down .Terminal agitation generally occurs within the last two weeks of a person's life. But it's different for everyone. https://my.clevelandclinic.org/health/symptoms/terminal-agitation). There is also no stop date indicated for the PRN Haldol. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #54's February 2025 Medication Administration Record (MAR) reveals that the scheduled Haldol for terminal agitation was administered twice daily per order, and the PRN Haldol was administered on 2/12/25. The MAR also reflects that starting on 1/28/2025, staff should document Non-Pharmacological Intervention(s) used before PRN anti-depressant, antianxiety, anti-psychotic or sedative/hypnotic medication Document by number:1 Reposition for comfort 2 massage 3 involve in activity/alt. activity to divert 4 provide quiet setting with reduced stimuli as needed 5 relaxation technique 6 music 7 remove from area 8 direction/distraction 9 toilet 10 ambulate 11 provide food/drink 12 educated 13 one:one 14 other -add to PN (progress note) the description. There is no documentation that any Non-Pharmacological interventions were attempted prior to administration of the PRN administration of Haldol. There is also no documentation that the Resident was experiencing symptoms of terminal agitation. Resident #54's March MAR revealed that the scheduled Haldol twice daily for terminal agitation per order, and one PRN dose on 3/1/25. There is no documentation that any Non-Pharmacological interventions were attempted prior to administration of the PRN administration of Haldol. There is no documentation that any Non-Pharmacological interventions were attempted prior to administration of the PRN administration of Haldol. There is also no documentation that the Resident was experiencing symptoms of terminal agitation. Per interview with the Unit Manager (UM) on 3/26/2025 at 10:07 AM when a resident is experiencing terminal agitation, they get restless sometimes they want to hold us, they may be frightened or restless moving all around. It varies for everyone, usually the last day or two before they die. The UM confirmed that Resident #54's is not in the active dying phase and her/his agitation is caused by her/his disease process, not from terminal agitation. Per interview with the facility's Medical Director on 3/27/2025 at 1:10 PM she had been asked by the management team to prescribe Resident #54 medications that would manage her/his aggressive behaviors. The Medical Director confirmed that the order for Haldol states that it is to be used for terminal agitation and that Resident #54 is not currently experiencing terminal agitation, and that the PRN order does not have a stop date. 2. Per record review Resident #12 was admitted to Hospice services on 1/16/2024 for end-of-life care. Review of Physicians order revealed an order dated 2/7/2025 for Seroquel (antipsychotic) 25 milligrams (mg) every 8 hours as needed for terminal agitation with no stop date. Review of the Resident's Medication Regimen Review reveals that on 3/4/2025 the Pharmacist noted that the Seroquel has no specified stop date and recommended discontinuing it. During an interview on 3/27/2025 at 4:36 PM the facility's Medical Director confirmed the Seroquel was ordered for terminal agitation, and that Resident #12 was not experiencing symptoms of terminal agitation. She also confirmed that there was no stop date for the PRN Seroquel and that she had just reviewed the pharmacy recommendations and will discuss discontinuing the Seroquel with the Resident's daughter. 3. Per record review Resident #29 has a Physician's order dated 2/27/2025 for Lorazepam 0.5 milligrams (mg) two times a day. There is no indication for use identified within the order. During an interview on 3/27/2025 at 1:10 PM the facility's Medical Director confirmed that there was no indication for the Lorazepam. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4. Per record review Resident #20 has the following orders without stop dates Lorazepam Oral Tablet 0.5 MG (Lorazepam) Give 0.5 mg by mouth every 4 hours as needed for Agitation/restlessness written on 3/7/2025 without a stop date or rationale written by the provider for continued use of PRN medications. Per record review Resident #20 had the following pharmacy recommendations made on 3/4/25, Currently there is an active order for Lorazepam PRN without a specific stop date. Please note that CMS guidelines do not allow maintained open-ended orders for PRN psychotropic's on medication profiles, even for Hospice residents. Please evaluate and consider discontinue Lorazepam PRN, if appropriate. Per interview with the Regional Director of Nursing on 3/26/25 at approximately 2:00 PM she confirmed that PRN medications for Resident #20 did not have a stop date and should have. 5. Per interview with Resident #61 on 3/24/25 at 11:54 AM s/he discussed that s/he was being prescribed Buspar [also known as Buspirone, a medication used to treat anxiety] and that it was not helping ease his/her anxiety. Per record review of Resident #61's MAR [Medication Administration Record] s/he had an order for Melatonin 5 mg [milligrams] tablet: Take 10 mg [milligrams] by mouth at bedtime for sleep with an order dated for 9/2/24. Resident #1 also had an order for Buspirone [Buspar] 5 mg [milligram] tablet: Take one tablet by mouth three times a day for anxiety with an order date of 10/2/24. Per record review, Resident #61 was prescribed Buspirone on 10/3/24, 1 tablet by mouth three times a day for anxiety. A psychiatric progress note dated 12/1/24 states, [S/he]'s treated for PTSD [Post-Traumatic Stress Disorder] sxs [symptoms] with sertraline [also known as Zoloft, an antidepressant] and recently added Buspar. Buspar is not helping anxiety and sertraline is not controlling sxs [symptoms] of anxiety, depression, insomnia .3.PTSD/Anxiety/Insomnia. Not controlled on present meds. Buspar not helping. Continue sertraline and trazadone. D/C [discontinue] Buspar. Add low dose Risperdal 0.5 mg [milligrams] HS [at bedtime] which may be beneficial for MS [Multiple Sclerosis, a disease that destroys the myelin sheath covering nerve cells]. Per record review of a psychiatric note dated 3/11/25 at 10:30 SM states, [Resident #61] takes Sertraline for depression/anxiety/PTSD, Trazodone for depression/insomnia, Sertraline Buspar for anxiety, Gabapentin for pain, and Melatonin for insomnia. The resident states that Buspar does not help [his/her] anxiety, and Risperidone worked better for controlling [his/her] PTSD and Anxiety. On 1/22/24 resident expressed suicidal ideation, stated 'I'm going to kill myself', 'I need Risperidone for my anxiety,' and was sent to the hospital. No medications changes were made. [S/he] has been cooperative but anxious. [S/he] has a history of attempted suicide . -start Risperidone 0.5mg [milligrams] BID [twice daily] Increase Sertraline to 100mg daily in AM [morning], DC [discontinue] Buspar-ineffective .GDR/DC [Gradual Dose Reduction/Discontinue] Buspar and Melatonin-ineffective. On 3/26/25 at 9:30 AM the DON [Director of Nursing] confirmed that the Buspar and Melatonin were not discontinued per psychiatric recommendation. An interview was conducted with the DON on 3/26/25 at 2:11 PM. The DON confirmed the medication changes were not addressed and stated, I can fix this.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. Based on observation, interview, and record review the facility failed to ensure medication error rates were not 5% or greater. The total error rate for all observations was calculated at 12%. There were 25 observations and three medication errors. Findings include: Per observation of LPN #1 on 3/25/25 at 10:12 AM, LPN #1 administered Resident #50 one Omeprazole Oral Tablet Delayed Release 20 mg [milligram] tablet (a medication used for acid reflux), 2 puffs of Dulera Inhalation Aerosol 100-5 MCG/ACT [micrograms per actuation] (a medication used to treat asthma), and 31 units of Basaglar KwikPen Subcutaneous Solution Pen injector 100 units/mL [units per milliliter] (insulin used to treat high blood sugar) for a blood glucose reading of 333. Per record review of Resident #50's MAR [Medication Administration Record] for March 2025, the Omeprazole was due to be administered at 7:00 AM. The insulin and Dulera inhaler were due to be administered at 9:00 AM. Per record review of the facility's Administering Medications policy [last reviewed/revised 2/25/25] states, 4. Medications must be administered within one hour of their prescribed time, unless otherwise specified for example, before and after meal orders. Per interview with LPN#1 on 3/25/25 at 10:12 AM, LPN #1 confirmed that the above medications were late. She stated the medications were late because she was not used to working on this particular side of the facility.

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain dental services for each resident. Based on interview and record review, the facility failed to promptly provide routine and emergency dental services to meet the residents' needs related to dental pain for one of 16 residents in the applicable sample (Resident #61). Findings include: An interview was conducted with Resident #61 on 3/24/25 at 11:56 AM. Resident #61 discussed that s/he has not seen a dentist since being at the facility since 8/7/24. S/he stated s/he was having dental pain. Per interview with Resident #61 on 3/26/25 at 10:25 AM, s/he stated s/he was in 10 out of 10 pain at times due to upper and lower right dental pain. Resident #61 stated, I have a lot of teeth that need to be pulled .I feel like I don't matter and that my health isn't being taken care of. Per record review of the facility's Dental Services policy [no last revised\reviewed date] states, Centers will provide or obtain an outside resource routine and emergency dental services, including 24-hour emergency dental care, to meet the needs of each patient .When necessary or if requested, Center staff will assist the patient in making dental appointments . Per record review, Resident #61 had a physician appointment on 2/7/25 related to tooth pain via tele-health video. The progress note discusses that there were no medication changes made. On 3/26/25 at 1:26 PM the Regional Director of Nursing confirmed there was no follow-up appointments or treatment to address Resident #61's dental concerns.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation and interview, the facility failed to maintain a clean kitchen environment, which has the potential to impact all residents in the facility. Findings include: On 3/24/25, at 10:24 AM, it was observed that shelves under the main cooking counter/steam table were very dirty with dried food and crumbs. Clean pots and pans were stacked directly on the dirty shelves. Other shelves around the kitchen had dirty, food-stained paper under clean pans, cups and kitchen tools. The dietary manager confirmed shelves were not clean at this time. On 3/25/25, at 11:34 AM, in the first-floor kitchenette, a staff member picked up the ice scoop from inside the ice chest with bare hands and put the scoop back into the ice chest. This surveyor noted that the ice scoop was directly on the ice, with the handle touching the ice. There was a container on the counter to store the ice scoop. It was empty. On 3/25/25, at 12:15 PM, the ice scoop was still inside the ice chest. At this time, a Dietary Aide confirmed that the ice scoop should not be stored inside the ice chest, but rather in the container outside the ice chest.

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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 0847 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Inform resident or representatives choice to enter into binding arbitration agreement and right to refuse. Based on interviews and record review the facility failed to ensure that the binding arbitration agreement was explained in a form or manner the resident or resident's representative acknowledges that he/she understands for 2 out of 3 residents sampled, (Resident #31 and Resident #43). Findings include: 1. Per record review, Resident #43's Minimal Data Set (MDS) states that he/she had a Brief Interview for Mental Status (BIMS) done on 3/11/25, with a score of 8, indicating that he/she is moderately cognitively impaired. Resident #43's representative, a sibling, signed this resident's Arbitration Agreement on 3/8/25. During an interview on 3/27/25, at 10:38 AM, Resident #43's representative stated They (the facility) emailed me a bunch of paperwork to sign but never explained it. I live in another state and work full time. They told me it was just routine admission paperwork that needed to be signed so [Resident #43] could be admitted He/she did not realize what arbitration was. He/she stated he/she would not have signed an arbitration agreement if he/she knew what it meant. 2. Per record review, Resident #31's MDS states that he/she had BIMS done on 3/11/25 with a score of 5, indicating severe cognitive impairment. Resident #31 signed his/her own Arbitration Agreement on 3/5/25. During a telephone interview on 3/27/25, at 11:57 AM, Resident #31's representative with Power of Attorney (POA) stated he/she gave permission via telephone for the resident to sign a Change in Medicare form. The POA stated he/she was never told about or gave permission for the Resident to sign an Arbitration Agreement. When asked he/she thought Resident #31 was capable of understanding the implications of an Arbitration Agreement, he/she said No. When asked if he/she would have signed an Arbitration Agreement as POA for Resident #31 he/she said No. During an interview on 3/27/25, at 11:06 AM, the Director of Admissions stated he/she emails forms to family out of state and they can call her if they have questions. He/she further stated Resident #31's POA gave permission for him/her to sign his/her own paperwork, but could not provide any documentation of this. When asked to explain an arbitration agreement, he/she stated If there is an issue, we ask them to come to us before seeking legal advice. When asked if he/she understood and explained to new Residents and their representatives that it took away the right for Residents and their representatives to use a court of law to settle a dispute, he/she Um, yes. During an interview on 3/27/25, at 5:03 PM, the Director of Admissions was asked about his/her training pertaining to Arbitration Agreements. He/she stated that there was minimal training on the subject and was told, Just tell them they don't have to sign it, that they can change their mind in 30 days, and, oh, yeah, it takes away all their legal rights.

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	03/27/2025

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. Based on interview and review of employee training records, the facility failed to develop a system to document the minimum 12 hours of nurse aide training per year required to ensure the continuing competence of the LNAs (Licensed Nursing Assistants). Findings include: Per review of the training records for 3 sampled staff members, there was no documented evidence of the 12 hours of training per year required to meet identified staff or resident needs. On 3/26/25 at approximately 3:00 PM, an LNA revealed she did not know how the facility tracked training records and relied on the facility to determine if she met the minimum standard hours. During an interview with the Regional Director of Nursing on 3/26/25 at approximately 4:55 PM, she stated the facility did not have complete access to the prior owner's employee records and had not yet developed a tracking system for current employees.