



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

August 21, 2024


Jessica Jennings, Administrator
Saint Albans Healthcare and Rehabilitation Center
596 Sheldon Road
Saint Albans, VT 05478-8011

Provider #: 475021

Dear Ms. Jennings:

The Division of Licensing and Protection conducted an onsite complaint investigation on **August 21, 2024**. The purpose of the investigation was to determine if your facility was in compliance with Federal participation requirements of the Medicare/Medicaid Program. The investigation was completed on **August 21, 2024**, and there were no regulatory violations related to the complaint allegations.

Sincerely,


Pamela M. Cota, RN
Licensing Chief

Enclosure

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

PRINTED: 08/21/2024
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 475021	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 08/21/2024
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NAME OF PROVIDER OR SUPPLIER SAINT ALBANS HEALTHCARE AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 596 SHELDON ROAD SAINT 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)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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F 000	<p>INITIAL COMMENTS</p> <p>The Division of Licensing and Protection conducted an unannounced, onsite complaint investigation, including report(s) # [ACTS 22917, 22814], on 8/21/2024 to determine compliance with 42 CFR Part 483 requirements for Long Term Care Facilities. No deficiencies were cited as a result of this survey.</p>	F 000		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (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.