VERMONT

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

June 18, 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 **May 26, 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
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 COMPLETED 05/26/2026

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

(X4) ID 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
=0000	INITIAL COMMENTS The Division of Licensing and Protection conducted an unannounced, onsite investigation of 1 facility reported incident, including report #2744763 on 5/26/26 to determine compliance with 42 CFR Part 483 requirements for Long Term Care Facilities. The following regulatory deficiencies were identified:	F0000	F600 – Free From Abuse and Neglect 1. Corrective Action for Resident Affected Resident #1 was immediately assessed following the incident. The allegation was reported and investigated according to facility policy. The employee involved was immediately removed from resident care pending investigation and appropriate corrective action was taken. Resident #1 was monitored following the incident and no further concerns related to this event were identified. 2. Identification of Other Residents Potentially Affected All residents have the potential to be affected by the alleged deficient practice. The Administrator and Director of Nursing reviewed facility grievances, abuse allegations, and reportable incidents from the	
=0600 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 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.	F0600		

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F0600 SS = D	Continued from page 1 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."	F0600	previous 30 days to identify any similar concerns. No additional residents were identified as having been affected. 3. Measures Put Into Place/Systemic Changes Although the facility maintains an established abuse prevention program that includes pre-employment screening, orientation training, and annual abuse prevention education, the facility provided additional reinforcement education to all staff regarding resident rights, abuse prevention, professional conduct expectations, and reporting requirements following this isolated incident 4. Monitoring The Administrator or designee will review all allegations of abuse, neglect, mistreatment, and grievances weekly for four weeks and monthly for two months to ensure allegations are promptly reported, investigated, and addressed according to facility policy.	
F0609 SS = D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4)	F0609		

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F0609 SS = D	Continued from page 2 §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is NOT MET as evidenced by: 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.	F0609	Results of these reviews will be presented to the Quality Assurance and Performance Improvement Committee for further review and recommendations as indicated. Completion Date: June 15, 2026 **Tag F0600 POC accepted on 6/17/26 by G. Prefontaine/S. Stem** F609 – Reporting of Alleged Violations 1. Corrective Action for Resident Affected The facility completed and submitted the required investigative findings related to the incident. No resident-specific corrective action was required. 2. Identification of Other Residents Potentially Affected The Administrator reviewed reportable incidents from the previous 90 days to verify required reporting and investigative documentation was completed and maintained according to facility policy. No documentation concerns were identified. 3. Measures Put Into Place/Systemic Changes	

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F0609 SS = D	Continued from page 3 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."	F0609	The Administrator, Director of Nursing, Social Services Director, and designees responsible for reportable incidents were re-educated regarding federal and state requirements for submission of investigative summary within five working days. A tracking log of final investigative summaries has been implemented to monitor all reportable incidents and ensure timely completion and submission of required investigative documentation. 4. Monitoring The Administrator or designee will audit 100% of reportable incidents for three months to ensure required reports are completed and submitted within regulatory timeframes. Results will be reviewed through the Quality Assurance and Performance Improvement Committee, with additional corrective action implemented as necessary. Completion Date: June 15, 2026 **Tag F0609 POC accepted on 6/17/26 by G. Prefontaine/S. Stem**	