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

March 26, 2026

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 plans of correction for the complaint investigation conducted on **March 5, 2026.** 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, 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 COMPLETE 03/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Villa Rehab	7 Forest Hill Drive , St. Albans, Vermont, 05478

X4) ID REFIX 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) COMPLETIOI DATE
0000	INITIAL COMMENTS The Division of Licensing and Protection conducted an unannounced, onsite investigation of one FRI [Facility Reported Incident], including report #2740146 on 2/18/26 and 3/2/26 with a follow up email from the Administrator on 3/5/26 to determine compliance with 42 CFR Part 483 requirements for Long Term Care Facilities. The following regulatory deficiencies were identified:	F0000		
0657 S = E	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive	F0657		

ıy deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other ıfeguards provide sufficient protection to the patients. (See reverse for further instructions.) Except for nursing homes, the findings stated above are disclosable 90 ays following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 day: llowing the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program ırticipation.

ABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Dana Mallett	NHA	3/26/26

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 475055	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETE 03/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Villa Rehab	**7 Forest Hill Drive , St. Albans, Vermont, 05478**

X4) ID REFIX 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) COMPLETIOI DATE
0657 S = E	Continued from page 1 and quarterly review assessments. This REQUIREMENT is NOT MET as evidenced by: Based on interview and record review the facility failed to ensure care plans were updated with interventions after recurrent falls for 2 of 3 sampled residents (Resident #1 and Resident #2). Findings include: 1. Per review of Resident #1's care plan dated 10/17/24 and revised 2/12/26, it states, "[Resident #1] is at risk for falls related to decreased mobility, pain issues and cognitive deficits, and recent falls. Most recent fall with several fractures in [his/her] bilateral lower extremities." Per review of a provider's note dated 1/16/26, it states, "Primary Chief Complaint: Fall without injury… Nurse called to report a fall without injury. Pt [Patient] was attempting to self-transfer when they lost their balance and fell onto the ground. Negative LOC [Loss of Consciousness] …" The resident's care plan read, "1/16/25: fall out of [his/her] wheelchair in [his/her] bedroom...Will monitor closely." Per review of a health status note dated 2/5/26, it states, "This writer heard a thud from the nurses' station at 0045. Upon entering the room, found [Resident #1] sitting on the floor in front of [his/her] wheelchair. [S/he was sitting between the wheelchair and the empty bed on the left side… denies hitting [his/her] head. [Resident #1] was transferred into bed to assist with the Hoyer… [Resident #1] is complaining of all over pain per [his/her] baseline especially to [his/her] LLE [left lower extremity]. VSS [vital signs] stable and neuro [neurological] vital signs stable. ROM [range of motion] within normal limits to all extremities." Per review of Resident #1's care plan, there were no interventions related to preventing the resident from falling from his/her wheelchair after falls on 1/16/26 and 2/5/26. Per review of the facility's "Comprehensive care Plans" policy [last revised 1/7/26] it states, "6. The comprehensive care plan will include measurable objectives and time frames to meet the resident's needs as identified in the resident's comprehensive assessment. The objectives will be utilized to monitor the resident's progress. Alternative interventions will be documented, as needed…8. Qualified staff responsible for carrying out interventions specified in the care	F0657	F0657– Care Plan Timing and Revision 1. Affected residents had their care plans immediately reviewed and revised by the interdisciplinary team. Individualized, measurable fall interventions were added based on root cause analysis including increased supervision clearly defined and therapy referrals. All updates provided to staff via EHR, Care Plan, and Shift Report. All employees received immediate re-education on accessing the care plan and providing updates. 2. An audit was completed for all residents with falls within the last 30 days. High fall risk residents identified. Care plans were reviewed and revised after each fall. 3. The facility implemented a dedicated care plan coordinator responsible for daily review of incidents and triggers for care plan updates and ensuring all care plans are current and individualized. The facility's new dedicated care plan coordinator collaborates with the IDT weekly to audit care plans. Staff has been re-educated on regulatory requirements regarding care plan timing and revision, documentation, and access.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 475055	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETEI 03/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Villa Rehab	7 Forest Hill Drive , St. Albans, Vermont, 05478

X4) ID REFIX 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) COMPLETIOI DATE
0657 S = E	Continued from page 2 plan will be notified of their roles and responsibilities for carrying out the interventions, initially and when changes are made." An interview was conducted with LPN#1 on 2/18/26 at 1:15 PM. LPN [Licensed Practical Nurse] #1 stated she did not know how to access the care plan for Resident #1 stating, "You just showed me how to [access the care plan]." LPN#1 confirmed there were no interventions implemented in the care plan to prevent the resident falling from her wheelchair. She also confirmed there were no fall interventions added to the resident's care plan after falls on 1/15/26 and 2/5/26. An interview was conducted with the DON [Director of Nursing] on 2/18/26 at 1:10 PM. The DON confirmed Resident #1's care plan should have been updated with interventions for falls out of his/her wheelchair for the falls that occurred on 1/16/26 and 2/5/26. 2.Per review of Resident #2's care plan dated 8/27/25 and revised on 1/23/26, it states, "[Resident #2] is at risk for falls related to bilateral left knee amputation, decreased mobility/balance, and history of falls." Per a fall risk assessment on 12/27/25 scores Resident #2 at a 17 out of 32 and is "at risk" for falls. Per review of an incident note in Resident #2's EMR [Electronic Medical Record] dated 1/11/26, it states, "LNA called to nurse saying resident is on the floor. Upon rooming in resident was found covered in feces sitting on [his/her] bottom with [his/her] back propped against the wall near beside [his/her] wheelchair. When asked what happened [s/he] said [s/he] was trying to get out of here, and then said [s/he] was just "hanging around". Reside [sic] could not give a credible account of how [s/he] landed or on what, but [his/her] fall mat was beside [his/her] bed undisturbed. Neuro vitals taken, pain assessment, nursing head to toe, hoyered to bed, cleaned up, provider and family notified." Per review of Resident #2's care plan it states, "1/11/26 [Resident #2] was found on floor after attempting to self-transfer. No injury noted. 1/23/26 [Resident #2] was found on floor mat beside [his/her] bed..." Per review of an incident note written on 2/3/26, it states, "Resident was found sitting on [his/her] bottom on the fall mat stated that [s/he] was down on the loading dock of the amtrack trying to make it across before the train came when [his/her] legs buckled and [s/he] went down. Contacted [provider] orders for neuro	F0657	4. The DON or their designee will audit 2 care plans weekly for 4 weeks, monthly for 1 month, and then as needed. Audits will validate timeliness of updates, accuracy, and individualization. Results will be reviewed in weekly QAPI meetings with corrective action taken as needed. Date of Completion: 4/5/2026 **Tag F0657 POC accepted on 3/26/26 by C. Howard/S. Stem**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 475055	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETEI 03/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Villa Rehab	7 Forest Hill Drive , St. Albans, Vermont, 05478

X4) ID REFIX 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) COMPLETIOI DATE
0657 S = E	Continued from page 3 [neurological] checks and reinforce fall protocol. Resident has no known injuries from this particular incident. [S/he] is resting in his room with call bell in reach." Per review of an incident note written on 2/1/26, it states, "Resident attempted to self transfer out of bed to get remote when [s/he] lost control and almost fell head first when LNA darted in and scooped resident under arm to avoid hitting head. Two skin tears present which were cleansed with vashe, pat dry, and covered with tegaderm. Geri sleeves applied to bilateral arms. Family notified as well as MD. Neurovitals were within normal limits. Resting at present with call bell in reach." Per review of Resident #2's care plan there were no additional documented interventions in the resident's care plan for the falls that occurred on 1/11/26 on 1/23/26. An interview was conducted with the DON on 2/18/26 at 11:37 AM. The DON stated the resident's room was changed to be closer to the nurse's station. She stated the resident was being referred to rehabilitation and the resident was on frequent checks. She confirmed this information was not in the resident's care plan. An interview was conducted with the DON on 3/2/26 at 1:35 PM. The DON confirmed Resident #2's care plan did not have any interventions added after the falls on 1/11/26 and 1/23/26.	F0657		
0689 S = G	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 ensure 1 of 3 residents sampled was provided with adequate supervision and assistance devices to	F0689	F0689 – Free of Accident Hazards/Supervision/Devices 1. The facility reviewed the resident's clinical status including fall history and overall condition. The facility ensured care interventions were consistent with the resident's goals of care. The facility completed a comprehensive retrospective review of resident's care including fall interventions, supervision levels, and care	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 475055	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETEI 03/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Villa Rehab	**7 Forest Hill Drive , St. Albans, Vermont, 05478**

X4) ID REFIX 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) COMPLETIOI DATE
0689 S = G	Continued from page 4 prevent accidents (Resident #1), by failing to systematically evaluate the effectiveness of interventions or revise care plan interventions after falls occurred. As a result, Resident #1 suffered a fall and sustained significant fractures in both ankles. This is a repeat deficiency with the violation cited during a previous complaint survey dated 7/30/25. Findings include: Per record review, Resident #1 is assessed as having cognitive impairment, with diagnoses which include Alzheimer's Disease, osteoarthritis of the knee and muscle weakness. Resident #1 is dependent on staff for activities of daily living and hygiene and requires a mechanical lift for transfers. Per record review of a Fall Risk Evaluation on 12/30/25 scores the resident as an 11 out of 32 and is "at risk" for falls. Per record review of a Fall Risk Evaluation on 1/13/26 scores the resident as a 13 out of 32 and is "at risk" for falls. Per the facility's "Fall risk, fall prevention and post-fall protocol" policy [last revised 1/7/26] states, "3. For residents determined to be at risk for falls, prevention strategies and an "At risk for Falls" care plan will be implemented. Strategies will be based on results of the fall risk assessment resident's individualized care plans related to falls will include interventions, including adequate supervision, consistent with a resident's needs, goals, and current standards of practice in order to reduce the risk for falls…9. The interdisciplinary team will monitor the effectiveness of the care plan interventions, and modify the interventions as necessary, in accordance with current standards of practice." Per record review, Resident #1 has a care plan for being at risk for falls, which included interventions of: "Assess presence of drugs that may cause falls," "Encourage resident to get in bed when tired" "Involve in activity programs as tolerated," and "Maintain safety (call bell within reach, bed in lowest position, proper lighting, appropriate footwear etc)." Per review of physician notes, the resident fell on 12/11/25 out of their wheelchair in their room. The resident was found on the floor by staff and complained of severe knee pain. The resident's care plan was updated at this time only to record the fall with injury, stating the resident sustained a head hematoma [bruise with swelling and pain] and large bruise to their knee. The only update to his/her care plan was "Follow facility fall policy."	F0689	plan accuracy. Opportunities for improvement identified and implemented immediately with all residents as needed to prevent recurrence. This includes specific, measurable interventions and revisions following repeated falls. 2. An audit was completed of all residents with falls within the last 30 days and high fall risk residents have been identified. The audit included verification of appropriate supervision levels and the presence of individualized interventions. Any identified deficiencies were corrected immediately including implementation of additional supervision. 3. A post-fall observation tool has been implemented to help IDT perform root cause analysis after every fall. The post fall observation tool is immediately sent for a therapy referral and the IDT reviews weekly. A mandatory care plan review task is now triggered automatically in the facility's EHR to ensure completion and compliance. Individualized supervision has been defined. All staff will be re-educated on supervision requirements	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 475055	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETE 03/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Villa Rehab	**7 Forest Hill Drive , St. Albans, Vermont, 05478**

X4) ID REFIX 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) COMPLETIOI DATE
0689 S = G	Continued from page 5 The resident's record states that the resident fell again on 1/16/26 while trying to self-transfer. The resident did not sustain injuries, and the care plan was updated at this time to record the fall and adds an intervention of "will monitor closely", without timeframes or definition of what that meant for staff's responsibilities. The resident's record states that the resident fell on 2/5/26, again in their room and again involving the resident's wheelchair, with the resident being found on the floor after staff heard a thud. The resident was complaining of left leg pain. The resident's care plan addressing falls/safety was not updated after this fall to include any new interventions despite the pattern revealed with these 3 falls. Another fall occurred on 2/8/26 where staff responded to the resident screaming from their room and found the resident on the floor in front of their wheelchair. The resident was in pain and acute distress, holding their right knee and not moving their right leg. The resident was brought to the local emergency room and diagnosed with a fracture. Repeated imagery on 2/9/26 revealed bilateral [both sides] displaced severe ankle fractures. Per interview with a staff Licensed Practical Nurse (LPN #1) on 2/18/26 at 4:44 PM, she did not know how to access the care plan for Resident #1. When showed by the surveyor, the LPN confirmed there were no fall interventions implemented to specifically prevent falls from the wheelchair, and confirmed no interventions were added after the falls on 1/16/26 or 2/5/26. Per interview with the DON on 3/2/26 at 1:00 PM she stated that increased supervision was not implemented for Resident #1. At 2:21 PM the DON confirmed that the resident was on 2-hour checks and the facility did not formally increase any supervision. The DON confirmed the IDT notes were not in the resident's record. The DON confirmed that the only intervention added was a sleep hygiene assessment which is not noted in his/her care plan.	F0689	and care plan access with a return demonstration and competency validation. 4. The DON or designee will review all falls daily along with the consequent tasks to follow each for 4 weeks and then weekly. Results are reported to QAPI weekly. Interdisciplinary risk assessments will be discussed weekly as QAPI. All residents will be assessed for fall risk on admission, with significant change in condition, quarterly and as needed. A medication review after every fall will be completed by DON. Compliance and effectiveness will be monitored and adjusted as needed to prevent recurrence. Completion Date: 4/15/2026 **Tag F0689 POC accepted on 3/26/26 by C. Howard/S. Stem**	