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

March 16, 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 **February 17, 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 02/17/2026

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 two complaints and one FRI [Facility Reported Incident], including reports #2717739, #2718446, and #2661298 on 2/17/26 to determine compliance with 42 CFR Part 483 requirements for Long Term Care Facilities. The following regulatory deficiency was 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 Self Report initiated on 11/5/25 was initiated per regulatory requirement. The final results of the investigation were submitted by day 5 per regulatory requirement. However, it was sent to the incorrect email. Investigation results were resubmitted to the correct email on 2/17/26 when the error was discovered. 1. Residents residing in the facility have the potential to be affected by the alleged deficient practice. 2. The facility's "Abuse, prevention and prohibition program" reviewed with updates as needed. Education provided to LNHA and DON emphasizing timely investigation and submission accuracy.	
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 record review and staff interview, the	F0609		

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F0609 SS = D	Continued from page 1 facility failed to ensure that a facility investigation of abuse was submitted to the state agency within the required five-day timeframe. Findings include: On 11/5/25 the State Survey Agency received an online self-report regarding allegations of staff to resident neglect/abuse for an incident that occurred on 11/3/25. The State Survey Agency did not receive a report of the facility's investigation results within 5 working days of the alleged incident. Per interview with the Administrator on 2/17/26 at approximately 1:45 PM, s/he stated the facility's investigation summary was sent to the State Survey Agency on 11/10/26 and provided an email receipt of the summary. Upon review of the email receipt, the summary was sent to an incorrect email address. The Administrator confirmed the email address used was not the correct email address to submit a facility's investigation summary. Per facility policy titled "Abuse Prevention and Prohibition Program," reviewed/revised 12/2025, "The Administrator will provide the state survey agency, law enforcement and the Ombudsman with a copy of the investigative report within 5 days of the incident."	F0609	3. The Administrator and/or designee will review all self-reports to ensure 5 day investigation results submitted to the correct state survey contact daily for (4) weeks, then monthly for two (2) months to ensure abuse is being reported timely to the correct state contact per the plan of correction. 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 March 20, 2026 **Tag F 609 POC accepted on 3/16/26 by C. Howard/S. Stem**	