VERMONT

Department of Disabilities, Aging and Independent Living
Division of Licensing and Protection
280 State Drive/HC 2 South
Waterbury, VT 05671-2060
www.dlp.vermont.gov

[phone] 802-241-0344
[fax] 802-241-0343

AGENCY OF HUMAN SERVICES

September 25, 2025

Ms. Deana Mattison, Administrator
The Villa Rehab
7 Forest Hill Drive
St. Albans, VT 05478

Provider ID #: 475055

Dear Ms. Mattison:

Enclosed is a copy of your acceptable revised plans of correction for the recertification survey conducted on **July 30, 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: 475055	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Villa Rehab	7 Forest Hill Drive , St. Albans, Vermont, 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
E0000	Initial Comments The Division of Licensing and Protection conducted an onsite, unannounced survey of the facility's emergency preparedness program on 7/30/2025 during an annual re-certification survey. There were no regulatory violations related to emergency preparedness as a result of this survey.	E0000	**F 0604 – Right to be free from physical restraints** **1. The resident has been discharged from the facility. There is no action to be taken for this resident.**	
F0000	INITIAL COMMENTS The Division of Licensing and Protection conducted an unannounced, onsite recertification survey and investigation of one complaint, report #2570304, from 7/28/2025 through 7/30/2025 to determine compliance with 42 CFR Part 483 requirements for Long Term Care Facilities. Deficiencies were cited as a result of this survey.	F0000	**2. All residents have the potential to be affected by the same deficient practice. Ongoing training will occur with focus on residents with behaviors.** **3. Policies and procedures related to physical restraints will be reviewed for accuracy and all staff will be provided with education regarding proper redirection, dementia, behavioral interventions, and resident elopement emergency training. All agency staff will be trained on proper facility procedures prior to working in the facility.** **4. Corrective action will be monitored through chart review. DON will review all charts with reported behaviors for one month. If all charts are accurate and appropriate, chart review will decrease to review and oversight as needed. DON will report to QAPI that proper procedure was followed. DON and Administrator will round on residents with known behaviors to ensure proper staff interactions. Improper interactions will result in immediate education and be followed**	
F0604 SS = D	Right to be Free from Physical Restraints CFR(s): 483.10(e)(1),483.12(a)(2) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(1) The right to be free from any physical . . . restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2). §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must-	F0604		08/29/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 475055	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Villa Rehab	7 Forest Hill Drive , St. Albans, Vermont, 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
F0604 SS = D	Continued from page 1 §483.12(a)(2) Ensure that the resident is free from physical . . . restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. When the use of restraints is indicated, the facility must use the least restrictive alternative for the least amount of time and document ongoing re-evaluation of the need for restraints. This REQUIREMENT is NOT MET as evidenced by: Based on interview and record review the facility failed to ensure that one of three residents (Resident #16) was free from physical restraints. During staff use of physical restraint Resident #16 became more agitated, aggressive, and resistive to redirection causing combative behavior, and threatening to hurt staff. As a result of the aggressive behaviors the facility refused to allow the Resident to return to the facility causing an extended stay in the hospital. Findings include: Per record review of progress notes between the hours of 7:00 AM and 12:00 PM Resident #16 made several attempts to exit the building throughout the morning. A progress note dated 7/19/2025 reveals that the Wander Guard alarm went off as Resident #16 went out the back door. A Licensed Nursing Assistant (LNA) went after her/him. While outside the Resident started heading to the end of the street to go through the bushes to head home. The LNA stayed with her/him for their safety. At this time, the Resident threatened to punch her if she did not remove her arm from behind her/his back. This nurse went to assist the LNA in getting the Resident back into the building. The note states "[Resident #16] was not having any part of this. " The LNA and RN (Registered Nurse) were able to guide the Resident back toward the building as the Resident turned quickly pushing the nurse's arm away from her/him and then drew her/his arm back to punch the RN. The Resident was guided again back toward the building. The LNA and RN were able to get the Resident heading back to the building but [the Resident] started to struggle and told the RN to take their hand off her/him or s/he was going to punch the RN in the face. Once the Resident was back in the facility the RN called the DON and was instructed to send the Resident to the emergency room for evaluation of altered mental status. The RN documents in the progress note that she informed the family that the facility would not be holding the Resident's bed. Per review of a First Report of Injury form completed on 7/20/2025 by the RN the description	F0604	up with during QAPI. Annual education will be completed with all staff. Date of Completion: 8/29/2025 Tag F 604 POC accepted on 9/25/25 by P. Cota	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 475055	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Villa Rehab	7 Forest Hill Drive , St. Albans, Vermont, 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
F0604 SS = D	Continued from page 2 of the event was "Resident eloped, refusing to return. Assisted resident back to facility due to unstable gait and altered balance. Resident was physically combative and verbally abusive. Resident jerked away from hold and my knee twisted. Resident became physically combative pulling and pushing myself and [LNA]." Per review of the facility's Internal investigation for incident on 7/19/2025, the facility was informed by the Case Manager at the hospital that the Resident had reported being pushed to the ground. Per an interview conducted by administration on 7/23/2025 with the LNA who was present during the incident on 7/19/2025, the LNA reflects that there is a path at the end of the cul-de-sac that the LNA physically blocked so the Resident would not go through. The RN joined her in attempting to get the Resident back into the building, and a CPI [Crisis Prevention Institute] maneuver was utilized per the RN's instructions. The LNA describes this as a hold with both the LNA and RN on one side of the Resident locking arms and walking with the Resident guiding where s/he would go. The LNA reports that there was a firm grip from the Resident at one point bending her hand backwards. The LNA reported that the RN's instruction was to lower the Resident to the ground." Per review of Resident #16's Physicians orders there was no order for the use of the CPI maneuver. During an interview with the Director of Nursing (DON) and the Administrator on 7/29/2025 at 9:50AM when discussing the facility internal investigation, the Administrator described the CPI maneuver as the RN and LNA locking arms and using their (the staff's) body weight to direct the Resident back to the facility. Resident #16 became aggressive and threatened that he was going to hit them. Review of Resident #16's care plan reveals a focus initiated on 7/16/2025 of "A secure care wander guard was placed on [the Resident's] right ankle due to risk of elopement" with interventions that include "1:1 visits as needed," "Engage [resident] in facility activities as able," and "Redirect/reorient [resident] as needed." There is no documented evidence that staff attempted 1:1 visits or engaged the Resident in facility activities on the morning of 7/19/2025. The care plan does not include the use of CPI maneuvers to manage elopement or aggressive behaviors for Resident #16. Another care plan focus states "[Resident} receives an antipsychotic medication for symptoms of delirium following acute CVA" with intervention initiated on 7/11/2025 of "Monitor and notify MD of negative effects of medications- increase in agitation or anxiety, insomnia, parkinsonism, feelings of suicide, dizziness, hallucinations, mania, impaired concentration, tachycardia, orthostatic hypotension, syncope, constipation." There is no evidence that the physician	F0604		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 475055	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Villa Rehab	7 Forest Hill Drive , St. Albans, Vermont, 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
F0604 SS = D	Continued from page 3 was made aware of the Residents increase confusion, anxiety, and agitation. During an interview on 7/29/2025 at 1:36 PM with the RN who was on duty at the time of the incident, she explained that when she arrived on duty the morning of 7/19/2025, Resident #16 wanted to leave because her/his partner had been in a bad accident. The RN stated that at this time she was able to redirect the Resident. When the night shift staff were leaving, Resident #16 tried to go out with them and the wander guard alarm went off. The night shift brought her/him back. S/He was a little upset about having to return but ate breakfast and took her/his medication. The RN reported that the Resident was anxious and irritable but not combative, kind of obstinate. A short time later the wander guard went off again and she found her/him in the cul-de-sac with an LNA. The LNA and RN "steered her/him around to try to get her/him back. The Resident said "take your hands off me or I'm going to punch you." Resisting and pulling again the RN asked the LNA if she knew CPI, she did not so the RN told the LNA what to do. The RN stated that at that time the Resident laid down in the yard of the neighbor and was no longer combative. When they tried to stand the Resident up s/he stated, "If you don't take your hands off me I'm gonna punch you in the face." The son had arrived and was upset with the Resident for saying that, so the RN told the son "Let me be the bad guy." The Resident settled down and we brought her/him in, and s/he tried to go out again." The RN stated that she has a background in mental health nursing. When asked if CPI was a technique that was approved by the facility, she said that she had received the training prior to working at this facility. When asked why staff hadn't increased supervision or provided 1:1 throughout the morning the RN stated that she was giving her/him space. The RN also was asked if she had reached out to the physician regarding the increased behaviors throughout the morning and she said no she hadn't. Per interview with the Administrator and the DON on 7/30/2025 at approximately 12:30 PM the Administrator confirmed that the RN on duty during the elopement did use CPI Crisis Prevention Institute Nonviolent Crisis Intervention however, it is not a program approved for use by staff at this facility. The Administrator confirmed that CPI is not part of their protocol for use with residents in crisis.	F0604		
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	F0609		08/29/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 475055	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Villa Rehab	7 Forest Hill Drive , St. Albans, Vermont, 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
F0609 SS = D	Continued from page 4 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 interview and record review the facility failed to ensure that an allegation of staff to resident abuse was reported to the licensing agency for one of three residents in the applicable sample (Resident #16). Findings include: Per review of a facility Internal Investigation for an incident on 7/19/2025, Resident #16 was transferred to the hospital due to increased behaviors on 7/19/2025. The hospital case manager alerted the facility Director of Nursing (DON) that while at the hospital, Resident #16 had made an allegation that staff had pushed her/him to the ground by a staff member prior to being transferred to the hospital. The internal investigation did not include evidence that the allegation had been reported to the State Licensing Agency. Per interview on 7/29/2025 at 8:45 AM with the Administrator and DON the Case Manager from the hospital had sent an email to the DON stating that she had made a report to Adult Protective Services regarding an allegation from Resident #16 that she/he had been pushed. The Administrator and DON confirmed that they had done an internal investigation of the incident, but they did not file a report with the licensing agency.	F0609	**F 0609 – Reporting of Alleged Violations** **1. Corrective action has been completed. The state agency completed review of the allegation.** **2. Any resident that has the potential to be affected by improper reporting will be identified through chart review after a high risk event.** **3. Proper policy and procedure have been reviewed. DON and Administrator will review all reports and create an audit form to ensure all notifications have been made.** **4. Any allegations will be immediately reviewed. Improper reporting will be brought to the attention of the owner for review and action for not following policy and procedure.** **Date of Completion: 8/29/2025** **Tag F 609 POC accepted on 9/25/25 by P. Cota**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 475055	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Villa Rehab	7 Forest Hill Drive , St. Albans, Vermont, 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
F0609 F0627 SS=D SS = D	Inappropriate Discharge CFR(s): 483.15(c)(1)(2)(i)(ii)(7)(e)(1)(2);483.21(c)(1)(2) §483.15(c) Transfer and discharge- §483.15(c)(1) Facility requirements- §483.15(c)(1)(i) The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless- (A)The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility; (B)The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility; (C)The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident; (D)The health of individuals in the facility would otherwise be endangered; (E)The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. Nonpayment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or (F)The facility ceases to operate. §483.15(c)(1)(ii) The facility may not transfer or discharge the resident while the appeal is pending, pursuant to § 431.230 of this chapter, when a resident exercises his or her right to appeal a transfer or discharge notice from the facility pursuant to § 431.220(a)(3) of this chapter, unless the failure to discharge or transfer would endanger the health or safety of the resident or other individuals in the facility. The facility must document the danger that failure to transfer or discharge would pose.	F0609 F0627	F 0627 – Inappropriate Discharge 1. The resident is no longer under the care of the facility. Any referral made to return to the facility will be reviewed at that time for appropriate admittance. 2. Any resident with the potential to be affected would be brought to administration's attention by any staff. Any residents discharged for care related reasons will require an immediate meeting between the DON, Administrator, Physician, and the family. Nursing staff will be educated regarding the discharge process. 3. Policies and procedures will be reviewed and updated to ensure all staff know how to properly handle this situation. If this situation occurs, an investigation of the resident chart and proper notification will occur by administration for all emergency discharges going forward. 4. Corrective actions will be monitored by the administrative team by completing a chart review when indicated. Date of Completion: 8/29/2025 Tag F 627 POC accepted on 9/25/25 by P. Cota	08/29/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 475055	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Villa Rehab	7 Forest Hill Drive , St. Albans, Vermont, 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
F0627 SS = D	Continued from page 6 §483.15(c)(2) Documentation. When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider. (i)Documentation in the resident's medical record must include: (A) The basis for the transfer per paragraph (c)(1)(i) of this section. (B) In the case of paragraph (c)(1)(i)(A) of this section, the specific resident need(s) that cannot be met, facility attempts to meet the resident needs, and the service available at the receiving facility to meet the need(s). (ii)The documentation required by paragraph (c)(2)(i) of this section must be made by- (A) The resident's physician when transfer or discharge is necessary under paragraph (c) (1) (A) or (B) of this section; and (B) A physician when transfer or discharge is necessary under paragraph (c)(1)(i)(C) or (D) of this section. §483.15(c)(7) Orientation for transfer or discharge. A facility must provide and document sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge from the facility. This orientation must be provided in a form and manner that the resident can understand. §483.15(e)(1) Permitting residents to return to facility. A facility must establish and follow a written policy on permitting residents to return to the facility after they are hospitalized or placed on therapeutic leave. The policy must provide for the following. (i)A resident, whose hospitalization or therapeutic leave exceeds the bed-hold period under the State plan,	F0627		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 475055	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Villa Rehab	**7 Forest Hill Drive , St. Albans, Vermont, 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
F0627 SS = D	Continued from page 7 returns to the facility to their previous room if available or immediately upon the first availability of a bed in a semi-private room if the resident- (A) Requires the services provided by the facility; and (B) Is eligible for Medicare skilled nursing facility services or Medicaid nursing facility services (ii)If the facility that determines that a resident who was transferred with an expectation of returning to the facility, cannot return to the facility, the facility must comply with the requirements of paragraph (c) as they apply to discharges. §483.15(e)(2) Readmission to a composite distinct part. When the facility to which a resident returns is a composite distinct part (as defined in § 483.5), the resident must be permitted to return to an available bed in the particular location of the composite distinct part in which he or she resided previously. If a bed is not available in that location at the time of return, the resident must be given the option to return to that location upon the first availability of a bed there. §483.21(c)(1) Discharge Planning Process The facility must develop and implement an effective discharge planning process that focuses on the resident's discharge goals, the preparation of residents to be active partners and effectively transition them to post-discharge care, and the reduction of factors leading to preventable readmissions. The facility's discharge planning process must be consistent with the discharge rights set forth at 483.15(b) as applicable and- (i) Ensure that the discharge needs of each resident are identified and result in the development of a discharge plan for each resident. (ii) Include regular re-evaluation of residents to identify changes that require modification of the discharge plan. The discharge plan must be updated, as needed, to reflect these changes. (iii) Involve the interdisciplinary team, as defined by §483.21(b)(2)(ii), in the ongoing process of developing the discharge plan. (iv) Consider caregiver/support person availability and	F0627		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 475055	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Villa Rehab	**7 Forest Hill Drive , St. Albans, Vermont, 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
F0627 SS = D	Continued from page 8 the resident's or caregiver's/support person(s) capacity and capability to perform required care, as part of the identification of discharge needs. (v) Involve the resident and resident representative in the development of the discharge plan and inform the resident and resident representative of the final plan. (vi) Address the resident's goals of care and treatment preferences. (vii) Document that a resident has been asked about their interest in receiving information regarding returning to the community. (A) If the resident indicates an interest in returning to the community, the facility must document any referrals to local contact agencies or other appropriate entities made for this purpose. (B) Facilities must update a resident's comprehensive care plan and discharge plan, as appropriate, in response to information received from referrals to local contact agencies or other appropriate entities. (C) If discharge to the community is determined to not be feasible, the facility must document who made the determination and why. (viii) For residents who are transferred to another SNF or who are discharged to a HHA, IRF, or LTCH, assist residents and their resident representatives in selecting a post-acute care provider by using data that includes, but is not limited to SNF, HHA, IRF, or LTCH standardized patient assessment data, data on quality measures, and data on resource use to the extent the data is available. The facility must ensure that the post-acute care standardized patient assessment data, data on quality measures, and data on resource use is relevant and applicable to the resident's goals of care and treatment preferences. (ix) Document, complete on a timely basis based on the resident's needs, and include in the clinical record, the evaluation of the resident's discharge needs and discharge plan. The results of the evaluation must be discussed with the resident or resident's representative. All relevant resident information must be incorporated into the discharge plan to facilitate its implementation and to avoid unnecessary delays in the resident's discharge or transfer. §483.21(c)(2) Discharge Summary	F0627		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 475055	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Villa Rehab	**7 Forest Hill Drive , St. Albans, Vermont, 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
F0627 SS = D	Continued from page 9 When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following: (iv) A post-discharge plan of care that is developed with the participation of the resident and, with the resident's consent, the resident representative(s), which will assist the resident to adjust to his or her new living environment. The post-discharge plan of care must indicate where the individual plans to reside, any arrangements that have been made for the resident's follow up care and any post-discharge medical and non-medical services. This REQUIREMENT is NOT MET as evidenced by: Based on interview and record review, the facility refused to allow a resident to return to the facility after being transferred to the hospital and inappropriately discharged the resident, for one of three residents in the applicable sample (Resident #16). Findings include: Per record review, Resident #16 was admitted to the facility after a stay at the hospital for treatment of a stroke. Admission diagnoses include aphagia (a brain disorder that affects how you speak and understand language. It happens after damage to the language processing center of your brain), and cognitive communication deficit (difficulties in communication that arise from impairments in cognitive processes, such as attention, memory, and problem-solving). An Admission Summary progress note dated 7/11/2025 reflects that Resident #16 was alert and oriented x 3 (person, place, and time), though has a "history of forgetfulness in the evening, redirectable... Family reports sundowning [a state of confusion, agitation, and restlessness that some individuals with dementia or other cognitive impairments experience in the late afternoon and evening] in the evening since being in the hospital. Resident is impulsive and tends to want to get up on [her/his] own." Review of a MDS (Minimum Dats Set, a standardized, comprehensive assessment of an adult's functional, medical, psychological, and cognitive status) with an assessment reference date of 7/17/2025 reveals a Brief Interview for Mental Status (BIMS) score of 12 which suggests mild cognitive impairment. A progress note dated 7/12/2025 reveals that Resident #16 was "walking/pacing around the room unassisted without walker. Resident had a frowned look on [her/his] face and began speaking in an agitated manner to this nurse... This resident began stating,	F0627		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 475055	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Villa Rehab	**7 Forest Hill Drive , St. Albans, Vermont, 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
F0627 SS = D	Continued from page 10 'I'm leaving. I passed all my tests, and I am going home.' This nurse explained to the resident that [s/he] is here to have therapy following [her/his] recent stroke. Resident became very irritated with this nurse and asked me to leave the room... At approximately [8:20 PM] resident came walking past the nurses station into the main lobby at a very fast pace with son following behind [her/him]. Again, without the use of [her/his] assistive device. This nurse immediately went to resident and attempted to offer the walker and assistance. Resident shoved this nurses arm and said, 'don't touch me' Resident became unsteady and began to go flaccid." Resident #16 was sent to the hospital for evaluation and returned with a diagnosis of dehydration and syncope (temporary loss of consciousness). There is no evidence in the Resident's medical record that a bed hold, or transfer/discharge notice was provided to the Resident or their family member. Per a progress note dated 7/19/2025, Resident #16 was exhibiting confusion regarding the wellbeing of their partner and their children and was attempting to leave the facility. Staff redirected the Resident several times and then s/he exited the facility through a door on Hall #3. A Licensed Nursing Assistant (LNA) saw her/him leaving and followed her/him out. While the LNA and a Registered Nurse (RN) were attempting to redirect her/him, the resident became aggressive, threatening, and combative. S/He was sent to the ED and was not allowed to return based on her/his condition at the time of transfer. The progress notes further state "This nurse spoke with [Director of Nursing (DON)] about the events, and she requested that [the Resident] be transferred to the ED [emergency department] for Altered Mental Status and Aggressive Behavior. Also, due to aggressive and combative behavior [her/his] bed would not be held and this was explained to the family." There is no documented evidence that a bed hold, or transfer notice was provided to the Resident. Per interview with the Administrator and DON on 7/29/2025 at 8:45 AM confirmed that the RN had told the family and the case manager at the receiving hospital that the Resident would not be able to return to the facility. Review of the Facility Assessment that details the facility population and what resources are necessary to care for the residents competently during both day-to-day operations and emergencies states that the building is equipped with Entry/Exit Accessibility Equipment code alert wander system. A facility policy titled Elopements and Wandering Residents last reviewed on 5/1/2025 states, Policy: This facility ensures that residents who exhibit wandering behavior and/or are at risk for elopement receive adequate supervision to prevent accidents, and receive care in accordance with their person-centered plan of care addressing unique	F0627		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 475055	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Villa Rehab	7 Forest Hill Drive , St. Albans, Vermont, 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
F0627 SS = D	Continued from page 11 factors contributing to wandering or elopement risk." Under section 6. Procedure Post Elopement part f, "When repeated elopement attempts occur, after the facility has exhausted possible care approaches, the resident may be referred for alternate placement in an appropriate facility." There is no documented evidence that the facility attempted to refer Resident #16 to an appropriate facility. Although Resident #16 had been exhibiting behaviors throughout the morning there is no documented evidence that the Resident's physician was consulted with or notified regarding the above behaviors prior to transfer to the hospital. There is also no documented evidence that the Physician evaluated the Resident's status prior to the facility determining that the Resident's needs could not be met. Per interview on 7/30/2025 at 11:50 AM the RN who was on duty during the 7/19/2025 incident confirmed that the Resident's physician was not consulted with or notified of the Resident's behaviors and attempted elopements prior to being sent out to the hospital. Per interview with the hospital Case Manager on 7/30/2025 at 10:45 AM the RN on duty on 7/19/2025 had stated that the facility would not be taking the Resident back. Resident #16 has remained in the hospital waiting for an appropriate facility to accept her/him, since the transfer on 7/19/2025. Per interview with the facility Owner 7/30/2025 at approximately 3:15 PM she confirmed that the facility does admit residents who are at risk for wandering and elopement, but due to the Resident's violent behaviors, the facility could not care for her/him. Review of a letter dated 7/22/2025 that was sent to the Resident from the Administrator reads "The administrative team at The Villa Rehab Center has met and has determined that at this time we will not be accepting you back at our facility. We are not able to meet your current needs due to recent behaviors including eloping and physical violence. As you know these behaviors have impacted our staff and other residents of this facility, as well as the care we are able to provide to you. The behaviors endangered the health and wellbeing if individuals in the facility. As of today, since this letter is serving as a discharge from our facility, we will no longer be able to monitor the care you are receiving at the hospital as you are no longer our patient. If you would like us to continue to monitor your care while you remain in the hospital to see if at some point you are again appropriate to return and would like to return, please let us know... Should you wish to appeal this decision, you will be required to remain in the hospital during that time due to the potential for endangerment to the staff and residents of this facility..." Handwritten on the notice is "Mailed to [the Resident] 7/22" and "Mailed to state ombudsman 7/22/2025." Per interview on	F0627		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 475055	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Villa Rehab	7 Forest Hill Drive , St. Albans, Vermont, 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
F0627 SS = D	Continued from page 12 7/30/2025 at approximately 3:30 PM, the owner was asked if the facility had notified the State Agency of the emergency discharge. She said she had not because it was not an emergency discharge. A copy of an email that was sent to the Ombudsman on 7/22/2025 that was provided by the Administrator states "I am the Administrator of The Villa Rehab in St. Albans, Vermont. I'm reaching out due to an emergency discharge we've had to initiate."	F0627		
F0628 SS = F	Discharge Process CFR(s): 483.15(c)(2)(iii)(3)-(6)(8)(d)(1)(2); 483.21(c)(2) §483.15(c)(2) Documentation. When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider. (iii) Information provided to the receiving provider must include a minimum of the following: (A) Contact information of the practitioner responsible for the care of the resident. (B) Resident representative information including contact information (C) Advance Directive information (D) All special instructions or precautions for ongoing care, as appropriate. (E) Comprehensive care plan goals; (F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care. §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's	F0628	**F 0628 – Discharge Process** **1. A review of the two residents' discharges will be completed to ensure proper paperwork is completed and complete paperwork if needed so the discharge process is up to date.** **2. All residents will be identified by discharge status. Unaccounted for paperwork will be completed immediately.** **3. Education on discharge process and new policy and procedures regarding discharge process will be given to all nursing staff and social services for all required discharge forms.** **4. Corrective actions will be monitored by DON reviewing resident charts for all discharge paperwork for one month. An audit form will be created to ensure this action is completed. DON will report findings to QAPI.** **Date of Completion: 9/5/2025** **Tag F 628 POC accepted on 9/25/25 by P. Cota**	09/05/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 475055	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Villa Rehab	**7 Forest Hill Drive , St. Albans, Vermont, 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
F0628 SS = F	Continued from page 13 representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge;	F0628		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 475055	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Villa Rehab	7 Forest Hill Drive , St. Albans, Vermont, 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
F0628 SS = F	Continued from page 14 (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). §483.15(d) Notice of bed-hold policy and return-	F0628		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 475055	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Villa Rehab	**7 Forest Hill Drive , St. Albans, Vermont, 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
F0628 SS = F	Continued from page 15 §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. §483.21(c)(2) Discharge Summary When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following: (i) A recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results. (ii) A final summary of the resident's status to include items in paragraph (b)(1) of §483.20, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or resident's representative. (iii) Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over-the-counter). This REQUIREMENT is NOT MET as evidenced by:	F0628		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 475055	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Villa Rehab	**7 Forest Hill Drive , St. Albans, Vermont, 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
F0628 SS = F	Continued from page 16 Based on interview and record review, the facility failed to have a system to ensure transfer notices and ombudsman notices were provided for 2 of 2 sampled residents transferred to the hospital. This has the potential to impact all residents. Findings include: 1.) Per record review, Resident #16 was admitted to the facility after a stay at the hospital for treatment of a stroke. A progress note dated 7/12/2025 reveals that Resident #16 was transferred to the hospital for evaluation of altered mental status. There is no evidence in the Resident's medical record that a bed hold, or transfer/discharge notice was provided to the Resident or their family member. Per a progress note dated 7/19/2025, Resident #16 was again transferred to the hospital for evaluation for altered mental status and aggressive behavior. The Registered Nurse who was transferring the Resident out documented "Also, due to aggressive and combative behavior [her/his] bed would not be held and this was explained to the family." There is no documented evidence that a bed hold, or transfer notice was provided to the Resident. Per interview with the Administrator and DON on 7/29/2025 at 8:45 AM confirmed that the RN had told the family and the case manager at the receiving hospital that the Resident would not be able to return to the facility. Review of a letter dated 7/22/2025 that was sent to the Resident from the Administrator reads "The administrative team at The Villa Rehab Center has met and has determined that at this time we will not be accepting you back at our facility. We are not able to meet your current needs due to recent behaviors including eloping and physical violence. As you know these behaviors have impacted our staff and other residents of this facility, as well as the care we are able to provide to you. The behaviors endangered the health and wellbeing if individuals in the facility. As of today, since this letter is serving as a discharge from our facility, we will no longer be able to monitor the care you are receiving at the hospital as you are no longer our patient. If you would like us to continue to monitor your care while you remain in the hospital to see if at some point you are again appropriate to return and would like to return, please let us know... Should you wish to appeal this decision, you will be	F0628		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 475055	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Villa Rehab	7 Forest Hill Drive , St. Albans, Vermont, 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
F0628 SS = F	Continued from page 17 required to remain in the hospital during that time due to the potential for endangerment to the staff and residents of this facility..." Handwritten on the notice is "Mailed to [the Resident] 7/22" and "Mailed to state ombudsman 7/22/2025." Per interview on 7/30/2025 at approximately 3:30 PM, the owner was asked if the facility had notified the State Agency of the emergency discharge. She said she had not because it was not an emergency discharge. A copy of an email that was sent to the Ombudsman on 7/22/2025 that was provided by the Administrator states "I am the Administrator of The Villa Rehab in St. Albans, Vermont. I'm reaching out due to an emergency discharge we've had to initiate." Per record review, Resident # 4 was transferred to the emergency department (ED) on 1/1/25, 6/8/25, and 7/1/25. There is no evidence in Resident #4's medical record that a transfer notice was given to him/her for the above ED transfers. 2.) Review of facility policy titled "Discharge and Transfer Communications," undated, reveals 4 sections, all referring to discharge (hospital, home, unauthorized, and death). There is no section referring to transfer. Under the section "Discharge to hospital," the procedure includes giving a notice of bed hold but does not discuss a transfer notice or any of the required element of the notice. Per interview on 7/29/25 at 4:15 PM, the Social Services Director (SSD) described the notices given to a resident or their representative on transfer to the hospital. She stated that nursing gives the bed hold policy notice, and a transfer notice is not given to a resident unless they are admitted to the hospital. Per interview on 7/30/25 at approximately 12:50 PM, the Director of Nursing was asked if there was an additional policy regarding resident transfers and transfer communication and she stated she was only aware of the bed hold policy. Per interview on 7/30/25 at 12:50 PM, the Charge Nurse confirmed that nursing staff do not send a transfer notice when a resident is sent to the hospital. Per interview on 7/30/2025 at 1:26 PM, the SSD confirmed that there were no transfer notices for	F0628		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 475055	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Villa Rehab	7 Forest Hill Drive , St. Albans, Vermont, 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
F0628 SS = F	Continued from page 18 Resident #4 for the above ED visits. While reviewing the facility policy, she explained that she is not aware that the policy does not address transfer communication requirements. The SSD also stated that she does not send notification of transfers to the ombudsman as part of her process.	F0628		
F0689 SS = D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is NOT MET as evidenced by: Based on interview and record review the facility failed to provide adequate assessment and supervision for 1 of 3 residents in the sample (Resident #16), to prevent a resident who was exit seeking to exit the facility. This resulted in staff using physical restraint in attempt to return the Resident to the facility, causing the Resident to exhibit increased agitation, resistiveness, and combativeness toward staff. Findings include: Per record review, Resident #16 was admitted to the facility after a stay at the hospital for treatment of a stroke. Admission diagnoses include aphagia (a brain disorder that affects how you speak and understand language. It happens after damage to the language processing center of your brain), and cognitive communication deficit (difficulties in communication that arise from impairments in cognitive processes, such as attention, memory, and problem-solving). A hospital discharge summary dated 7/11/2025, reveals that the Resident had been prescribed an antipsychotic medication for delirium and that s/he had remained hospitalized due to placement problems until the Villa had approved admission for 7/11/2025. An Admission Summary progress note dated 7/11/2025 reflects that Resident #16 was alert and oriented x 3 (person, place, and time), though has a "history of forgetfulness in the evening, redirectable... Family	F0689	**F 0689 – Free of Accident Hazards/Supervision/Devices** **1. This resident was discharged with no further action available.** **2. All residents have potential to be affected with none currently affected.** **3. Education will be provided to all staff on hazards/supervision/devices upon hire and annually thereafter.** **4. QAPI will review all incidents for proper staff interventions. Any findings will require further education and/or disciplinary action.** **Date of Completion: 9/5/2025** **Tag F 689 POC accepted on 9/25/25 by P. Cota**	09/05/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 475055	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Villa Rehab	7 Forest Hill Drive , St. Albans, Vermont, 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
F0689 SS = D	Continued from page 19 reports sundowning [a state of confusion, agitation, and restlessness that some individuals with dementia or other cognitive impairments experience in the late afternoon and evening] in the evening since being in the hospital. Resident is impulsive and tends to want to get up on [her/his] own." Review of the Resident's care plan reveals there is no mention of sundowning or interventions. A progress note dated 7/12/2025 states "At [7:30 PM] this nurse was asked by [resident representative], to come into the resident's room. This nurse went in to find the resident walking/pacing around the room unassisted without walker. Resident had a frowned look on [her/his] face and began speaking in an agitated manner to this nurse. This nurse then attempted to reason with the resident and got [her/him] to allow me to obtain [her/his] vitals... This resident began stating, 'I'm leaving. I passed all my tests, and I am going home.' This nurse explained to the resident that [s/he] is here to have therapy following his recent stroke. Resident became very irritated with this nurse and asked me to leave the room. This nurse asked resident if [s/he] would allow this nurse to give [her/his] bedtime medications to [her/him]. [S/He] agreed. Resident had difficulty swallowing even with nectar thick liquids. Took four ties to administer [her/his] meds. This nurse explained to the [resident representative] that [s/he] needs time to calm down. [S/He] agreed... At approximately [8:20 PM] resident came walking past the nurses station into the main lobby at a very fast pace with [representative] following behind [her/him]. Again without the use of [her/his] assistive device. This nurse immediately went to resident and attempted to offer the walker and assistance. Resident shoved this nurses arm and said, 'Don't touch me' Resident became unsteady and began to go flaccid. This nurse held resident by the waistband to keep [her/him] from falling while [representative] ran to get wheelchair. Resident sat down and immediately became totally flaccid. Arms were dangling down alongside of wheelchair, head was hanging down and to the right, resident was severely drooling, pupils were sluggish and sightly dilated. This nurse immediately obtained a set of vitals... This nurse called 911 as the resident is a full code and sent to [emergency room] for eval and treat. [hospital] ER is discharging resident. Stated resident was dehydrated and will arrive back to facility shortly." A facility policy titled Elopements and Wandering Residents last reviewed on 5/1/2025 states, Policy: This facility ensures that residents who exhibit wandering behavior and/or are at risk for elopement	F0689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 475055	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Villa Rehab	**7 Forest Hill Drive , St. Albans, Vermont, 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
F0689 SS = D	Continued from page 20 receive adequate supervision to prevent accidents, and receive care in accordance with their person-centered plan of care addressing unique factors contributing to wandering or elopement risk... Policy Explanation and Compliance Guidelines... 3. The facility shall establish and utilize a systemic approach to monitoring and managing residents at risk for elopement or unsafe wandering, including identification and assessment of risk, evaluation and analysis of hazards and risks, implementing interventions to reduce hazards and risks and monitoring for effectiveness and modifying interventions when necessary. 4. Monitoring and Managing Residents at Rusk for Elopement or Unsafe Wandering a. Residents will be assessed for risk of elopement and unsafe wandering upon admission and throughout their stay by the interdisciplinary care plan team. Under section 6. Procedure Post Elopement part f, "When repeated elopement attempts occur, after the facility has exhausted possible care approaches, the resident may be referred for alternate placement in an appropriate facility." There is no documented evidence that the facility attempted to refer Resident #16 to an appropriate facility. Although Resident #16 had been exhibiting behaviors throughout the morning there is no documented evidence that the Resident's physician was consulted with or notified regarding the above behaviors prior to transfer to the hospital. Review of the Residents record there is no evidence that the Resident was assessed for risks of elopement or re-evaluated by the interdisciplinary care plan team after s/he began exit seeking. A Skilled Evaluation dated 7/13/2025 stated under wandering "chronic." Review of Resident #16's care plan reveals that the care plan was not updated on return and there were no interventions added related to the Resident's wandering, attempting to exit, or aggressive behaviors toward staff. An Alert Note dated 7/15/2025 at 12:15 AM reveals that on the 7:00 PM to 11:00 PM shift Resident #16 stated that s/he was so confused. S/He had been putting her/his robe on the wrong way then putting her/his shirt on over the robe, pacing all over the building saying that s/he was leaving. A wander Guard was placed for safety. A Behavior Note written on 7/15/2025 at 12:12 PM states "Notified facility PA [physician assistant] that resident was wandering a lot in the evening and saying [s/he] is going to leave as [s/he] becomes more confused in the evening. Order to place wander guard for safety purposes at this time…Will continue to monitor behaviors and need for wander alarm. This	F0689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 475055	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Villa Rehab	**7 Forest Hill Drive , St. Albans, Vermont, 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
F0689 SS = D	Continued from page 21 morning resident had forgotten why s/he was here, reminded her/him s/he is getting therapy while here until strong enough to go home. Resident reoriented and in agreement." Review of Resident #16's care plan reveals a focus initiated on 7/16/2025 of "A secure care wander guard was placed on [the Resident's] right ankle due to risk of elopement" with interventions that include "1:1 visits as needed," "Engage [resident] in facility activities as able," and "Redirect/reorient [resident] as needed." There are no care plan interventions related to approaches in care related to the Resident's confusion or preventing/managing aggressive behaviors. A progress note dated 7/19/2025 reveals that between the hours 7:00 AM and 12:00 PM Resident #16 had been confused and had attempted to exit the facility several times throughout the morning, because s/he thought that her/his partner had been injured in a car accident and s/he needed to get to the hospital. The RN redirected the Resident to her/his room. The Wander Guard alarm went off and the Resident was attempting to elope at this time, following the night shift staff out the front door. The Resident was brought back inside and continued to want to get to the hospital and was redirected to her/his room. A short time later s/he was found in Hall 3 wandering in and out of rooms. The RN again redirected her/him to return to her/his room. The Resident went into the living room then was found wandering in the hall outside her/his room and going into other rooms. S/he was redirected to her/his room again where s/he fell asleep. The Resident woke up and came out wandering. The note states that the Resident appeared to be agitated and disorganized, carrying a shoe, and had 2 different shoes on, looking for their phone. The nurse returned to the nurse's station, and the Wander Guard alarm went off again as the Resident went out the back door. A Licensed Nursing Assistant (LNA) went after her/him. While outside, the Resident started heading to the end of the street to go through the bushes to head home. The LNA stayed with her/him for their safety; the Resident threatened to punch her if she did not remove her arm from behind her/his back. The RN went to assist the LNA in getting the Resident back into the building. But the Resident did not want to return to the building. The LNA and RN guided back toward the building as the Resident became combative and turned quickly pushing this nurse's arm away from her/him and drew her/his arm back to punch the RN. The LNA and RN continued to guide the Resident back toward the building. Resident #16 then stopped and let go of the two of them and laid down on the ground. Staff called over the walkie talkie and they were asked to	F0689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 475055	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Villa Rehab	7 Forest Hill Drive , St. Albans, Vermont, 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
F0689 SS = D	Continued from page 22 call the Resident's youngest [child] and have [him/her] return to assist with the Resident. When her/his [representative] arrived, the LNA and the RN were able to get the Resident heading back to the building. The Resident started to struggle against them and told the RN to take her hand off her/him or s/he was going to punch her in the face. Once back in the building they brought her/him to her/his room. "This nurse spoke with the [Director of Nursing] DON about the events, and she requested that [the Resident] be transferred to the ED for Altered Mental Status and Aggressive Behavior. Also, due to aggressive and combative behavior her/his bed would not be held and this was explained to the family." Per review of the facility's Internal investigation for incident on 7/19/2025, the facility was informed by the Case Manager at the hospital that the Resident had reported being pushed to the ground. Per an interview conducted by administration on 7/23/2025 with the LNA who was present during the incident on 7/19/2025, the LNA reflects that there is a path at the end of the cul-de-sac that the LNA physically blocked so the Resident would not go through. The RN joined her in attempting to get the Resident back into the building, and a CPI [Crisis Prevention Institute] maneuver was utilized per the RN's instructions. The LNA describes this as a hold with both the LNA and RN on one side of the Resident locking arms and walking with the Resident guiding where s/he would go. The LNA reports that there was a firm grip from the Resident at one point bending her hand backwards. The LNA reported that the RN's instruction was to lower the Resident to the ground." There is no documented evidence that staff attempted 1:1 visits or engaged the Resident in facility activities per Resident #16's care plan. Instead s/he was continuously redirected to her/his room and left unsupervised. Also, the Resident's care plan does not include the use of CPI maneuvers to manage elopement or aggressive behaviors. During an interview with the Director of Nursing (DON) and the Administrator on 7/29/2025 at 9:50 AM when discussing the facility internal investigation, the Administrator described the CPI maneuver as the RN and LNA "locking arms and using their (the staff's) body weight to direct the Resident back to the facility. Resident #16 became aggressive and threatened them that he was going to hit them. During an interview on 7/29/2025 at 1:36 PM the RN who was on duty at the time of the incident confirmed the content of the progress note from 7/19/2025. She also	F0689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 475055	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Villa Rehab	**7 Forest Hill Drive , St. Albans, Vermont, 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
F0689 SS = D	Continued from page 23 stated that at one point the Resident began "Resisting and pulling again so I asked [the LNA] if she knew CPI (Crisis Prevention Institute), she did not so I told her what to do." The RN stated that at that time the Resident laid down in the yard of the neighbor. When they tried to stand her/him up he stated "If you don't take your hands off me I'm gonna punch you in the face." "I told [the representative] let me the bad guy. [The Resident] settled down and we brought her/him in and s/he tried to go out again." The RN stated that she has a background in mental health nursing and received CPI training prior to working at this facility. When asked why staff hadn't increased supervision with the multiple attempts to leave the building or provide 1:1 throughout the morning, the RN stated that she was giving her/him space. When asked if she had reached out to the physician regarding the increased behaviors throughout the morning and she said no she hadn't. Further review of Resident #16's care plan reveals that no interventions related to aggressive behaviors, and the care plan does not include the use of CPI maneuvers to manage elopement or aggressive behaviors. Another care plan focus, states "[Resident] receives an antipsychotic medication for symptoms of delirium following acute CVA" with interventions initiated on 7/11/2025 of "Monitor and notify MD of negative effects of medications- increase in agitation or anxiety, insomnia, parkinsonism, feelings of suicide, dizziness, hallucinations, mania, impaired concentration..." There is no evidence that the physician was contacted at any point throughout the morning of 7/19/2025 when the Resident was showing signs of increased confusion, anxiety, and agitation. During an interview on 7/30/2025 at 11:50 AM with the RN who was on duty during the elopement on 7/19/2025, she confirmed that she had not received facility specific training regarding elopement prevention or what to do if a resident eloped, prior to the 7/19/2025 incident. Per interview with the Administrator and the DON on 7/30/2025 at approximately 12:30 PM the Administrator confirmed that the RN on duty during the elopement did use CPI Crisis Prevention Institute Nonviolent Crisis Intervention however, it is not a program approved for use by staff at this facility. The Administrator confirmed that CPI is not part of their protocol for use with residents in crisis.	F0689		
F0726 SS = F	Competent Nursing Staff	F0726		09/09/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 475055	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Villa Rehab	7 Forest Hill Drive , St. Albans, Vermont, 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
F0726 SS = F	Continued from page 24 CFR(s): 483.35(a)(3)(4)(d) §483.35 Nursing Services The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.71. §483.35(a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. §483.35(a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs. §483.35(d) Proficiency of nurse aides. The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and record review the facility failed to ensure that staff were competent in medication administration for 4 of 5 licensed nurses and failed to ensure that 10 of 10 direct care staff were competent in infection control measures. Findings include: Per review of the Facility Assessment, last reviewed 5/5/25, indicates that the facility offers "medication management," and "infection prevention and control" as services and care offered to meet the residents' needs. The Facility Assessment reveals that the training program :included an orientation process and ongoing	F0726	F 0726 – Competent Nursing Staff 1. Corrective action will be addressed by completing staff education. 2. All residents have potential to be affected. Education is universal and will be completed by all staff. This will include Medication Administration and Infection Prevention and Control. 3. A review of the facility assessment and required competencies will be completed and a review of education will be completed to ensure staff have proper training to care for our resident population. 4. All current staff education files to be reviewed and missing education to be completed. Administration reviews a sample of staff files quarterly for continued education accuracy. Date of Completion 9/9/2025 Tag F 726 POC accepted on 9/25/25 by P. Cota	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 475055	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Villa Rehab	7 Forest Hill Drive , St. Albans, Vermont, 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
F0726 SS = F	Continued from page 25 training for all new and existing staff,.." and is based on staff need and resident characteristics. 1.) Medication administration errors were observed during survey. See F759 for more information. Per review of employee education files, 4 of 5 licensed nursing staff did not have documentation to demonstrate that they had the skill necessary to administer medication. 2) Infection control deficiencies were identified with resident care during survey. See F880 for more information. Per review of employee education files, 5 of 5 licensed nursing staff and 5 of 5 LNAs did not have documentation to demonstrate that they were competent in infection control practices other than handwashing. Per interview on 7/29/25 at 2:40 PM, Registered Nurse #1 explained that she was an agency nurse and her competencies were not assessed before working. She stated that she received electronic medical record training and was handed a packet for onboarding. Per interview on 7/30/25 10:32 AM, the Director of Nursing (DON), who is responsible for direct care staff training and competencies, confirmed that infection control competencies include more than just hand washing. She explained that infection control competencies should also include standard precautions, how to handle fluids, personal protective equipment use, and medication handling. She stated that there have been gaps in staff education and competency evaluation. Per interview on 7/30/25 at 3:01 PM the DON stated that they have no additional documentation of competencies for the 10 staff sampled.	F0726		
F0759 SS = E	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is NOT MET as evidenced by:	F0759		09/04/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 475055	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Villa Rehab	7 Forest Hill Drive , St. Albans, Vermont, 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
F0759 SS = E	Continued from page 26 Based on interview and record review the facility failed to ensure a medication error rate of less than %5. 2 of 26 medication administrations were observed to be in error making the error rate 7.7%. Findings include: 1.) Per record review, Resident has physician orders for 1 capsule metoprolol succinate 50 mg extended release oral capsule and 2 tablets PRN (as needed) docusate sodium 50 mg. Per observation of a medication administration for Resident #7 on 7/29/25 at 8:33 AM, Registered Nurse #1 (RN #1) administered one medication in the incorrect form and 1 medication in the incorrect dosage. RN #1 gave Resident #7 1 tablet metoprolol succinate 50 mg extended release oral tablet and 1 tablet docusate sodium. Per review of the Resident # 7's Medication Administration Record for that medication observation, RN #1 documented that Resident #7 received 1 tablet metoprolol succinate and 2 tablets of docusate sodium. RN #1 did not call a provider to notify them of the incorrect form of the metoprolol succinate or the change in dosage administered and there is no evidence in Resident #7's medical record that a provider was contacted of the change. Per review of the facility's "Medication Administration" policy [no revision date] states, "Ensure that the six rights of medication administration are followed: a. Right resident b. Right drug c. Right dosage d. Right route e. Right time f. Right documentation....12. Compare medication source (bubble pack, vial, etc.) with MAR to verify resident name, medication name, form, dose, route, and time... 20. Sign MAR after administered.: Per interview on 7/30/25 at 12:50 PM, the Charge Nurse confirmed that the medication given did not match Resident #7's physician orders and the provider was not made aware that the medications administered were different than what was ordered. Per interview on 7/30/25 at approximately 1:45 PM, the Director of Nursing confirmed that the nurse was not following physician orders for both medications administered.	F0759	**F 0759 – Free of Medication Error Rates 5% or more** **1. Residents will be reviewed for adverse side effects after medication errors have been found.** **2. All residents have the potential to be affected with no current errors found.** **3. All nurses will receive medication administration training.** **4. DON will watch medication pass from each nurse for one month and report findings to QAPI. Immediate education will be given for any errors and disciplinary action will be taken for any continued issues.** **Date of Completion: 9/4/2025** **Tag F 759 POC accepted on 9/25/25 by P. Cota**	
F0812 SS = F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements.	F0812		08/29/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 475055	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Villa Rehab	7 Forest Hill Drive , St. Albans, Vermont, 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
F0812 SS = F	Continued from page 27 The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and record review the facility failed to ensure that food was prepared in a safe sanitary manner and environment. This has the potential to impact all residents in the facility. Findings include: Per record review of the facility's "Food Safety Requirements" policy [last revised 1/1/25] states, "Food safety practices shall be followed throughout the facility's entire food handling process...Elements of the process include the following:...b. Storage of food in a manner that helps prevent deterioration or contamination of the food, including from growth of microorganisms...6. All equipment used in the handling of food shall be cleaned, sanitized, and handled in a manner to prevent contamination." Per observation of the kitchen on 7/28/25 at 8:45 AM, there was a pool of water on the floor in front of refrigerator. The kitchen staff member stated, "The sink leaks." She stated the maintenance director would be in the next day to address the water on the floor. Per observation on 7/28/25 at 8:45 AM, there was food debris under serving table including pasta and breadcrumbs. There were dark stains on the floor directly under the serving table. There was food debris	F0812	**F 0812 – Food Procurement, Store/ Prepare/ Serve-Sanitary** **1. Corrective action has been completed. The sink leak, the food debris, and expired food from the freezer has been corrected.** **2. All residents have the potential to be affected with no current issues found.** **3. Education will be provided to the dietary manager and all dietary staff. Education provided to report all maintenance concerns to maintenance or administration immediately. Any issues regarding safety or infection control will be immediately addressed. A weekly cleaning and sight review log has been created.** **4. Dietary Manager will review cleaning logs weekly as well as a sight review. The dietary manager will complete environmental rounds to ensure compliance.** **Date of Completion: 8/29/2025** **Tag F 812 POC accepted on 9/25/25 by P. Cota**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 475055	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Villa Rehab	**7 Forest Hill Drive , St. Albans, Vermont, 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
F0812 SS = F	Continued from page 28 underneath the refrigerator. Per observation, the coffee maker had not been cleaned and had coffee stains and white smear stains on it. The shelves under the serving tray had white and brown stains on it. At approximately 8:50 AM the kitchen staff member confirmed the floor was dirty and had debris on it, stating, "We sweep and mop before lunch and in the evening." Per observation of the kitchen on 7/29/25 at 9:30 AM, standing water was still present on the floor in front of the refrigerator. The kitchen staff member confirmed on 7/29/25 at 11:56 AM that the sink was still leaking water on the floor. Per observation of the freezer, a package of 8 hot dogs was found to have an expiration date of 8/27/24. A package of Hormel pepperoni was found to have expired on 5/22/24. On 7/29/25 at 11:59 AM the kitchen staff member confirmed these items were expired. Per observation of the kitchen on 7/30/25 at 9:44 PM, there was still standing water on the floor in front of the refrigerator. There is still debris and old food under the shelves that hold pots and pans and under the refrigerator. There was still dirt and debris under the refrigerator.	F0812		
F0838 SS = F	Facility Assessment CFR(s): 483.71(a)(1)(3)(b)(1)(c)(1)-(5) §483.71 Facility assessment. The facility must conduct and document a facility-wide assessment to determine what resources are necessary to care for its residents competently during both day-to-day operations (including nights and weekends) and emergencies. The facility must review and update that assessment, as necessary, and at least annually. The facility must also review and update this assessment whenever there is, or the facility plans for, any change that would require a substantial modification to any part of this assessment. §483.71(a) The facility assessment must address or include the following: §483.71(a)(1) The facility's resident population, including, but not limited to: (i) Both the number of residents and the facility's resident capacity;	F0838	**F 0838 – Facility Assessment** **1. No residents are affected currently.** **2. Education and review of required education for the facility assessment will encompass all resident care needs.** **3. DON is currently enrolled in an Infection Preventionist certification class. In the interim, our current infection preventionist will join QAPI meetings where all infections are reviewed. Our current infection preventionist will meet with DON weekly and be notified of any new infections to ensure proper procedure is in place. The infection preventionist will provide education in any needed areas.**	08/29/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 475055	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Villa Rehab	7 Forest Hill Drive , St. Albans, Vermont, 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
F0838 SS = F	Continued from page 29 (ii) The care required by the resident population, using evidence-based, data-driven "methods" that considering the types of diseases, conditions, physical and behavioral health needs, cognitive disabilities, overall acuity, and other pertinent facts that are present within that population, consistent with and informed by individual resident assessments as required under § 483.20; (iii) The staff competencies and skill sets that are necessary to provide the level and types of care needed for the resident population; (iv)The physical environment, equipment, services, and other physical plant considerations that are necessary to care for this population; and (v) Any ethnic, cultural, or religious factors that may potentially affect the care provided by the facility, including, but not limited to, activities and food and nutrition services. §483.71(a)(2) The facility's resources, including but not limited to the following: (i) All buildings and/or other physical structures and vehicles; (ii) Equipment (medical and non- medical); (iii) Services provided, such as physical therapy, pharmacy, behavioral health, and specific rehabilitation therapies; (iv) All personnel, including managers, nursing and other direct care staff (both employees and those who provide services under contract), and volunteers, as well as their education and/or training and any competencies related to resident care; (v) Contracts, memorandums of understanding, or other agreements with third parties to provide services or equipment to the facility during both normal operations and emergencies; and (vi) Health information technology resources, such as systems for electronically managing patient records and electronically sharing information with other organizations. §483.71(a)(3) A facility-based and community-based risk	F0838	**4. The facility assessment is updated to include our part time infection preventionist need. Infection preventionist will assist DON during this time for any education needs. Facility Education/Staff Competencies Necessary to Care for Resident Population worksheet has been updated to reflect education needs.** **Date of Completion: 8/29/2025** **Tag F 838 POC accepted on 9/25/25 by P. Cota**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 475055	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Villa Rehab	**7 Forest Hill Drive , St. Albans, Vermont, 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
F0838 SS = F	Continued from page 30 assessment, utilizing an all-hazards approach as required in §483.73(a)(1). § 483.71(b) In conducting the facility assessment, the facility must ensure: § 483.71(b)(1) Active involvement of the following participants in the process: (i) Nursing home leadership and management, including but not limited to, a member of the governing body, the medical director, an administrator, and the director of nursing; and (ii) Direct care staff, including but not limited to, RNs, LPNs/LVNs, NAs, and representatives of the direct care staff, if applicable. (iii) The facility must also solicit and consider input received from residents, resident representatives, and family members. §483.71(c) The facility must use this facility assessment to: §483.71(c)(1) Inform staffing decisions to ensure that there are a sufficient number of staff with the appropriate competencies and skill sets necessary to care for its residents' needs as identified through resident assessments and plans of care as required in § 483.35(a)(3). §483.71(c)(2) Consider specific staffing needs for each resident unit in the facility and adjust as necessary based on changes to its resident population. §483.71(c)(3) Consider specific staffing needs for each shift, such as day, evening, night, and adjust as necessary based on any changes to its resident population. §483.71(c)(4) Develop and maintain a plan to maximize recruitment and retention of direct care staff. §483.71(c)(5) Inform contingency planning for events that do not require activation of the facility's emergency plan, but do have the potential to affect resident care, such as, but not limited to, the	F0838		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 475055	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Villa Rehab	7 Forest Hill Drive , St. Albans, Vermont, 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
F0838 SS = F	Continued from page 31 availability of direct care nurse staffing or other resources needed for resident care. This REQUIREMENT is NOT MET as evidenced by: Based on interview and record review the facility failed to ensure that the facility assessment provided adequate information related to competencies and training and failed to address needed positions. Findings include: 1. Per review of the facility Infection Preventionist job description implemented on 5/1/2025 section 6. states "The IP must be employed at least part-time and the amount of time should be determined by the facility assessment, to determine the resources it needs for its IPCP [Infection Prevention Control Program]. Designated IP hours per week may vary based on the facility and its resident population." Section 7. States "The facility based on the facility assessment will determine if the individual functioning as the IP should be dedicated solely to the IPCP. The IP must have the time necessary to properly assess develop implement, monitor, and manage the IPCP for the facility, address training requirements, and participate in required committees such as QAA [Quality Assessment and Assurance]." 8. The IP will physically work on site in the facility." Per review of the "Facility Assessment," last reviewed by the facility on 5/5/2025, revealed that it does not address the need for an IP. The facility did not identify the need for a part time Infection Preventionist. During an interview on 7/30/2025 at approximately 3:15 PM the Owner of the facility confirmed that there was not a designated part time IP employed by the facility. See F882 for more information. 2.) During survey, deficient practices were observed related to medication administration and infection control practices. See F 759 and F880 for more information. Investigation revealed that the facility failed to ensure that staff were competent in medication administration for 4 of 5 licensed nurses and failed to ensure that 10 of 10 direct care staff were competent in infection control measures. See F726 for more information. Per review of the Facility Assessment, last reviewed 5/5/25, indicates that the facility offers "medication management," and "infection prevention and control" as services and care offered to meet the residents' needs.	F0838		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 475055	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Villa Rehab	**7 Forest Hill Drive , St. Albans, Vermont, 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
F0838 SS = F	Continued from page 32 The Facility Assessment reveals that the training program: included an orientation process and ongoing training for all new and existing staff..." and is based on staff need and resident characteristics. The section detailing competencies need to meet residents' needs refers to a worksheet titled "Facility Education/Staff Competencies Necessary to Care for Resident Population" and reads "The worksheet identifies which staff are required certain competencies and skill sets, and the frequency of education." The Facility Assessment does not include this worksheet. During an interview on 7/30/25 at 10:32 AM with the Director of Nursing and the Administrator, it was confirmed that they do not have this attachment.	F0838		
F0880 SS = F	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;	F0880	**F 0880 – Infection Prevention and Control** **1. Education for all staff will stop all residents from being affected by this deficient practice.** **2. Provided education will ensure no residents are affected going forward.** **3. Maintenance, Administrator, and DON will complete a review of and update our Legionella policy to include a risk assessment for identified areas of potential contamination.** **Education will be provided to all staff on infection prevention and control standards.** **4. Infection and prevention are reviewed weekly at QAPI and interim infection preventionist is to attend.** **Environmental rounds of four rooms will be performed every week for one month to ensure infection prevention policy and procedure is followed.** **Immediate education will be provided to staff upon incident and reviewed at QAPI.**	09/05/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 475055	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Villa Rehab	7 Forest Hill Drive , St. Albans, Vermont, 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
F0880 SS = F	Continued from page 33 (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and record review the facility failed to ensure that a risk assessment was completed to identify areas at risk for Legionella (a bacteria found in water that can cause a serious type of pneumonia, Legionnaires' disease) could grow and spread in the facility's water system, and failed to ensure proper infection control practices were followed. Findings include: 1. Per review of the facility's water management	F0880	Date of Completion 9/5/2025 **Tag F 880 POC accepted on 9/25/25 by P. Cota**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 475055	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Villa Rehab	7 Forest Hill Drive , St. Albans, Vermont, 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
F0880 SS = F	Continued from page 34 program, it did not contain a risk assessment to identify and prevent areas in the building where Legionella could grow and spread in the facility's water system. Per review of the facility policy with a reviewed/revised date of 3/2021 states, "surveillance is one component of the facility's water management plans for reducing the risk of Legionella and other opportunistic pathogens in the facility's water systems" and "In the absence of Legionella infections for a period of at least one year, the facility shall implement primary prevention strategies." Per interview with the Infection Preventionist (IP), Administrator, and the Director of Nursing (DON) on 7/29/25 at approximately 3:30 PM, the facility had not completed a formal risk assessment, including identifying areas in the building where Legionella could grow or reside. The facility lacked a process to prevent the growth and transmission of communicable diseases and infections related to Legionella prevention. The Administrator deferred to the Director of Maintenance when asked regarding a Water Management plan. During an interview with the Director of Maintenance, the Administrator, and the facility Owner on 7/30/25 at approximately 9:00 AM, the Director of Maintenance confirmed that there is no written assessment of wastewater management. The Administrator stated there was a map of the facility's water system and would provide this information once it was located. The Administrator provided a flowgraph map of the water supply, but it fails to identify areas of potential contamination or risk. During an interview with the facility Owner on 7/30/25 at approximately 11:30 PM, she confirmed that the flowgraph was the only document for the wastewater assessment. The CDC's "Developing a Water Management Program to Reduce Legionella Growth & Spread in Buildings: A PRACTICAL GUIDE TO IMPLEMENTING INDUSTRY STANDARDS" example from page 11 labelled "Identify Areas Where Legionella Could Grow & Spread - EXAMPLE: BUILDING A" was shown to the Owner and asked if the facility had an assessment map showing the potential hazards. The Owner confirmed the facility doesn't have an assessment. https://www.cdc.gov/control-legionella/media/pdfs/toolkit.pdf/ 2. On 7/28/25 at 10:00 AM, the linen cart located on the second floor unit was observed to have the	F0880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 475055	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Villa Rehab	7 Forest Hill Drive , St. Albans, Vermont, 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
F0880 SS = F	Continued from page 35 protective cover open and the linens uncovered, and at approximately 12:30 PM, a hospitality staff member was observed bringing a laundry basket of clothing to the second floor without a cover. Review of the Infection Prevention and Control Program policy [last revised 5/13/25] states, "Clean linen shall be delivered to resident care units on covered linen carts with covers down," and the stored linen on care units will be covered. During an interview on 7/29/25 at 1:15 PM, the hospitality staff observed with the uncovered laundry basket on 7/28/25, confirmed that laundry baskets are transported uncovered when clean items are brought back to residents. They questioned whether baskets should be covered when transporting clean linens and clothing, as per the facility's policy. The hospitality staff also confirmed that linen carts on the units should be covered. 3.) Per observation on 7/29/25 at 8:34 AM, Registered Nurse #1 (RN #1) was observed preparing medications for Resident #7. When RN #1 took the pills out of the packaging, she put the pills in her ungloved hand before putting them in the medication cup. During the administration of the medications, RN#1 was observed handling the medications again with ungloved hands before they were administered to Resident #7. On 7/29/25 at10:01 AM RN #1 was observed preparing medications for another resident, again putting the medications directly into her ungloved hand. Per interview on 7/29 at 2:32 PM, the Charge Nurse confirmed that nursing staff should not touch medications with ungloved hands. 4.)Per interview with the Charge Nurse during observation of resident rooms on 7/29/25 at 12:35 PM, the Charge Nurse stated that oxygen tubing and humidifier bottle should dated when it is changed and should be done weekly. She confirmed that Resident #3 did not have dates on the tubing used on his/her wheelchair and concentrator and did not have a date on the humidifier bottle and should. She confirmed that the oxygen tubing on room 6 did not have a date on it and should. 5.) Per observation on 7/28/2025 at 9:47 AM, a Licenses Nursing Assistant came out of room 6 with dirty linens pressed on her chest wearing. This LNA was not wearing gloves.	F0880		
F0882 SS = F	Infection Preventionist Qualifications/Role	F0882		08/29/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 475055	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Villa Rehab	7 Forest Hill Drive , St. Albans, Vermont, 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
F0882 SS = F	Continued from page 36 CFR(s): 483.80(b)(1)-(4) §483.80(b) Infection preventionist The facility must designate one or more individual(s) as the infection preventionist(s) (IP)(s) who are responsible for the facility's IPCP. The IP must: §483.80(b)(1) Have primary professional training in nursing, medical technology, microbiology, epidemiology, or other related field; §483.80(b)(2) Be qualified by education, training, experience or certification; §483.80(b)(3) Work at least part-time at the facility; and §483.80(b)(4) Have completed specialized training in infection prevention and control. This REQUIREMENT is NOT MET as evidenced by: Based on interview and record review the facility failed to ensure that a infection preventionist was employed at least part time. Findings include: During an interview with the Registered Nurse (RN) identified as the Infection IP and the Director of Nursing (DON) on 7/29/25 at approximately 3:30 PM, they confirmed that the RN was covering as the IP and is an employee of another facility that is owned by the same owner. The IP stated that they are at the facility on an as-needed basis, about one day a week. When asked to describe the facilities IP Program the IP stated that she works with the Pharmacist and reviews antibiotic usage and ensures that antibiotic time outs are implemented. When asked about the facilities infection surveillance logs, updates to policies and procedures, and water management (Legionella prevention) for the facility the IP deferred to the Administrator. The facility Infection Preventionist job description implemented on 5/1/2025 section 6. states "The IP must be employed at least part-time and the amount of time should be determined by the facility assessment, to determine the resources it needs for its IPCP [Infection Prevention Control Program]. Designated IP hours per week may vary based on the facility and its	F0882	F 0882 – Infection Preventionist Qualifications/Role 1. DON is currently enrolled in an Infection Preventionist certification class. In the interim, our current infection preventionist will join QAPI where all infections are reviewed. Our current infection preventionist will meet with DON weekly and be notified of any new infections to ensure proper procedure is in place 2. All residents having the potential to be affected by this deficient practice will no longer be affected after corrective action is put in place. 3. DON is currently enrolled in an Infection Preventionist certification class. Upon completion, DON will be able to take over full responsibility of the role. 4. DON will ensure interim IP is attending weekly QAPI meetings, being kept up to date on new infections, meeting weekly, and providing any needed education. Date of Completion: 8/29/2025 Tag F 882 POC accepted on 9/25/25 by P. Cota	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 475055	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Villa Rehab	7 Forest Hill Drive , St. Albans, Vermont, 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
F0882 SS = F	Continued from page 37 resident population." Section 7. States "The facility based on the facility assessment will determine if the individual functioning as the IP should be dedicated solely to the IPCP. The IP must have the time necessary to properly assess develop implement, monitor, and manage the IPCP for the facility, address training requirements, and participate in required committees such as QAA [Quality Assessment and Assurance]." 8. The IP will physically work on site in the facility." The facility policy titled Infection Prevention and Control Program last reviewed/revised on 5/13/2025 under Policy Explanation and Compliance Guidelines: The designated Infection Preventionist is responsible for oversight of the program and serves as a consultant to our staff on infectious diseases, resident room placement, implementing isolation precautions, staff and resident exposures, surveillance, and epidemiological investigations of exposures of infectious diseases....Surveillance: a. ... b. The Infection Preventionist serves as the leader in surveillance activities, maintains documentation of incidents, findings, and any corrective actions made by the facility and reports surveillance findings to the facility's Quality Assessment and Assurance Commitee. Review of the "Facility Assessment," last reviewed by the facility on 5/5/2025, revealed that it does not address the need for an IP. The facility did not identify the need for a part time Infection Preventionist. Per interview on 7/30/25 at 9:00 AM with the Administrator, DON, and Owner of the facility the IP is an employee at their other facility and is covering as IP. The Owner stated that the IP had "no specific hours" and the IP is "used as needed." When told that the IP had reported that she was there one day a week the Owner stated that she "was going to say something like that." When told of the regulatory requirement for a part-time IP, the Owner stated that a part-time IP "was not needed for 20 residents." During an interview on 7/30/2025 at approximately 3:15 PM the Owner of the facility confirmed that there was not a designated part time IP employed by the facility.	F0882		
F0945 SS = F	Infection Control Training CFR(s): 483.95(e) §483.95(e) Infection control.	F0945		09/09/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 475055	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Villa Rehab	7 Forest Hill Drive , St. Albans, Vermont, 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
F0945 SS = F	Continued from page 38 A facility must include as part of its infection prevention and control program mandatory training that includes the written standards, policies, and procedures for the program as described at §483.80(a)(2). This REQUIREMENT is NOT MET as evidenced by: Based on interview and record review, the facility failed to ensure that staff have infection prevention and control training that covers facility policy and procedures for 10 of 10 sampled direct care staff. Findings include: Per review of employee education files, 5 of 5 licensed nursing staff and 5 of 5 LNAs did not have documentation to demonstrate that they received infection control training, including training on the facility infection prevention and control policy and procedures, other than hand hygiene. Per interview on 7/29/25 at 2:40 PM, Registered Nurse #1 explained that she is an agency nurse and the only training that the facility provided was training on the electronic medical record training and an onboarding packet. Per interview on 7/30/25 at 10:32 AM, the Director of Nursing, who is responsible for direct care staff training and competencies, described that infection control training should be done on hire and annually. She stated that there have been gaps in staff education and competency evaluation. Per interview on 7/30/25 at approximately 1:45 PM, the Administrator confirmed that there was no infection control education done during onboarding. Per interview on 7/30/25 at 3:01 PM the DON stated that they have no additional documentation of infection control education for the 10 staff sampled.	F0945	F 0945 – Infection Control Training 1. Education for all staff will stop all residents from being affected by this deficient practice. 2. Provided education will ensure no residents are affected going forward. 3. Education will be provided to all staff as well as agency staff on infection prevention and control standards. 4. All current staff education files to be Reviewed and missing education to be completed. Administration reviews a sample of staff files quarterly for continued education accuracy. Date of Completion: 9/9/2025 Tag F 945 POC accepted on 9/25/25 by P. Cota	
F0947 SS = F	Required In-Service Training for Nurse Aides CFR(s): 483.95(g)(1)-(4) §483.95(g) Required in-service training for nurse aides. In-service training must- §483.95(g)(1) Be sufficient to ensure the continuing competence of nurse aides, but must be no less than 12	F0947	F 0947 – Regular In-service Training for Aides 1. All staff education files to be reviewed and missing education files will be completed in line with facility assessment worksheet. 2. Providing education based on our residents needs as found in the facility assessment will ensure no residents are affected going forward.	09/04/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 475055	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Villa Rehab	7 Forest Hill Drive , St. Albans, Vermont, 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
F0947 SS = F	Continued from page 39 hours per year. §483.95(g)(2) Include dementia management training and resident abuse prevention training. §483.95(g)(3) Address areas of weakness as determined in nurse aides' performance reviews and facility assessment at § 483.71 and may address the special needs of residents as determined by the facility staff. §483.95(g)(4) For nurse aides providing services to individuals with cognitive impairments, also address the care of the cognitively impaired. This REQUIREMENT is NOT MET as evidenced by: Based on interviews and record review the facility failed to provide the required 12 hours of in-service training for 2 of 2 applicable licensed nursing assistants (LNAs). Findings include: Education records were reviewed for 5 LNA staff. 2 of the 5 LNAs have worked at the facility for over a year; LNA #4 was hired on 6/26/17 and LNA #5 was hired on 1/18/21. LNA # 4 did not have evidence of 12 hours of in-service training within the past year. LNA #5 had a checklist from a skills fair in their file. There was no other evidence that they received any additional in-service training within the past year. Per interview on 7/30/25 10:32 AM, the Director of Nursing (DON), who is responsible for direct care staff training and competencies, explained that the 12-hour in-service training is done at a skills fair. She revealed that the in-service is documented with the same checklist that is in LNA #5's file. On 7/30/25 at 12:43 PM, the Administrator explained that the in-service training only lasts 9 hours, being held from 7:00 AM until 4 PM and does not have any way to account for the other required hours. Per interview on 7/30/25 at 3:01 PM the DON stated that they have no additional documentation of in-service training for the 2 staff sampled.	F0947	**3. A chart will be created to ensure 12 hours of continuing education for each LNA to ensure all education requirements are completed.** **4. Quarterly checks will be completed for ongoing compliance by DON and administrator.** **Date of Completion: 9/4/2025** **Tag F 947 POC accepted on 9/25/25 by P. Cota**	