



**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

October 17, 2024

April Furlow, Administrator  
The Villa Rehab  
7 Forest Hill Drive  
St Albans, VT 05478-1615

Provider #: 475055

Dear Ms. Furlow:

The Division of Licensing and Protection conducted an onsite complaint investigation on **October 16, 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 **October 16, 2024**, and there were no regulatory violations related to the complaint allegations.

Sincerely,

A handwritten signature in cursive script that reads "Pamela M. Cota RN".

Pamela M. Cota, RN, BS  
Assistant Division Director  
State Survey Agency Director

Enclosure

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

PRINTED: 10/17/2024  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>475055</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>10/16/2024</b>
NAME OF PROVIDER OR SUPPLIER  <b>THE VILLA REHAB</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>7 FOREST HILL DRIVE</b> <b>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	
F 000	INITIAL COMMENTS  The Division of Licensing and Protection conducted an unannounced, onsite complaint investigation of report #22620& #22769 on 10/16/2024 to determine compliance with 42 CFR Part 483 requirements for Long Term Care Facilities. No deficiencies were cited as a result of this survey.	F 000			
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.