STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	475055	A. Building B. Wing	05/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Villa Rehab	7 Forest Hill Drive St. 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. Based on interview and record review, the facility failed to protect 1 of 4 residents (Resident #1) from verbal abuse by a Licensed Nursing Assistant (LNA). Findings include:Per interview on 5/26/26 at 12:48 PM with a Licensed Practical Nurse (LPN), she reported that she was the nurse on duty on 2/16/26 at approximately 1 to 2 AM, who witnessed and reported an LNA for abuse against Resident #1. The LPN stated that the LNA came up close to her when she was at the med cart and cursed saying that the LPN better go get Resident #1 and then cursed again stating Resident #1 had just urinated in their face. The LPN then walked into Resident #1's room and saw that s/he was standing there naked, with urine on the floor, and that s/he looked terrified. The LPN reported that while assisting Resident #1 with care, the LNA then came in the room and cursed at Resident #1 about how s/he urinated in the LNA's face.Per record review of Resident #1's progress notes, there is a note titled Incident Note dated 2/17/26 that states that an LNA went into Resident #1's room and cursed at the resident about how they urinated in the LNA's face. The note then mentions that the Resident looked startled and terrified.Per review of the facility investigation titled Complaint Investigation with the date of the complaint as 2/16/26, it states that the Employee was seen yelling at and using profanity at a resident after urine accidentally splashed on his face. This employee then stated he wanted to punch [him/her] (resident) in the face because he was so mad.Per review of Resident #1's medical diagnosis, they have a diagnosis of dementia.Per review of the reasonable person concept, a person with intact mental status (without a diagnosis of dementia or disease process that affects a person's response) would have experienced mental anguish as a result of being left undressed and then sworn and yelled at by a staff member.Per review of the facility policy titled Abuse, Suspicious Crimes & Resident to Resident Incident Investigating/Reporting reviewed on 1/7/26 it states Our Facility will not permit our residents to be subject to abuse by anyone, including staff members, other residents, family members, legal guardians, friends, consultants, volunteers, sponsors, staff of other agencies serving the residents or other individuals. The policy then defines verbal abuse; is defined as any use of oral, written or gestured language that willfully includes disparaging and derogatory terms to residents or their families, or within their hearing distance, regardless of their age, ability to comprehend or disability. Examples would be, but are not limited to: threats of harm, saying things to frighten a resident, telling a resident they will never see their family again, etc.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	475055	A. Building B. Wing	05/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Villa Rehab	7 Forest Hill Drive St. 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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based on interview and record review, the facility failed to submit their five-day investigative report to the Division of Licensing and Protection within the allotted time. Findings include:Per interview on 5/26/26 at 12:48 PM with a Licensed Practical Nurse (LPN), she reported that she was the nurse on duty on 2/16/26 at approximately 1 to 2 AM, who witnessed and reported a Licensed Nursing Assistant (LNA) for abuse against Resident #1. The LPN stated that the LNA came up close to her when she was at the med cart and cursed saying that the LPN better go get Resident #1 and then cursed again stating Resident #1 had just urinated in their face. The LPN then walked into Resident #1's room and saw that s/he was standing there naked, with urine on the floor, and that s/he looked terrified. The LPN reported that while assisting Resident #1 with care, the LNA then came in the room and cursed at Resident #1 about how s/he urinated in the LNA's face. Refer to F600 for more information.Per interview on 5/26/26 at 1:18 PM with the Director of Nursing and Administrator, the Administrator stated she could not find the five-day investigative report for this incident and was unable to provide evidence that they had submitted the required five-day investigative report in a timely manner.Per review of the facility policy titled Compliance with Reporting Allegations of Abuse/Neglect/Exploitation reviewed 1/7/26, it states that the facility will report all alleged and substantiated incidents to the state agency and other agencies as required and that the Administrator will follow up with the appropriate agencies, and Within 5 working days of the incident, report sufficient information to describe the results of the investigation, and indicate any corrective actions taken, if the allegation was verified.Per review of the facility policy titled Abuse, Suspicious Crimes & Resident to Resident Incident Investigating/Reporting reviewed on 1/7/26 it states that Within 5 working days the Social Worker, Director of Nursing Services and/or Administrator, will complete a thorough investigation of the reported abuse, suspicious crime or resident to resident incident. This person will complete the Facility Reported Incidents-Investigative Summary Form. These results will be sent to the Division of Licensing and Protection, Adult Protective Services, and the Local Law Enforcement Office when being used.