VERMONT

Department of Disabilities, Aging and Independent Living
Division of Licensing and Protection
280 State Drive/HC 2 South
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AGENCY OF HUMAN SERVICES

July 1, 2026

Ms. Kelly Scanlon, Administrator
Springfield Health & Rehab
105 Chester Road
Springfield, VT 05156

Provider ID #: 475025

Dear Ms. Scanlon:

Enclosed is a copy of your acceptable plans of correction for the complaint investigation conducted on **June 8, 2026.** Please post this document in a prominent place in your facility.

We may follow up to verify that substantial compliance has been achieved and maintained. If we find that your facility has failed to achieve or maintain substantial compliance, remedies may be imposed.

Sincerely,

Pamela M Cota RN
Pamela M. Cota, RN, BS
Assistant Division Director
State Survey Agency Director

Enclosure

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 475025	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 06/08/2026

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

(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 DEFICIENCY)	(X5) COMPLETION DATE
F0000	INITIAL COMMENTS The Division of Licensing and Protection conducted an unannounced, onsite investigation of 3 facility reported incidents, including reports #2994521, 3020022, and 3001882 on 6/8/2026 to determine compliance with 42 CFR Part 483 requirements for Long Term Care Facilities. The following regulatory deficiencies were identified:	F0000	Springfield Center for Living and Rehabilitation provides this plan of correction without admitting or denying the validity or existence of the alleged deficiencies. The plan of correction is prepared and executed solely because it is required by federal and state law.	
F0550 SS = D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the	F0550	1. Residents residing in the facility have the potential to be affected by the alleged deficient practice. 2. The facility's " Resident Rights policies were reviewed and education provided to all staff emphasizing "ensuring that residents are treated in a manner that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's right to be treated with dignity and respect, and to make choices. 3. The DON or designee will interview 6 residents per week for (4) weeks, then monthly for two (2) months to monitor effectiveness of the plan. 4. Results of the audits will be reported to the QAA committee x3 months at which time the QAA committee will determine further frequency of the audits. 5. Corrective action will be completed by **Tag F0550 POC accepted on 7/1/26 by S. Freeman/S. Stem**	7/8/2026

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 reverse for further 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
Kelly Scanlon	LNHA	6/25/2026

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F0550 SS = D	Continued from page 1 resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is NOT MET as evidenced by: Based on interview and record review, the facility failed to ensure that a resident was treated in a manner that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's right to be treated with dignity and respect, and to make choices, for 1 of 3 sampled residents (Resident #1). Findings include: Per record review, Resident #1 has diagnoses that include vascular dementia, major depressive disorder, and anxiety disorder. Per an MDS (Minimum Data Set, a resident assessment tool) dated 5/20/26, Resident #1 had a BIMS (Brief Interview for Mental Status) score of 1 indicating severely impaired cognition (the ability to perceive, learn, remember, reason, and problem-solve). Per record review of the facility follow-up investigation report received by Survey & Certification on 5/1/26, LNA #2 felt uncomfortable assisting LNA #1 with the care of Resident #1 on 4/23/26. Resident #1 was being resistive to care being provided by LNA #1 and LNA #2. "She [LNA #2] stated that when [Resident #1] was resistive to care and attempting to bite, that [LNA #1] said 'stop being a retard' to Resident #1. LNA #2 further stated that Resident #1 replied to LNA #1, saying, 'I am not a retard.' The facility investigation states that LNA #1 admitted to saying "Don't be a retard and hit and bit me." The facility investigation report states that the allegation was verified and that "[LNA #1] admitted to using unkind words when caring for [Resident #1]. [LNA #1] was notified that not treating [Resident #1] with dignity and respect, by using the unkind words, goes against resident's rights." Per review of the facility's "Resident Rights – Quality Of Life" policy and procedure, dated 12/2024, its purpose is "to ensure all residents are treated with a level of dignity they are entitled to while residing at the facility." The policy states, "Each resident shall be care for in a manner that	F0550		

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F0550 SS = D	Continued from page 2 promotes and enhances the quality of life, dignity, respect and individuality." Item number VII states, "Facility Staff speaks respectfully to residents at all times, including addressing the resident by his or her name of choice." The Administrator confirmed during an interview on 6/8/26 at 12:10 PM, that LNA #1 admitted she called Resident #1 a retard. She realized it was inappropriate.	F0550		
F0609 SS = D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is NOT MET as evidenced by: Based on interview and record review, the facility failed to report an incident of alleged abuse for 1 of 3 sampled residents. This is a repeat deficiency for this facility, with the violation cited during two previous partial surveys dated 2/17/26 and 12/9/25. Findings include: Per record review, Resident #1 has diagnoses that	F0609	1. Residents residing in the facility have the potential to be affected by the alleged deficient practice. 2. The facility's " Abuse Investigation and Reporting" and " Abuse, Neglect and Exploitation" policies were reviewed and Program" policies were reviewed and education provided to all staff were reviewed and education provided to all staff emphasizing timely reporting, what is considered abuse and definitions of the different types of abuse. 3. The administrator and DON have been educated on " Abuse Investigation and Reporting, Abuse, Neglect and Exploitation, and Abuse Prevention Program"" emphasizing what is considered abuse and the regulation requirements (report immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegations involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury to DAIL and APS. 4. The DON or designee will audit state reportables weekly for (4) weeks, then monthly for two (2) months to ensure all state reportables are being reported	

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F0609 SS = D	Continued from page 3 include vascular dementia, major depressive disorder, and anxiety disorder. Per an MDS (Minimum Data Set, a resident assessment tool) dated 5/20/26, Resident #1 had a BIMS (Brief Interview for Mental Status) score of 1 indicating severely impaired cognition (the ability to perceive, learn, remember, reason, and problem-solve). Per record review of the facility follow-up investigation report dated 5/1/26 of an allegation of abuse, LNA #2 felt uncomfortable assisting LNA #1 with the care of Resident #1 on 4/23/26. Resident #1 was being resistive to care being provided by LNA #1 and LNA #2. "She [LNA #2] stated that when [Resident #1] was resistive to care and attempting to bite, that [LNA #1] said 'stop being a retard' to Resident #1. LNA #2 further stated that Resident #1 replied to LNA #1, stating, 'I am not a retard.' The facility investigation states that LNA #1 admitted to saying "Don't be a retard and hit and bit me." The facility investigation states that the allegation was verified and that "[LNA #1] admitted to using unkind words when caring for [Resident #1]. [LNA #1] was notified that not treating [Resident #1] with dignity and respect, by using the unkind words, goes against resident's rights." LNA #2 did not report to LPN #1 that LNA #1 called Resident #1 a retard until 4/26/26, three days after it occurred. Per review of the facility policy and procedure titled, "Abuse Prevention and Prohibition Program," dated 12/2024, section IX, subsection A, "Facility Staff are Mandatory Reporters" and are "obligated by the Elder Justice Act any state specific regulations to report known or suspected instances of abuse of elder or dependent adults." Per interview with the Administrator on 6/8/26 at 12:10 PM, it was confirmed that the incident that occurred on 4/23/26 was not reported to Survey & Certification until three days after the incident, on 4/26/26. An investigation of this incident was not begun until 4/26/26, three days after the incident.	F0609	timely as per state regulations and to monitor effectiveness of the plan. 5. Results of the audits will be reported to the QAA committee x3 months at which time the QAA committee will determine further frequency of the audits. 6. Corrective action will be completed by **Tag F0609 POC accepted on 7/1/26 by S. Freeman/S. Stem**	7/8/2026