VERMONT

Department of Disabilities, Aging and Independent Living
Division of Licensing and Protection
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AGENCY OF HUMAN SERVICES

January 13, 2026

Ms. Jessica Jennings, Administrator
Saint Albans Healthcare and Rehabilitation Center
596 Sheldon Road
Saint Albans, VT 05478

Provider ID #: 475021

Dear Ms. Jennings:

Enclosed is a copy of your acceptable plans of correction for the complaint investigation conducted on **December 22, 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: 475021	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 12/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Saint Albans Healthcare and Rehabilitation Center	**596 Sheldon Road , Saint 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
F0000	INITIAL COMMENTS The Division of Licensing and Protection conducted an unannounced, onsite investigation of 2 FRIs (facility-reported incidents), including reports #2666623 and #2638610 on 12/22/25 to determine compliance with 42 CFR Part 483 requirements for Long Term Care Facilities. The following regulatory deficiency was identified:	F0000		
F0600 SS = D	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation 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- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is NOT MET as evidenced by: Based on interview and record review, the facility failed to protect the residents' right to be free from physical and verbal abuse by staff and other residents for two (Resident #1 and Resident #2) of 3 sampled. Findings include: 1) Per review of the facility's "OPS 300 Abuse Prohibition" policy [last revised 11/14/25] states, "Centers prohibit abuse, mistreatment, neglect, misappropriation of resident/patient (hereinafter 'patient') property, and exploitation of all residents ...Verbal abuse is any use of oral, written, or gestured language that willfully includes disparaging	F0600	F0600 St. Albans Health & Rehabilitation Center provides this plan of correction without admitting or denying the validity or existence of the alleged deficiency. The plan of correction is prepared and executed solely because it is required by federal and state law. The staff member involved in the incident with Resident #1 was suspended pending Investigation immediately by the DON and was not brought back into the center. Resident #1 was assessed and monitored for psychosocial distress. He did not experience any psychosocial distress related to this Incident. Resident #3 is now deceased. All residents have the potential to be affected by this alleged deficient practice. Staff will be educated on the center's abuse policy and residents refusal of care.	

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F0600 SS = D	Continued from page 1 and derogatory terms to patients or their families ..." Per review of Resident #1's medical records, s/he has a diagnosis of diabetes mellitus, acute kidney failure, and obesity. S/he had a BIMS [Brief Interview of Mental Status] of 15 out of 15 on 10/7/25, indicating his/her cognitive function is intact. The MDS [Minimum Data Set] states that Resident #1 requires assistance with ADLs [activities of daily living] and requires 2 people and a mechanical lift for transfers and toileting. Per record review of the facility's internal investigation of the alleged abuse dated 11/9/2025, Resident #1 reported verbal abuse that occurred on 11/9/25. Per the internal investigation, Resident #1 stated that s/he had a verbal argument with an LNA [Licensed Nursing Assistant], who called him a derogatory expletive. Per the facility's internal investigation, Resident #1 stated that the LNA entered his/her room and attempted to change the oxygen tubing. When Resident #1 explained that the tubing gets changed on Tuesdays the LNA called him/her derogatory expletive, and said I was useless because I can't walk... He told me don't ring if I need anything later." Per the facility's internal investigation, Resident #1's roommate was interviewed and confirmed that the LNA had called Resident #1 a derogatory expletive. Per the record review of the facility's internal investigation, the facility confirmed that verbal abuse occurred. Per interview with the Director of Nursing [DON], on 12/22/25 at 2:15 PM, the DON confirmed that the verbal abuse occurred and that Resident #1 was not free from abuse. 2) Per review of the facility's "Abuse, Neglect, and Exploitation" policy [last revised 11/14/25] states, "Abuse" means the willful infliction of injury, unreasonable confinement, intimidation, or punishment resulting with resulting physical harm, pain, or mental anguish, which can include staff to resident abuse and certain resident to resident altercations...1. The facility will develop and implement written policies and procedures that: a. Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of property." Per record review, Resident #2 was admitted to the facility with a diagnosis of moderate vascular dementia with anxiety. Resident #3 was admitted to the facility	F0600	Staff will be educated on residents with Dementia who exhibit aggressive behaviors towards other residents. Audits will be conducted by the Administrator, Director of Nursing, and or her designee until substantial compliance has been achieved to assure that residents remain free from Abuse. Weekly x4 then monthly x 3 Results of the audits will be reviewed during QAPI For further evaluation and recommendations. Date of Compliance: January 20, 2025 **Tag F 600 POC accepted on 1/12/26 by D. Hoffman/S. Stem**	

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F0600 SS = D	Continued from page 2 with a diagnosis of severe vascular dementia with mood disturbance and agitation. Per the facility's initial report to the State Survey Agency dated 10/8/25, an LNA witnessed a resident-to-resident altercation between Resident #2 and Resident #3, during which Resident #3 struck Resident #2 several times in the face with a closed fist. Resident #3 "has a history of resident-to-resident altercations." Per record review, Resident #3's MDS (Minimum Data Set) dated 7/22/25, Resident #3 displays physical behavioral symptoms directed towards others (hitting, kicking, pushing, scratching, grabbing, abusing others sexually). A review of Resident #3's care plan reveals a focus on exhibiting physical and verbal behaviors related to dementia, and a history of grabbing, kicking, hitting, pinching, and spitting at staff with updates that include a resident to resident interaction in which s/he hit another resident on 1/6/25 and a resident to resident interaction on 2/2/25 where s/he grabbed another resident's arm. An intervention dated 1/7/25 reads "Monitor interactions with fellow residents and remove resident from environment if he is becoming agitated by others." Per progress notes 10/4/25, Resident combative with staff during care; punching, kicking, grabbing clothes, 10/7/25, "agitated and aggressive" during morning care, punching and kicking at LNA. Per interview with the UM [Unit Manager] on 12/22/25 at 12:40 PM, she revealed that both residents were in the day room on the day of the interaction. The LNAs were providing care to other residents and were not in the day room. Per interview with the DON on 12/22/25 at 2:15 PM, she confirmed the incident with Resident #2 involving physical abuse from another resident did occur.	F0600		