



**AGENCY OF HUMAN SERVICES**  
**DEPARTMENT OF DISABILITIES, AGING AND INDEPENDENT LIVING**

Division of Licensing and Protection  
HC 2 South, 280 State Drive  
Waterbury, VT 05671-2060  
<http://www.dail.vermont.gov>  
Survey and Certification Voice/TTY (802) 241-0480  
Survey and Certification Fax (802) 241-0343  
Survey and Certification Reporting Line: (888) 700-5330  
To Report Adult Abuse: (800) 564-1612

January 3, 2022

Ms. Coleen Condon, Administrator  
Franklin County Rehab Center Llc  
110 Fairfax Road  
St Albans, VT 05478-6299

Provider ID #: 475047

Dear Ms. Condon:

The Division of Licensing and Protection completed a survey at your facility on **December 21, 2022**. The purpose of the survey was to determine if your facility was in compliance with Federal participation requirements for nursing homes participating in the Medicare/Medicaid programs.

This survey found that your facility was in substantial compliance with the participation requirements.

Congratulations to you and your staff.

Sincerely,

Pamela M. Cota, RN  
Licensing Chief

Enclosure

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/03/2023  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>475047</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>12/21/2022</b>
NAME OF PROVIDER OR SUPPLIER  <b>FRANKLIN COUNTY REHAB CENTER LLC</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>110 FAIRFAX ROAD ST ALBANS, VT 05478</b>	
(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
E 000	Initial Comments	E 000		
	A review of the facility's Emergency Preparedness Program was conducted in conjunction with the annual recertification survey on 12/21/22. There were no regulatory deficiencies as a result of the review.			
F 000	INITIAL COMMENTS	F 000		
	An unannounced onsite recertification survey and staff vaccination requirement review was conducted by the Division of Licensing and Protection from 12/19/22 to 12/21/22. As a result of the survey, the facility was found to be in substantial compliance.			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

*Coleen Condou*

TITLE

*Administrator/owner* 1/3/2023

(X6) DATE

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.