



**Department of Disabilities, Aging and
Independent Living**
Division of Licensing and Protection
280 State Drive/HC 2 South
Waterbury, VT 05671-2060
www.dlp.vermont.gov

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AGENCY OF HUMAN SERVICES

April 24, 2025

Mr. Travis Bergeron, Administrator
Pines Rehab & Health Ctr
601 Red Village Road
Lyndonville, VT 05851-9068

Provider ID #: 475044

Dear Mr. Bergeron:

On **April 15, 2025**, we conducted a revisit to the survey of **February 26, 2025**, to verify that your facility had achieved substantial compliance. Based on our revisit, we found that your facility is in substantial compliance with participation requirements found in Title 42, Code of Federal Regulations as of **April 12, 2025**.

If you have any questions concerning this letter, please contact me at (802) 241-0480.

Sincerely,

A handwritten signature in cursive script that reads "Pamela M. Cota RN".

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

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/24/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 475044		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 04/15/2025	
NAME OF PROVIDER OR SUPPLIER PINES REHAB & HEALTH CTR				STREET ADDRESS, CITY, STATE, ZIP CODE 601 RED VILLAGE ROAD LYNDONVILLE, VT 05851			
(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
{E 000}	Initial Comments			{E 000}			
	The Division of Licensing and Protection conducted an emergency preparedness review during the annual recertification survey on 2/26/25. There were no regulatory violations identified.						
{F 000}	INITIAL COMMENTS			{F 000}			
	The Division of Licensing and Protection conducted an unannounced, onsite revisit survey at the facility on the date indicated in the upper right hand corner of this form. The violation(s) previously identified have been corrected.						

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

TITLE

(X6) DATE

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