STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	475014	A. Building B. Wing	05/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Premier Rehab and Healthcare at Burlington	300 Pearl Street Burlington, VT 05401

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 record review and interview, the facility failed to assure that 2 of 4 residents reviewed were free from physical abuse (Resident #1 and Resident #3). 1. Per record review, Resident #1 was the victim of a physical assault on 5/18/25 at 9:30 AM. A progress note dated 5/18/25 says, Resident noted to have verbal altercation with [Resident #2], resulting in [Resident #2] hitting resident on the side of the face. Per interview with Resident #1 on 5/20/25 at 11:43 AM, s/he reported that Resident #2 was touching his/her belongings and when s/he tried to get Resident #2 to stop, it resulted in him/her getting hit in the head by Resident #2. A review of the facilities policy titled Abuse, Neglect and Exploitation dated 4/2025 states Abuse means the willful infliction of injury .with resulting physical harm, pain, or mental anguish .Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain, or mental anguish. Per interview with the [NAME] President of Clinical Operations, the Administrator, and the Assistant Director of Nursing on 5/20/25 at 3:29 PM, they confirmed that this incident occurred between Resident #1 and Resident #2. 2. Per record review, Resident #3 was the victim of a physical assault on 5/16/25 at 10:29 AM from Resident #4. A progress note dated 5/16/25 says, Resident was standing in the doorway, and another resident came up to [him/her] and punched [him/her] in the left side of the chest. Skin assessment completed. No bruising noted. Per interview with the [NAME] President of Clinical Operations, the Administrator, and the Assistant Director of Nursing on 5/20/25 at 3:35 PM, they confirmed that this incident occurred between Resident #3 and Resident #4.

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
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(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 ensure that an allegation of abuse was reported to the licensing agency for 1 of 5 sampled residents (Resident #5). Per record review, the facility was unable to provide evidence that they submitted a report to the state licensing agency after Resident #5 reported an allegation of abuse; being hit with a wet towel by a staff member. Additionally, there is no evidence of an investigation in Resident #5's medical record. Per interview with Resident #5's nurse on 5/20/25 at 11:54 AM, she reported that she sent a message using the electronic health record (EHR) reporting this incident on 4/29/25 and that Resident #5's hospice nurse also communicated with the Assistant Director of Nursing and the former Director of Nursing about this allegation of abuse. She reported that the Director of Nursing and Administration were aware of the allegation of abuse. A review of the facilities policy titled Abuse, Neglect and Exploitation dated 4/2025 states that an Alleged Violation is a situation or occurrence that is observed or reported by staff, resident, relative, visor or others but has not yet been investigated and, if verified, could be indication of noncompliance. Additionally, the section titled Policy Explanation and Compliance Guidelines marked number 2 states The facility will designate an Abuse Prevention Coordinator in the facility who is responsible for reporting allegations or suspected abuse, neglect, or exploitation to the state survey agency and other officials in accordance with state law and that an immediate investigation is warranted when suspicion of abuse, neglect or exploitation, or reports of abuse, neglect or exploitation occur. The section of this policy titled Reporting/Response states The facility will have written procedures that include: Reporting of all alleged violations to the Administrator, state agency, adult protective services and all other required agencies . within specified timeframes . Per interview with the [NAME] President of Clinical Operations, the Assistant Director of Nursing, and the Administrator on 5/20/25 at 3:49 PM, they reported that the hospice nurse informed them of the allegation of abuse, but they didn't report the allegation to the state because they didn't believe abuse had occurred based on Resident #5 having hallucinations.