

Division of Licensing and Protection
103 South Main Street
Waterbury, VT 05671-2306
<http://www.dail.vermont.gov>
Voice/TTY (802) 871-3317
To Report Adult Abuse: (800) 564-1612
Fax (802) 871-3318

September 3, 2015

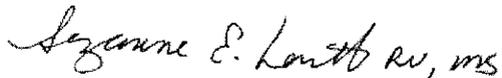
Timothy Ford, Administrator
Springfield Hospital
Po Box 2003
Springfield, VT 05156-2003

Provider #: 471306

Dear Mr. Ford:

The Division of Licensing and Protection conducted an onsite complaint investigation on **September 1, 2015**. 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 **September 1, 2015** and there were no regulatory violations related to the complaint allegations.

Sincerely,



Suzanne Leavitt, RN, MS
Assistant Division Director
Director State Survey Agency

Enclosure



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

PRINTED: 09/03/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 471306	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 09/01/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SPRINGFIELD HOSPITAL	STREET ADDRESS, CITY, STATE, ZIP CODE PO BOX 2003 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
--------------------	--	---------------	---	----------------------

C 000	<p>INITIAL COMMENTS</p> <p>An unannounced on-site investigation was conducted by the Division of Licensing and Protection on 8/31/15 and 9/1/15 to determine compliance with Conditions of Participation as related to one complaint and one facility self-report. There were no regulatory violations identified as a result of the survey.</p>	C 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.