STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	475047	A. Building B. Wing	04/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Franklin County Rehab Center, LLC	110 Fairfax Road St. Albans, VT 05478

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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 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. Based on interview and record review, the facility failed to ensure that 2 of 2 licensed nurses, a Registered Nurse (RN) and a Licensed Practical Nurse (LPN) (RN #1 and LPN #1) and 4 of 5 Licensed Nursing Assistants (LNAs) in the sample (LNAs #1, #2, #3, and #4) were assessed for appropriate competencies and skill sets needed to provide resident care based on resident assessment, individual plans of care, and identified in the facility assessment. This has the potential to impact all residents. Findings include:Review of the facility assessment last reviewed by the facility Quality Assessment and Assurance (QAA) committee on 1/22/2026 the facility assessment will be used to: - 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 assessment and plans of care; Under the heading INFORMATION ABOUT OUR STAFF TRAINING/EDUCATION AND COMPETENCIES it refers to a document titled Facility Education/Staff Competencies Necessary To Care For Resident Population that identifies four categories of competencies to include knowledge, assessment, pharmacological/treatment/care considerations, and technical/hands-on skills. This document includes competencies such as wound care, dressing changes, medication administration, activities of daily living, respiratory care, incontinence care, and oral care/grooming to be completed upon hire and annually. Per review of LNA #1's education and competency file she is a traveler and began working at the facility on 1/26/2026. There was no evidence that LNA #1 had been assessed for competency in the areas identified in the facility assessment. Review of LNA #2's education and competency file revealed that there was no evidence the LNA had been assessed for competency in the areas identified in the facility assessment. Review of LNA #3's education and competency file she is a Traveler and began working at the facility on 12/15/2025. There was no evidence in their file that they had been assessed for competency in the areas identified in the facility assessment. Per review of LNA #4's education and competency file she is a traveler who was hired on 10/6/2025. There was no evidence in the file that she had been assessed for competency in the areas identified in the facility assessment. Review of an RN #1 training and competency file revealed that she had not been assessed for competency in the areas identified in the facility assessment. Review of LPN #1 who is a traveler with a date of hire of 6/16/25 revealed that there was no evidence that the facility had assessed her for competency in the areas identified in the facility assessment. Per interview on 4/21/2026 at approximately 3:00 PM the Nurse Educator confirmed that RN #1 had not been assessed for competencies since she took a management position and no longer required competency evaluation. The Nurse Educator stated that travelers/agency staff meet with the Director of Nursing (DON) when they are hired and that she is not involved in the onboarding of agency/travelers. During an interview on 4/21/2026 at approximately 3:25 PM the DON stated that competencies are completed through the travel agency and observed by in-house staff to assess patient preferences, facility-specific preferences, and expectations. The DON confirmed that competencies are not documented for travelers by the facility as they are for in-house staff.

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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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation and interview, the facility failed to store food in accordance with professional standards for food service safety. This has the potential to impact all residents. Findings include: A kitchen tour was conducted with the Dietary Manager on 4/20/26 at 10:45 AM. Per observation of the kitchen prep area, the following expired items were found: Cream of Tartar dated 6/8/17. Taco seasoning dated 11/7/23. Tarragon dated 5/3/24. Rotisserie seasoning dated 12/12/24. Allspice dated 6/11/19. Per observation of the walk-in refrigerator, the following items were found improperly stored: Pancakes sealed in plastic but not dated. (2) Ziploc bags of fruit that were not dated. Per observation of the walk-in freezer, the following items were found improperly stored: An open sleeve of frozen hamburgers which was not dated. Per interview with the Dietary Manager at the time of the tour, they stated that expired seasonings and spices should be thrown out. They stated that prepared and open food should be labeled with the date it was opened or made and the date that it should be discarded, and containers and packages should be sealed. They confirmed that the above items were either expired or improperly stored. Review of the facility policy dated, Date Marking for Food Safety, dated 9/10/20, states the following. Perishable food shall be clearly marked to indicate the date or day by which the food shall be consumer or discarded. The Head [NAME] or designee shall be responsible for checking the refrigerator daily for food items that are expiring and shall discard accordingly. The dietary manager shall spot check refrigerators weekly for compliance.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. Based on observation, interview, and record review, the facility failed to ensure that infection control measures were followed related to preventing contamination of laundry by leaving wet clean laundry in the washer overnight, which has the potential to impact all residents, and failed to ensure that infection control measures regarding hand hygiene were followed during medication administration for 2 of 2 sampled residents (Resident #7 and Resident #40). Findings include: 1) Per interview on 4/22/2026 at 10:30 AM, a member of housekeeping confirmed the process for leaving wet laundry in the washers overnight every day. Per an interview with the Assistant Director of Nursing, who is also the Infection Preventionist, at 9:30 AM on 4/22/2026, she confirmed that laundry should not be left wet overnight in the washers. The facility policy Laundry, last reviewed/revised on 7/6/25, does not address leaving wet clean laundry in the washer overnight, per CDC infection control recommendations. Leaving wet, clean laundry in the washing machine overnight can lead to the growth of mildew (a fungus that grows in warm, damp environments). Some symptoms that exposure to mildew can cause are wheezing, coughing, skin rash, itchy eyes, and runny nose. People with asthma, respiratory illness, and immune disorders, as well as the elderly, are at an increased risk. Work cited: Cleveland Clinic https://health.clevelandclinic.org/mold-what-you-need-to-know-to-cut-your-risk Updated May 26, 2025, Retrieved February 20, 2026 Guidelines for Environmental Infection Control in Health-Care Facilities (2003), G.II. Laundry Facilities and Equipment Part II. Recommendations for Environmental Infection Control in Health-Care Facilities | Infection Control | CDC Last updated January 11, 2024, Retrieved April 23, 2026 2) During observation of medication administration on 4/21/2026 at 8:22 AM, an LPN (Licensed Practical Nurse) did not perform hand hygiene by either using hand sanitizer or soap and water as required when preparing and administering medications for Residents #7 and #40. Facility policy titled Medication Administration, review date 6/24/2025, states that hand hygiene will be performed before and after medication administration. using a hand sanitizer containing at least 60% alcohol or alternatively soap and water. Per interview on 4/21/2026 at 8:30 AM, the LPN confirmed that she did not perform hand hygiene before or after medication administration for Resident #7 and Resident #40 and should have.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. Based on interview and record review, the facility failed to review and revise resident care plans for 2 out of 17 sampled residents related to falls (Residents #40, and #48). Findings include:1) Per record review, Resident #40 has diagnoses that include: Anxiety disorder, major depressive disorder, peripheral neuropathy, atherosclerotic heart disease, weakness, presence of artificial hip, peripheral neuropathy, atherosclerotic heart disease, weakness, and presence of artificial hip. Per review of nursing progress notes, Resident #40 was found on the floor of his/her bathroom on 3/25/2026 after experiencing an unwitnessed fall.Per record review of Resident #40's care plan, s/he is at risk for falls related to weakness and peripheral neuropathy. His/Her care plan was last updated on 3/18/2026 with no new interventions entered for the fall on 3/25/2026. Per interview with the Director of Nursing (DON) on 4/21/2026 at 1:00 PM, care plans are revised and updated after each fall. She confirms that Resident #40's care plan was not revised and updated after the fall on 3/25/2026 and should have been.2) Per record review, Resident #48 has diagnoses that include: Muscle weakness, unsteadiness on feet, other drug induced secondary Parkinsonism, hypertensive heart disease with heart failure, congestive heart failure (CHF), major depressive disorder, anxiety disorder, and difficulty walking.Nursing progress notes from 3/21/2026, describe a fall experienced by Resident #48 while s/he was attempting to self-transfer. Per record review of Resident #48's care plan, s/he is at risk for falls related to weakness.Per record review the interdisciplinary team (IDT) met on 3/25/2026 and Resident #48's most recent fall [3/21/2026] was discussed with a statement that care plan had been updated as needed. The care plan was last revised on 3/8/2026 and did not reflect any new fall prevention measures for the fall on 3/21/2026. Per interview with the Director of Nursing (DON) on 4/21/2026 at 1:00 PM, care plans are revised and updated after each fall. She confirms that Resident #48's care plan was not revised and updated after the fall on 3/21/2026 and should have been.

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure that a resident was provided with an appropriately sized bed for 1 of 17 residents in the sample, (Resident #33). Findings include: Per record review Resident #33 was admitted on [DATE]. A care plan focus dated 3/20/2026 states that Resident #33 is at risk for skin breakdown related to decreased mobility. Interventions include Turn and position every 2 hours and as needed, revised on 3/23/2026. During an interview on 4/20/2026 at 11:37 AM, Resident #33 was observed lying on their back in bed with their feet hanging off the end of the bed by at least 4 inches. Their feet were extended downward with the weight of the blankets. The Resident stated that their feet always hang off because the bed was too short. S/he stated that they are 6' 1 feet tall and did not understand why the bed was so short. The Resident explained that it was hard to reposition themselves because the bed was so small. The Resident also said that staff were aware that the length of the bed caused her/his feet to hang over the end and were trying to get her/him another bed, but it has been a while. Per interview on 4/21/2026 at 11:33 AM the interim Charge Nurse about the resident's bed, she stated that maintenance had been notified of the bed being too short, and they were working to find an adequate solution. Per interview on 4/22/2026 at 12:30 PM the Director of Nursing (DON) and Assistant Director of Nursing confirmed that the facility had been aware that Resident #33's bed was too short and that the Resident's feet hung over the end of the mattress. The DON stated that the facility does not have extra beds to switch out when one doesn't fit a Resident and they had needed to find one that would fit.

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. Based on interview and record review, the facility failed to notify the resident's physician of a significant health change for 1 of 17 sampled residents (Resident #5), that experienced a significant weight loss. Findings include: Record review shows that Resident #5 has diagnoses that include multiple sclerosis, dementia, chronic kidney disease, type 2 diabetes mellitus, and hypothyroidism. Resident #5's care plan has a dietary information focus initiated 6/5/24 with an intervention stating I want to maintain my current weight initiated on 6/5/2024. Her/his dietary information care plan has an intervention stating, I have the following dietary risks: Risk for weight fluctuation initiated on 6/5/2024. Resident #5's care plan focus for diabetes mellitus initiated 6/5/24 includes an intervention which states Update MD with health changes initiated on 06/05/2024. Record review shows that Resident #5 weighed 253 pounds on 3/17/2026. The weight documented for Resident #5 on 4/14/26 was 239.8 pounds. Resident #5 was re-weighed on 4/14/26 with a weight of 239.5 pounds. The weight loss of 13.5 pounds or 5.3% in a 27-day period between 3/17/26 and 4/14/26 is a significant weight loss, per MDS (Minimum Data Set) guidelines. Review of the facility policy titled Resident Status, revised 1/1/2016, states that the Charge Nurse is responsible for calling the resident's physician in case of a sudden change in resident condition. Per interview with RN #1 (Registered Nurse) and RN #2 on 4/21/26 at 11:36 AM, RN #1 confirmed that nursing had not notified Resident #5's physician about this health change, stating as she reviewed the resident's medical record, There's nothing. RN #2 confirmed the physician had not been notified about this change.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on observation, interview, and record review the facility failed to develop a person-centered care plan for 1 of 17 sampled residents (Resident #2) in regard to monitoring behaviors and depression. The findings include:Per record review Resident #2, was admitted to the facility with a diagnosis of depression. Per Resident #2's Minimum Data Set (MDS; a comprehensive assessment used as a care-planning tool) dated 2/11/26, s/he has feelings of depression nearly every day and has behaviors.Per interview on 4/20/2026 at approximately 1:27 PM, Resident #2 was pleasantly answering this surveyor's questions and was making jokes, and overall in good spirits during the interview. However, the resident started to mention with an agitated tone how s/he is always getting a bladder scan and felt that the staff had nothing better to do. Per record review, progress notes dated 4/17/26 and 4/18/26 indicate that Resident #2 has been having an increase in agitation and verbal aggression towards staff. Also, Resident #2 was found to have a diagnosis of depression. The resident has not been care planned for depression or behaviors. Per interview on 4/21/2026 at approximately 1:14 PM, a Registered Nurse (RN) verbalized that resident was having increasing frequency in agitation and behaviors. When offered Geri-psych in the past they have refused the service. The RN verbalized that the resident should be care planned for the behaviors but has not looked at their care plan in some time. Per interview on 4/21/2026 at approximately 2:33 PM, the Assistant Director of Nursing (ADON) verbalized that Resident #2 does exhibit some behaviors at times and that they should be care planned for their behaviors. The ADON was unable to locate behaviors in Resident #2's care plan and confirmed that the resident was not and that they should be care planned for the behaviors and depression. Per interview on 4/21/2026 at approximately 3:09 PM, the MDS Coordinator confirmed that Resident #2 was not care planned for depression and that they should be. Per Policy titled Behavioral Health Services .2. The facility utilizes the comprehensive assessment process for identifying and assessing a resident's mental and psychosocial status and providing person-centered care. This process includes.e. Care plan development and implementation, and evaluation. Per Policy titled: Comprehensive Care Plans Policy Explanation and Compliance Guidelines:.3. The comprehensive care plan will describe, at a minimum, the following:a. The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being.b. Any services that would otherwise be furnished, but are not provided due to the resident's exercise of his or her right to refuse treatment.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. Based on interview and record review the facility failed to ensure interventions were implemented, evaluated, and modified after a significant weight loss for one of 17 sampled residents (Resident #5). Findings include: Record review shows that Resident #5 has diagnoses that include multiple sclerosis, dementia, chronic kidney disease, type 2 diabetes mellitus, and hypothyroidism. Resident #5's care plan has a dietary information focus initiated 6/5/24 with an intervention stating I want to maintain my current weight initiated on 6/5/2024. Her/his dietary information care plan has an intervention stating, I have the following dietary risks: Risk for weight fluctuation initiated on 6/5/2024. Resident #5's care plan focus for diabetes mellitus initiated 6/5/24 includes an intervention which states Update MD with health changes initiated on 06/05/2024. Record review shows that Resident #5 weighed 253 pounds on 3/17/2026. The weight documented for Resident #5 on 4/14/26 was 239.8 pounds. Resident #5 was re-weighed on 4/14/26 with a weight of 239.5 pounds. The weight loss of 13.5 pounds or 5.3% in a 27-day period between 3/17/26 and 4/14/26 is a significant weight loss, per MDS (Minimum Data Set) guidelines. Per record review, Resident #5's dietary care plan was not revised to reflect this significant weight loss. Resident #5's medical record did not contain documentation that her/his physician had noted or addressed this significant weight loss. It did not include documentation that the dietitian had noted or addressed the significant weight loss. It did not include documentation that nursing had noted or addressed the significant weight loss, given that two weights were taken on 4/14/26, both reflecting a greater than 5% weight loss in a 27-day period. Per interview with RN #1 (Registered Nurse) and RN #2 on 4/21/26 at 11:36 AM, RN #1 confirmed that that Resident #5's medical record did not contain documentation addressing her/his weight loss, stating as she reviewed the resident's medical record, There's nothing. RN #2 confirmed Resident #5's medical record did not contain documentation noting or addressing the significant weight loss.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observations and interviews, the facility failed to ensure medications were properly stored for 2 of 17 sampled residents (Resident #30s and Resident #14). This is a repeat deficiency for this facility, with the violation cited during the previous recertification survey dated 3/12/25. Findings include:Per observation on 4/20/2026 at approximately 1:07 PM, Resident # 30 had Biotene lozenges on their bedside table.Per observation on 4/21/2026 at approximately 9:54 AM, Resident #14 had a prescription topical ointment on their bedside table.Per interview on 4/21/2026 at approximately 10:31 AM, Resident #30 stated that the Biotene lozenges (medicated lozenges) are always left at their bedside and that they are allowed to self-administer as many as they need to. Per interview on 4/21/2026 at approximately 10:45 AM, the Assistant Director of Nursing (ADON) confirmed that all medications and medicated products ordered by the provider and received from the pharmacy should not be left at the bedside for residents to self-administer. The ADON confirmed that residents need an order for self-administration. The ADON confirmed that prescribed medicated ointment and the Biotene lozenges should not be at the bedside. Per facility policy titled Medicines, revised date 1/1/2016, it reads . 2) No medicines are allowed to be kept at the resident's bedside at any time unless so prescribed by the physician and determined to be safe by Nursing after completing a self-administration of medication assessment.