

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395690	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 12/12/2024
NAME OF PROVIDER OR SUPPLIER: SPRINGFIELD REHABILITATION AND HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE: 463 WEST SPROUL ROAD SPRINGFIELD, PA 19064		
STATE LICENSE NUMBER: 080402				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
F 0000	INITIAL COMMENT	F 0000		
F 0657	Based on an Abbreviated Survey in response to two complaints completed on December 12, 2024, it was determined that Springfield Rehabilitation and Healthcare Center was not in compliance with the following Requirements of 42 CFR Part 483, Subpart B, Requirements for Long Term Care Facilities and the 28 Pa. Code, Commonwealth of Pennsylvania Long Term Care Licensure Regulations related to the health portion of the survey process.	F 0657		
SS=D				

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

TITLE:

(X6) DATE:

Any deficiency statement ending with an asterisk (*) denotes a deficiency which may be excused from correction providing it is determined that other safeguards provide sufficient protection to the patients. The findings stated above are disclosable whether or not a plan of correction is provided. The findings are disclosable within 14 days after such information is made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

This form is a printed electronic version of the CMS 2567L. It contains all the information found on the standard document in much the same form. This electronic form once printed and signed by the facility administrator and appropriately posted will satisfy the CMS requirement to post survey information found on the CMS 2567L.

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F 0657 SS=D	Continued from page 1 483.21(b)(2)(i)-(iii) Care Plan Timing and Revision §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii) Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by:	F 0657	This Plan of Correction constitutes this facility's written allegation of compliance for the deficiencies cited. This submission of this plan of correction is not an admission of or agreement with the deficiencies or conclusions contained in the Department's inspection report. F0657 – CARE PLAN TIMING AND REVISION 1. Resident R1's plan of care was updated on 12/11/2024 2. An audit was conducted of all current residents care plans as it relates to refusals of care. Any variances were addressed and noted on the facility audit tool. 3. Nursing staff were educated by the Director of Nursing/Designee on communication regarding resident refusals of showers/bathing and ensuring the residents plan of care is up to date. 4. The Director of Nursing/Designee will conduct an audit of the care plans of 10 residents weekly for 4 weeks, and 10 residents	Completion Date: 01/02/2025 Status: APPROVED Date: 12/23/2024

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F 0657 SS=D	Continued from page 2	F 0657	monthly for 2 months to ensure refusals of care for showers/bathing are appropriately care planned. Audit results will be submitted to Quality Assurance Performance Improvement Committee for additional review and recommendations as needed. Further audit frequency will be determined based on prior audit findings.	

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F 0657 SS=D	Continued from page 3 Based on review of facility policy, clinical records, and staff interviews, it was determined that the facility failed to ensure that a resident's care plan was updated/revised to reflect the resident's specific care needs for 1 of 4 residents reviewed (Residents R1). Findings include: Review of Resident R1's Admission MDS (Minimum Data Set - a mandatory periodic resident assessment tool), revealed that the resident was admitted to the facility on September 9, 2024, and had diagnoses including muscle wasting, cognitive communication deficit, bed confinement status, and need for assistance with personal care. Continued review revealed that the resident had a BIMS (Brief Interview of Mental Status) of 0, which indicates that the resident was not cognitively intact. Review of Resident R1's clinical record, "GG-Shower/Bathe Self" indicated that "resident refused" a shower/or bath on 19 out of 30 days. Further	F 0657		

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F 0657 SS=D	Continued from page 4 review of Resident R1's clinical record revealed that "shower/bathe self (3-11/ 11-7)" revealed that "resident refused" a shower/or bath 25 times in 30 days. Further review of clinical records failed to reveal documentation of follow up attempts to encourage Resident R1 to bathe or shower; or reasoning behind Resident R1's refusals. Interview with the Registered Nurse, Employee E5, on December 11, 2024, at 12:00 p.m. revealed that Resident R1 "never refuses with me or the nurse assistant." Further interview revealed that Resident R1 "needs to be approached twice and she will come around and take the shower or bath" and that "staff never communicated to me that Resident R1 refuses showers or baths." Review of Resident R1's current care plan date-initiated September 12, 2024, revealed that the resident requires one staff assist with bathing and prefers bed baths. Further review revealed that no care plan and interventions were developed for refusals of showers/baths.	F 0657		

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F 0657 SS=D	Continued from page 5 Interview with the Facility Administrator and Director of Nursing on December 12, 2024, via electronic communication confirmed that a care plan and interventions for Resident R1's shower/bath refusals were not developed or implemented. 28 Pa. Code 211.12(d)(5) Nursing services.	F 0657			



Certified End Page

SPRINGFIELD REHABILITATION AND HEALTHCARE CENTER

STATE LICENSE NUMBER: 080402

SURVEY EXIT DATE: 12/12/2024

I Certify This Document to be a True and Correct Statement of Deficiencies and Approved Facility Plan of Correction for the Above-Identified Facility Survey


Jeanne Parisi
Deputy Secretary for Quality Assurance


Debra L. Bogen, MD, FAAP
Secretary of Health



**Pennsylvania
Department of Health**

THIS IS A CERTIFICATION PAGE

PLEASE DO NOT DETACH

THIS PAGE IS NOW PART OF THIS SURVEY