VERMONT

Department of Disabilities, Aging and Independent Living
Division of Licensing and Protection
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Waterbury, VT 05671-2060
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AGENCY OF HUMAN SERVICES

December 17, 2025

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 **December 9, 2025.** 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 12/09/2025

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 three complaints and one facility reported incident, including reports #2643962, #2643998, #2642785, and #2640263, from 10/21/25 through 10/22/25 and offsite investigation through 10/23/25 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.	
F0561 SS = D	Self-Determination CFR(s): 483.10(f)(1)-(3)(8) §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. §483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility.	F0561	LPN #2 no longer is working at the facility. 1. Residents residing in the facility have the potential to be affected by the alleged deficient practice. 2. The facility's " Resident Rights" policy were reviewed and education provided to all staff emphasizing honor of resident's choices as outline in their care plan to include not wanting certain staff to provide care to them and definition of Self-determination. 3. To ensure preferences are being communicated effectively communication books have been placed on all units and staff education has been provided. 4. The DON or designee will do random resident interviews reviewing and assessing if they feel their rights are being met for (4) weeks, then monthly for two (2) months 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	

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	Administrator	12/16/2025

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F0561 SS = D	Continued from page 1 This REQUIREMENT is NOT MET as evidenced by: Based on observation, record review, and staff interview, the facility failed to honor residents' choices as outlined in their care plan for 1 of 3 sampled residents (Resident #3). Findings include: Per record review, Resident #3 has diagnoses including major depressive disorder, post-traumatic stress disorder, schizoaffective disorder, and borderline personality disorder. Per record review, a facility grievance dated 10/13/25 denotes that Resident #3 did not wish to have LPN #2 care for them. A progress note from 10/15/25 written by the Director of Nursing (DON) states they "Spoke with resident regarding grievance against nurse. [She/he] has stated that she/he feels that a certain nurse isn't as attentive as [she/he] should be and refused to give [her/him] a popsicle that [she/he] paid for. [She/he] would prefer this nurse not care for [her/him] anymore."Facility policy titled "Care Plans, Comprehensive, Person-Centered," reviewed/revised 2/2025 states, "A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident." Resident #3's care plan reads, "[Resident #3] has potential to exhibit behaviors that are a result of past trauma(s), which may impact my moods or behaviors as evidenced by Anxiety/ GAD [Generalized Anxiety Disorder, a mental health condition characterized by persistent and excessive worry about various everyday things], Schizophrenia / Schizo-effective disorder." That section of the care plan contains an intervention "[Resident #3] has requested that [LPN#2] not care for [her/him]. [She/he] understands that if [LPN#2] is working that it may take a bit longer to get a nurse from a different wing to attend to [her/his] needs. Date Initiated: 10/15/2025."Per record review, LPN #2 administered morning and evening medications and provided multiple treatments to Resident #3 on 10/21/25. LPN #2 also assessed the resident's pain level and oxygen saturation. When interviewed on 10/22/25 at 9:03 AM, Resident #3 confirmed she/he had submitted this grievance. Resident #3 stated she/he did not want care from LPN #2 and "did not like it." Per staff interview on 10/22/25 at 9:58 AM, the Administrator confirmed that the care plan stated that LPN #2 is not to care for Resident #3. She/he confirmed that LPN #2 had provided care to Resident #3 on 10/21/25. She/he stated that LPN #2 had been off from work and she/he had not gotten word to her/him in time of this change, before she/he provided care to Resident #3.	F0561	determine further frequency of the audits. 5. Corrective action will be completed by December 19, 2025. **Tag F 561 POC accepted on 12/17/25 by C. Howard/S. Stem**	

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F0561 F0607 SS=D SS = E	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(5)(ii)(iii) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, §483.12(b)(4) Establish coordination with the QAPI program required under §483.75. §483.12(b)(5) Ensure reporting of crimes occurring in federally-funded long-term care facilities in accordance with section 1150B of the Act. The policies and procedures must include but are not limited to the following elements. §483.12(b)(5)(ii) Posting a conspicuous notice of employee rights, as defined at section 1150B(d)(3) of the Act. §483.12(b)(5)(iii) Prohibiting and preventing retaliation, as defined at section 1150B(d)(1) and (2) of the Act. This REQUIREMENT is NOT MET as evidenced by: Based on interview and record review, the facility failed to implement written policies and procedures that prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property related to the screening of prospective employees 2 out of 5 sampled staff. Findings include: Per record review, LPN #1 [Licensed Practical Nurse] did not have any adult state background check. LPN#1 has been working at the facility since 9/15/25 without	F0561 F0607	1. Residents residing in the facility have the potential to be affected by the alleged deficient practice. LNA #1 and LPN #1 are no longer working at the facility. 2. The facility's " Abuse, Neglect and Exploitation" policy was reviewed and education provided to HR, Administrator and DON emphasizing on the required backgrounds needed to be on file prior to starting at the facility. 3. An initial audit was conducted on all current staff working at the facility to ensure the required background checks have been completed and in their files. 4. The DON or designee will verify all newly hired employees files to include agency staffing to ensure the required backgrounds have been completed and in their files prior to first day of work 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 December 19. 2025. **Tag F 607 POC accepted on 12/17/25 by C. Howard/S. Stem**	

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F0607 SS = E	Continued from page 3 a Vermont Adult Abuse Registry background check. Per record review LNA#1 [Licensed Nursing Assistant] did not have any Vermont state adult background check. LNA#1 has been working at the facility since 8/13/25 without a Vermont Adult Abuse Registry background check. Per the facility's "Abuse, Neglect, and Exploitation" policy [no revision date] states, "A. Screening: 1. A background check will be conducted on all new employees and volunteers to include the following: a. A request for information about all substantiated findings from the Department for Children and Families' Child Abuse Registry b. A request for information about all substantiated findings from the Department of Disabilities, Aging and Independent Living [DAIL] Adult Abuse Registry c. A request for information on criminal convictions from the Vermont Crime Information Center d. An online search of the exclusions database of the Department of Health and Human Services office of the Inspector General...4. Information received as a result of background checks will be maintained in the employee's/volunteer's personnel file." Per interview with the Administrator on 10/22/25 at 11:26 AM, the Administrator confirmed they did not have Vermont adult background checks for either LNA #1 or LPN#1. She stated, "They are agency and usually the agency does the background checks." The Administrator was able to give Vermont adult background checks, but they were dated 10/22/25, the day of the interview. The Administrator conveyed via email on 10/23/25 that Human Resources is responsible for background checks.	F0607		
F0609 SS = E	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	F0609	Resident #3 grievance that was filed on 8/11/25 has been reported to APS and Dail. Resident #3 grievance that was filed on 10/13/25 has been reported to APS and Dail. 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	

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F0609 SS = E	Continued from page 4 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 three allegations of abuse to the state for one of two sampled residents (Resident #3). This is a repeat deficiency for this facility, with the violation cited during a previous partial survey, dated 3/3/25. Findings include: Per record review of the facility's "Abuse, Neglect, and Exploitation" policy p[no revision date] states, "Mental and verbal abuse: Is the use of verbal and nonverbal conduct which causes or has the potential to cause the resident to experience humiliation, intimidation, fear, shame, agitation, or degradation…G. Reporting/Response Abuse Neglect and Exploitation Procedure Form-CLR 1. For any actual or suspicious act of or sign of abuse, neglect or exploitation it is the responsibility of every employee and volunteer to make sure the resident is safe first. 2. Every employee and volunteer of CLR are mandated reporters and must cause a report to be made to APS [Adult Protective Services] by reporting any actual or suspected abuse, neglect or exploitation immediately to their supervisor." Per record review, a grievance filed by Resident #3 dated 8/11/25 states, "[Resident #3] Told me that during the overnight shift on 8/10 that [s/he] requested to see the nurse on duty for [his/her] throat and that she was told no by the LNA [Licensed Nursing Assistant] times 3 the last time [s/he] asked the LNA told her to stop [expletive] playing games walked out and slammed [his/her] door shut behind her." Per record review, a grievance filed 10/13/25, stated, "[Resident #3] Stated nurse told [him/her] to shut up and go to sleep it was midnight and [s/he] was asking for a popsicle [s/he] doesn't want [licensed nurse] to be [his/her] nurse if she's going to be mean to	F0609	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 review grievances and 24-hour report daily reviewing for any potential abuse for (4) weeks, then monthly for two (2) months to ensure abuse is being reported timely 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 December 19, 2025. **Tag F 609 POC accepted on 12/17/25 by C. Howard/S. Stem**	

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F0609 SS = E	Continued from page 5 [him/her]." There was no evidence or records that the above situations were reported to the state agency. Per interview with the Administrator on 10/21/25 at 3:04 PM, the Administrator confirmed these events were not reported to the state agencies.	F0609		
F0610 SS = E	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §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 investigate two of four sampled allegations of abuse for Resident #3. This is a repeat deficiency for this facility, with the violation cited during the previous recertification survey, dated 3/27/25. Findings include: Per record review of the facility's "Abuse, Neglect, and Exploitation" policy [no revision date], it states, "E. Investigation 1. Person witnessing the incident or receiving the alleged abuse, neglect or exploitation complaint will immediately make sure the resident is safe and then notify his/her supervisor 2. Supervisor will immediately notify the shift supervisor, who will notify the Administrator. 3. Shift supervisor will meet and discuss the complaint with the alleged victim if he/she is able, witness(s) [sic] if any, and alleged	F0610	Investigation was completed for both allegations of abuse for resident #3 and have been reported to APS and Dail. 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, Abuse, Neglect and Exploitation, and Abuse Prevention Program" policies 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 thoroughly investigation all potential abuse. 4. The DON or designee will review grievances and 24-hour report daily reviewing for any potential abuse for (4) weeks, then monthly for two (2) months to ensure investigations are being completed and to monitor effectiveness of the plan. 5. Results of the audits will be reported to the QAA committee x3 months at	

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F0610 SS = E	Continued from page 6 perpetrator to make a written report…1. 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…" Per record review of a grievance filed by Resident #3 dated 8/11/25 states, "[Resident #3] told me that during the overnight shift on 8/10 that [s/he] requested to see the nurse on duty for [his/her] throat and that [s/he] was told no by the LNA [Licensed Nursing Assistant] times 3 the last time [s/he] asked the LNA told her to stop [expletive] playing games walked out and slammed [his/her] door shut behind her." Per record review of a grievance filed 10/13/25, stated, "[Resident #3] Stated nurse told [him/her] to shut up and go to sleep it was midnight and [s/he] was asking for a popsicle [s/he] doesn't want [licensed nurse] to be [his/her] nurse if she's going to be mean to [him/her]." There was no evidence or record that shows that these allegations were investigated by the facility. Per interview with the Administrator on 10/21/25 at 3:04 PM, the administrator confirmed the facility did not do an internal investigation into any of the three mentioned grievances alleging abuse.	F0610	which time the QAA committee will determine further frequency of the audits. 6. Corrective action will be completed by December 19, 2025. **Tag F 610 POC accepted on 12/17/25 by C. Howard/S. Stem**	
F0761 SS = D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled In accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately	F0761	1. Residents residing in the facility have the potential to be affected by the alleged deficient practice. 2. The facility's " Storage of Medications" policy was reviewed and education provided to the licensed nursing staff (RNs, LPNs) emphasizing medications are not to be left unattended. 3. The DON or designee will do observational audit for (4) weeks, then monthly for two (2) months to ensure medications are being stored as per policy and not being left unattended and to monitor effectiveness of the plan.	

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F0761 SS = D	Continued from page 7 locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is NOT MET as evidenced by: Based on observation and interview, the facility failed to store medications appropriately on one randomly observed medication cart, potentially impacting residents on 1 of 2 units. Findings include: Per observation on 10/22/25 at 8:53 AM, an unopened Lidocaine 5% patch was found to be on top of the medication cart on the second floor. There was one resident sitting in the hallway, one resident self-propelling, and 8 residents in the dining room. Per record review of the facility's "Storage of Medications" policy [last revised 1/2025] states, "3. During a medication pass medications must be under the direot observation of the person administering medications or locked in the Med storage area/cart." An interview was conducted with Licensed Nurse #1 on 10/22/25 at 8:58 AM. She confirmed she left the lidocaine patch on the top of the medication cart unsupervised stating, "I was just coming out of a patient's room. The resident didn't want the patch, so I left it at the cart."	F0761	4. The DON or designee will do observational audits for (4) weeks, then monthly for two (2) months to ensure medication are being stored properly, not left unattended are 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 December 19, 2025. **Tag F 761 POC accepted on 12/17/25 by C. Howard/S. Stem**	