



AGENCY OF HUMAN SERVICES
DEPARTMENT OF DISABILITIES, AGING AND INDEPENDENT LIVING

Division of Licensing and Protection
HC 2 South, 280 State Drive
Waterbury, VT 05671-2060
<http://www.dail.vermont.gov>
Survey and Certification Voice/TTY (802) 241-0480
Survey and Certification Fax (802) 241-0343
Survey and Certification Reporting Line: (888) 700-5330
To Report Adult Abuse: (800) 564-1612

August 2, 2023

Cassandra Pitts, Administrator
Springfield Health & Rehab
105 Chester Rd
Springfield, VT 05156-2106

Provider #: 475025

Dear Ms. Pitts:

The Division of Licensing and Protection conducted an onsite complaint investigation on **July 31, 2023**. The purpose of the investigation was to determine if your facility was in compliance with Federal participation requirements of the Medicare/Medicaid Program. The investigation was completed on **July 31, 2023**, and there were no regulatory violations related to the complaint allegations.

Sincerely,

Pamela M. Cota RN
Pamela M. Cota, RN
Licensing Chief

Enclosure

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

PRINTED: 08/02/2023
FORM APPROVED
OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 475025 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | | (X3) DATE SURVEY COMPLETED C 07/31/2023 |
|---|--|---|---|----------------------|---|
| NAME OF PROVIDER OR SUPPLIER SPRINGFIELD HEALTH & REHAB | | | STREET ADDRESS, CITY, STATE, ZIP CODE 105 CHESTER RD SPRINGFIELD, VT 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 | |
| F 000 | INITIAL COMMENTS The Division of Licensing and Protection conducted an onsite, unannounced investigation of complaint #22086 on 7/31/23. There were no regulatory findings related to this investigation. | F 000 | | | |
| 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.