



**Department of Disabilities, Aging and
Independent Living**
Division of Licensing and Protection
280 State Drive/HC 2 South
Waterbury, VT 05671-2060
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AGENCY OF HUMAN SERVICES

May 16, 2025

Ms. Coleen Condon, Administrator
Franklin County Rehab Center, LLC
110 Fairfax Road
St Albans, VT 05478-6299

Provider ID #: 475047

Dear Ms. Condon:

The Department of Public Safety completed a Life Safety Code Survey at your facility on **May 5, 2025**. This survey found your facility to be in Substantial Compliance with all Fire Safety and ANSI standards.

Enclosed is the Deficiency Summary Sheet, Form CMS-2567, which requires your signature in accordance with instructions noted on the form. Please return the form to this office no later than **May 26, 2025**.

If you have any questions regarding this report, please do not hesitate to contact me.

Sincerely,

A handwritten signature in black ink that reads "tammy wehmeyer" in a cursive, lowercase style.

Tammy Wehmeyer
Administrative Services Manager

Enclosure

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

PRINTED: 05/16/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 475047		(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 05/05/2025	
NAME OF PROVIDER OR SUPPLIER FRANKLIN COUNTY REHAB CENTER LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 110 FAIRFAX ROAD ST ALBANS, VT 05478			
(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
K 000	INITIAL COMMENTS The Division of Fire Safety completed an unannounced onsite Life Safety Code inspection on 5/5/25. The facility was found to be in substantial compliance with applicable Life Safety Code requirements.			K 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.