STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	475021	A. Building B. Wing	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, VT 05478

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. (continued on next page)

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 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 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.