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	12/17/2025

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

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations and interviews, the facility failed to provide a safe, clean, comfortable, and homelike environment regarding construction debris and resident room equipment maintenance and repair on 1 of 4 units (Second Floor).Findings include:1. Per observation on 12/15/2025 at approximately 2:10 PM, a white/grey powder like substance was on the code cart, wound care/treatment cart, and the precaution supply carts. Per interview on 12/15/2025 at approximately 2:30 PM with the LPN on the Second floor, they confirmed the code cart, wound care cart, and precaution supply carts were dusty with white/grey powder and needed to be cleaned. Per interview with 12/15/2025 at 3:09 PM with the Director of Nursing (DON), she confirmed there was dust on the code cart, suction machine, precaution supply carts, and treatment cart containing construction dust and that they all needed to be cleaned. During observation of the Second floor on 12/17/25 at 9:41 AM, Hoyer lifts, a mechanical device used to lift and transfer residents with limited mobility safely, were observed with dust-like material that had a white powder look on the base of the equipment. Per interview on 12/17/2025 at 9:57 AM with the Infection Preventionist, Director of Nursing (DON), and the Regional Nurse Consultant, they confirmed the debris seen on the Second floor. During the observation of the Second floor on 12/17/25 at 11:28 AM, the Regional Nurse Consultant acknowledged that the Hoyer lifts required cleaning due to construction dust and reported that housekeeping was working on it. During an interview on 12/17/25 at 12:19 PM with the Assistant Administrator and the DON, the Assistant Administrator described the debris as construction particles and dust produced during sanding and wall preparation for wallpaper. During an interview on 12/17/25 at 1:40 PM with a maintenance person and the Second floor LPN, both confirmed that the kitchenette hood had a buildup of debris and had not been cleaned. According to the Centers for Disease Control and Prevention (2023, CDC) when the environment is disturbed such as by producing dust airborne infections can be released into the air which can cause healthcare associated infections. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Per observation on 12/15/2025 at 11:07 AM, a resident in room [ROOM NUMBER] had been discharged earlier that morning. The mattress was noted to have had a brown discoloration in the middle. The protective lining in the center of the mattress was a lighter blue than the rest of the mattress with the edges appearing chipped. There were two pillows observed with holes in the protective/plastic covering. Per interview on 12/15/2025 at 1:09 PM with a Licensed Practical Nurse (LPN) on the Second floor, s/he confirmed the mattress was compromised as noted above, and that there was a brown stain to the mattress where the top layer was worn, and that both pillows had holes in them. Per observation on 12/15/2025 at approximately 2:32 PM, room [ROOM NUMBER] appeared to have been cleaned and the bed containing the identified compromised mattress was noted to be made and ready for use. The bed linens were removed from one side of the mattress revealing the compromised mattress observed earlier in the day as noted above. The pillows noted above were on the bed with pillow cased in place. Per interview with a Housekeeping Staff who was finishing up in room [ROOM NUMBER], they confirmed the room had been terminally cleaned and the mattress/bed was ready for a new resident. The Housekeeping Staff was shown the mattress/bed and asked if the mattress was safe to use for a new resident and the Housekeeping Staff said she didn't know but it was re-made and ready for a new resident. Per interview on 12/15/2025 at 2:43 PM with the Administrator (ADM), she confirmed that the mattress was not appropriate for resident use in the above noted condition, it was compromised and could not properly be cleaned in that condition and needed to be thrown away. Per interview on 12/17/2025 at 8:11 AM with the Housekeeping Manager, he confirmed if a mattress cover is compromised it should be reported and removed from use and stated he was mortified by the condition of the mattress found in one of the resident rooms that was being terminally cleaned, thorough cleaning of a room after use in healthcare environments to control the spread of infections, and he wouldn't put a resident on a mattress I wouldn't sleep on myself. He confirmed that staff should contact the Administrator or Assistant Administrator for a replacement when equipment is worn out, damaged, or broken. Per interview on 12/17/2025 at 9:57 AM with the Infection Preventionist, Director of Nursing (DON), and the Regional Nurse Consultant, they confirmed that equipment that cannot be disinfected shouldn't remain in use for residents. When there are worn-out, damaged, or broken items, staff are expected to use TELS (the online platform for building maintenance) or contact the Assistant Administrator to request a replacement. Review of facility policy titled Care, Cleaning and Storage of Equipment, last reviewed 2/2025, states Equipment found to be in disrepair.should be reported to the supervisor on the day it is noted.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. Based on record review and interview the facility failed to put effective measures in place to ensure that further potential abuse does not occur while investigating an allegation of abuse for one of three sampled residents (Resident #73). Findings include:Per review of Resident #73's medical record, s/he had a BIMS [Brief Interview of Mental Status] score of 13 as of 9/26/25, indicating s/he is not cognitively impaired. S/he has medical diagnoses of COPD [Chronic Obstructive Pulmonary Disease], anxiety disorder, MDD [Major Depressive Disorder], and Wernicke's encephalopathy [a disease that is caused from a low level of thiamine]. Resident #73 is independent with ADLs [Activities of Daily Living] and hygiene.Per record review of a progress note written on 10/21/25 at 2:39 PM states, Resident is being monitor on accusation of abuse from staff. No interaction with accused staff noted in this shift. Resident is pleasant to work with today. No c/o [complaints of] of accusation from staff reported today. POC [plan of care] continued.Per record review, the alleged incident occurred on 10/20/25. The final investigation was submitted on 10/24/25.Per the facility's initial report dated 10/21/25 states, [Resident #73] says [s/he] was walking in the hallway on [his/her] unit late in the evening last night when [LNA#1] yelled at [him/her] and told [him/her] to go back to [his/her] room. When [Resident #73] told [LNA#1] no [Resident #73] says that [LNA#1] walked up behind [him/his] and made [him/her] fall onto [his/her] face in the hallway. [S/he] says [s/he] then walked into [his/her] room and [LNA#1] told [him/her] to go to bed. [Resident #73] got into bed and [LNA#1] told [him/her] to roll over. [Resident #73] told him no and [LNA#1] put his hands on the mattress and started bouncing [him/her] like a child [Resident #73] continues on to say that [LNA#2] does this as well. An interview was conducted with Resident #73 on 12/15/25 at 11:11 AM. Per Resident #73, LNA [Licensed Nursing Assistant] #1 stated, Get back to your room as the resident was in the hall. S/he stated the LNA pushed me because I wasn't go[ing] fast enough. Resident #73 stated s/he landed face down in the hallway. Resident #73 stated LNA#1 then grabbed him/her and started bouncing him/her off the bed. Resident #73 stated s/he kicked the staff member in the face. Resident #73 stated s/he has not seen the LNA lately, stating, I asked for that. He's not on this floor anyway. Per record review of the facility's internal investigation states, Both male caregivers have been moved to work on other units to prevent any further concerns. Per record review of the schedules during the investigation from 10/20/25 to 10/24/25, LNA#1 worked 10/20/25, 10/21/25, 10/23/25 and 10/24/25. LNA#2 worked on 10/21/25, 10/22/25, 10/23/25, and 10/24/25. Per record review of the facility's Abuse, Neglect, and Exploitation policy [last revised 9/2024] states, VI. Protection of Resident The facility will make efforts to ensure all residents are protected from physical and psychosocial harm, as well as additional abuse, during and after the investigation. Examples include but are not limited to:.D .Room or staffing changes, if necessary, to protect the resident(s) from the alleged perpetrator.An interview was conducted with the Administrator on 12/16/25 at 4:09 PM. The Administrator confirmed LNA#1 and LNA#2 were not removed from the facility during the investigation.

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to provide care to a resident with a wound vac (wound vacuum; a negative pressure pump that helps a wound heal faster by removing fluid and infection-causing bacteria with suction) in accordance with their facility policy for 1 of 1 sampled residents (Resident #14). The facility did not have a care plan or physician orders and evidence of monitoring in accordance with facility policy for the wound vac until 11/27/25, 22 days later, did not maintain a wound vac or following wound treatment orders after wound vac was removed on 11/13/25, and did not provide necessary education and ensure staff were competent to provide care to a resident with a wound vac. As a result, Resident #14 developed an infection requiring hospitalization and two surgical interventions. Findings include:Per record review, Resident #14 was admitted to the facility on [DATE] for rehabilitation services after a left hip replacement. A Transition of Care report from the sending hospital dated 10/21/25 reads, Patient is at high risk for developing post-operative infection. Resident #14's cognition was assessed on 11/29/25 with a BIMS (Brief Interview for Mental Status) score of 15 indicating cognitive intactness. Resident #14 has the following care plans: [Resident #14] is at risk for an infection related to: recent hospitalization, post surgery, SAR [sub acute rehab] placement, created on 10/21/25, and [Resident #14] has actual non-pressure skin impairment/s present R/T [related to] Surgical site, created on 10/22/25, with an intervention for Treatment as ordered to the wound, created on 10/22/25.Per interview on 12/16/25 at 8:55 AM, Resident #14 explained that s/he really wants to go back home and is very frustrated that s/he can't because s/he has to go back for another hip surgery- a revision to his/her hip due to an infection. S/He explained that s/he had a wound vac on the surgical hip and there was a period of time that it wasn't on when it should have been. S/He stated that it got full and stopped working. S/He said that there was an issue with the wound vac supplies, and the staff didn't know what to do with it, so they stopped using it.Facility policy titled Negative Pressure Wound Therapy [NPWT], revised 2/2025, reads, 1. Negative pressure wound therapy will be provided in accordance with physician orders, including the desired pressure setting, continuous or intermittent therapy, and frequency of dressing change. 7. Use and application of the therapy shall be accordance with manufacturer's recommendations. 9. Monitoring throughout the use of NPWT shall include, but is not limited to, the following: a. pain associated with the therapy; b. device setting is functioning properly; c. settings are prescribed; d. troubleshooting of any alarms, in accordance with pump/product specifications; e. response of the therapy, including wound characteristics and progress towards healing.Per record review a change in condition form dated 11/4/25 reads Increased drainage to L hip surgical incision site. Resident #14 was sent to the Emergency Department (ED).A 11/4/25 orthopedic survey consultation note reveals that Resident #14 presents with incisional drainage from his/her left hip. A Prevena wound vacuum was placed with intent for it to remain until scheduled outpatient follow up [11/10].Per record review, on return from the hospital on [DATE], Resident #14's care plan was not revised to include interventions related to the wound vac or wound vac monitoring, and did not have physician orders for the wound vac. There is no evidence that his/her wound vac was monitored in accordance with facility policy.Per interview on 12/16/25 at 3:04 PM, the Unit Manager explained that Resident #14 had multiple wound vacs placed since s/he was first admitted and she was not familiar with the type of wound vacs that s/he had. She was unable to find physician orders or care plan for the wound vac placed on 11/4/25.A 11/10/25 orthopedic note regarding a scheduled outpatient follow up reads overall incision healing well with 2 very small areas with ongoing serous draining, centrally and superiorly. Prevena wound vacuum sponger was replaced in clinic, well-tolerated. We stressed the importance of keeping the incision dry. I reviewed a prosthetic joint infection would require multiple surgeries including possible an explant and another revision. Plan: Maintain Prevena wound VAC for 5 days, then 3 times daily dry dressing changes.A 11/10/25 nursing note states Resident came back from Ortho appt with new orders as followed: wound vac for 5 days then TID [three times a day] dry dressing changes.A physician order starting 11/10/25 reads Keep wound vac in place for 5 days every shift until 11/15/2025, but does not include desired pressure settings. Resident #14's care plan was not revised to include interventions related to the wound vac or wound vac monitoring, and there is no evidence that his/her wound vac was monitored in accordance with facility policy.A 11/11/25 Advance Practice Registered Nurse (APRN) note reveals that Resident #14's hip wound incision was cultured and found to have MRSA (methicillin resistant staph aureus). The resident did not show signs of infection. A wound vac was applied and is to stay in place until 11/15/25

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. Based on interview and record review, the facility failed to ensure a resident who required dialysis received services consistent with professional standards of practice for one of two residents (Resident #106). Findings include:Facility policy titled Hemodialysis revised on 9/25, states The facility will assure that each resident receives care and services for the provision of hemodialysis consistent with professional standards of practice. This will include: The ongoing assessment of the resident's condition and monitoring for complications before and after dialysis treatments received at a certified dialysis facility . ongoing assessment and oversight of the resident before, during and after dialysis treatments . Ongoing communication and collaboration with the dialysis facility regarding dialysis care and services. Per review of the medical record for Resident #106, it revealed the resident has medical diagnosis that include end stage renal disease, dependence on renal dialysis, type 2 diabetes mellitus, anemia in chronic kidney disease, pulmonary hypertension, generalized edema, chronic obstructive pulmonary disease, insomnia, and chronic diastolic heart failure. Per review of Resident #106's physician orders, the resident is scheduled for dialysis treatments on Tuesdays, Thursdays, and Saturdays. Per record review of Resident #106's Hemodialysis Communication Record, there are 23 dates where the communication log is not filled out completely by either the facility, the dialysis center, or both since 8/19/25. Per interview with a nurse on 12/17/25 at approximately 2:10 PM, she confirmed that the facility staff should be completing the before and after dialysis treatment assessments which include assessing for bruit, thrill, blood pressure, temperature, pulse, time of last meal, diet, and the patient's general condition and that this wasn't completed for 12/16/25. She also confirmed that the dialysis center should complete the middle section of the Hemodialysis Communication Record. Per interview on 12/17/25 at 2:27 PM, the Director of Nursing (DON) confirmed that the Hemodialysis Communication Record was not being filled out completely by the facility and by the dialysis center and that they should be filled out completely. The DON confirmed that the nursing staff should be assessing Resident #106's condition before they leave the facility, ensuring that the dialysis center completes their portion of the documentation on return to the facility, and that on Resident #106's return to the facility, nursing staff assesses their condition and documents that in the Hemodialysis Communication Record. The DON revealed the Unit Manager should be ensuring the Hemodialysis Communication Record is filled out by the facility, and dialysis center, and the dialysis center should be contacted when the documentation is incomplete.

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F 0726 Level of Harm - Actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to provide necessary education and ensure staff were competent to provide care to a resident with a wound vac (wound vacuum; a negative pressure pump that helps a wound heal faster by removing fluid and infection-causing bacteria with suction) for 3 of 3 sampled licensed nurses providing care to Resident #14 . As a result, Resident #14 developed an infection requiring hospitalization and two surgical interventions. Findings include:Per record review, Resident #14 was admitted to the facility on [DATE] for rehabilitation services after a left hip replacement. Resident #14's cognition was assessed on 11/29/25 with a BIMS (Brief Interview for Mental Status) score of 15 indicating cognitive intactness.Per interview on 12/16/25 at 8:55 AM, Resident #14 explained that s/he really wants to go back home and is very frustrated that s/he can't because s/he has to go back for another revision to his/her hip due to an infection. S/he explained that s/he had a wound vac (wound vacuum; a negative pressure pump that helps a wound heal faster by removing fluid and infection-causing bacteria with suction) on the surgical hip and here was a period of time that it wasn't on when it should have been. S/He stated that it got full and stopped working. S/He said that there was an issue with the wound vac supplies, and the staff didn't know what to do with it, so they stopped using it.Per record review and interview, Resident #14 had a wound vac placed on his/her left hip surgical site on 11/4/25 due to drainage. Resident #14 required hip revision surgery on 11/19/25 due to an infection. Resident #14 did not have a care plan or physician orders and evidence of monitoring in accordance with facility policy for the wound vac until 11/27/25, 22 days later. See F684 for more information.Per interview on 12/16/25 at 3:04 PM, the Unit Manager explained that Resident #14 had multiple wound vacs placed since s/he was first admitted and she was not familiar with the type of wound vacs that s/he had. Education files for 3 licensed nursing staff that cared for Resident #14 while s/he had a wound vac were reviewed. 3 of 3 licensed nursing staff did not have wound vac training or competencies.Per interview on 12/17/25 at 11:24 AM, the Director of Nursing confirmed that education and competencies were not provided to staff for wound vacs.Review of the Facility Assessment, dated 10/6/25, reveals that the facility has determined it can care for residents who have major joint replacements and wounds. A section titled Information About Our Staff Training/Education and Competencies describes the skills and competencies required to meet resident needs and reads, We identified four categories of competencies: knowledge, assessment, pharmacological/treatment/care considerations, and technical/hands-on skills. Refer to the worksheet ‘Facility Education/Staff Competencies Necessary to Care for Resident Population.' The worksheet identifies which staff require certain competencies and skill sets, and the frequency of education. See also ‘Staff Development Training Plan.'Per interview on 12/17/25 at 1:20 PM, the Nurse Educator confirmed that there had been no education provided to staff for wound vacs. During this interview, the facility assessment was reviewed with the Nurse Educator. She was unfamiliar with the education and competency worksheet and the staff development training plan that the facility assessment referred to.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on interview, record review, and observation, the facility failed to safely store locked medications for 1 of 7 medication carts. Findings include: During observations on the second floor on 12/15/25 at 10:54 AM till 11:04 AM, the medication treatment cart was observed to be unlocked. There was one Resident walking up and down the hallway. Per interview with a nurse on 12/15/25 at 11:04 AM, she confirmed that the medication treatment cart should be locked and then locked the cart. Per review of the facility's Medication Storage policy reviewed 9/24, it states . All drugs and biologicals will be stored in locked compartments (i.e., medication carts, cabinets, drawers, refrigerators, medication rooms).

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F 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician. Per interview and record review, the facility failed to have a qualified food service director or a full-time qualified dietician. This has the potential to impact all residents. Findings include:Per interview on 12/16/25 at 8:14 AM, the Kitchen Manager explained that he was new to the position and does not have his certification as a dietary manager or food service manager yet.Per interview on 12/17/25 at 12:15 PM, the Administrator explained that the Registered Dietician (RD) works full time between two facilities. Per review of the RD's timecard for the previous week, the RD worked 25 hours at the facility.Per interview on 12/17/25 at 12:32 PM, the RD explained that she works at the facility 3 times a week and confirmed that she does not work full-time at this facility.

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F 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure meals and snacks are served at times in accordance with resident's needs, preferences, and requests. Suitable and nourishing alternative meals and snacks must be provided for residents who want to eat at non-traditional times or outside of scheduled meal times. Based on record review, observations, and interviews, the facility failed to provide substantial snacks at bedtime when there is more than14 hours between a substantial evening meal and breakfast the following day. This has the potential to impact all residents. Findings include: 1. Per review of the medical record for Resident #106, it revealed the resident has medical diagnosis that include end stage renal disease, dependence on renal dialysis, type 2 diabetes mellitus, anemia in chronic kidney disease, pulmonary hypertension, generalized edema, chronic obstructive pulmonary disease, insomnia, and chronic diastolic heart failure. Per review of Resident #106's physician orders, the resident is scheduled for dialysis treatments on Tuesdays, Thursdays, and Saturdays. Per record review of Resident #106's meal intake, from the dates of 11/1/25 through 12/17/25, there are six dates where Resident #106 either had no documentation for their dinner consumption, or the documentation stated RX resident not available. Per interview with Resident #106 on 12/15/25 at 3:18 PM, s/he revealed that when they get back from their dialysis appointments at 9:30 PM at night, s/he doesn't always get dinner because they take his/her tray away and throw it out. Resident #106 reports this having happened three to four times. Resident #106 also reported that the always available menu the facility offers is not available after 7 or 8 PM. Resident #106 has asked for snacks when they get back, and staff have made statements like you just want me to run around for you to the Resident when they request a drink or food. Per interview with Resident #106 on 12/17/25 at 8:26 AM, s/he stated that they had something to eat after their dialysis appointment on 12/16/25, but that it wasn't enough. S/he also reported the food was a turkey sandwich which was saturated. They reported that they ordered out more food as the kitchen was closed and they don't have snacks available for him/her. Per observation with the Unit Manager of the snacks on Floor 2 on 12/17/25 at 10:50 AM, she revealed that there are no sandwiches in the refrigerator and that if they have them the kitchen is supposed to bring them up. The Unit Manager confirmed that there should be more snacks in the cupboard like goldfish, peanut butter sandwich crackers, pretzels, and that it was missing these items. She revealed that dietary is supposed to fill the fridge when empty and that nursing staff should be calling down if they are missing snack items. When asked about what residents have to eat at night if they are hungry, she stated that she thinks nursing staff can go into the kitchen downstairs. Per observation of the floor 3 snacks, she confirmed that there should be sandwiches in the fridge available for residents. She confirmed that there was no peanut butter crackers or jelly in the cupboards. (continued on next page)

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F 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Per interview with the Kitchen Manager on 12/17/25 at 11:19 AM, they reported that the kitchen closes at around 7:45 PM to 8 PM and that there isn't an option for residents to have hot food at night. The Kitchen Manager stated that the units have peanut butter and jelly all the time and that they are working on getting sandwich fillings up there so they can make the resident a sandwich on the floor. The Kitchen Manager also revealed that it is the kitchens responsibility to keep the snacks stocked and that the evening cook is supposed to check all the snacking supplies or that nursing is supposed to call them. He confirmed that they do not keep track of what is stocked upstairs for snacks. The Kitchen Manager also stated after 7:45 PM, whatever is on the units for snacks are the options that residents have like pudding, fudge rounds, and saltines. When asked if those items constitute a meal, he confirmed that those are not dinner meals and that the kitchen is closed so there are no meal options for residents overnight. Additionally, he confirmed that the menu does say always available, but it is not always available once the kitchen is closed. Per interview with the kitchen manager on 12/17/25 at 12:21 PM, he reported that nursing staff have access to the kitchen but he doesn't know if they are allowed to go into the kitchen. Per interview with an LNA on 12/17/25 at 1:53 PM, she reported that she frequently cares for Resident #106. The LNA confirmed that they don't bring sandwiches and put them in the refrigerator and she confirmed that there are no meal alternatives after 8 PM. When asked if she could go into the kitchen if a resident wanted something different after the kitchen is closed, she reported that she has never done that before and wasn't sure if she was allowed to. The LNA also confirmed that nursing staff aren't consistently documenting Resident #106's meal intake on the evening shifts and that they should be documenting Resident #106's meal intake after they get back from dialysis. Per interview with LNA #2 on 12/17/25 at 1:47 PM, she confirmed that they don't have a meal replacement option for residents who want a meal after 8 PM and that they never have sandwiches stocked on the unit. When asked if she has ever gone to the kitchen to get a resident food, she stated that she has never had to. Per interview with the Director of Nursing on 12/17/25 at 2:37 PM, she confirmed that the staff should be documenting how much Resident #106 eats when they get back from their dialysis appointments and that they weren't always doing that. She confirmed that nursing staff should not be coding RX (Resident not Available) for dinner on the days Resident #106 goes out for dialysis and then comes back. 2. An interview was conducted with four residents (Resident #59, #104, #83, and #99) on 12/17/25 at 10:27 AM during a resident council task. Resident #59 has a BIMS [Brief Interview of Mental Status] score of 14 as of 12/2/25, indicated s/he is cognitively intact. Resident #104 has a BIMS of 15 as of 10/23/25 indicating they are cognitively intact. Resident #83 has a BIMS of 15 as of 10/13/25 indicating s/he is cognitively intact. Resident # 99 has a BIMS of 14 as of 10/24/25 indicating they are cognitively intact. At 10:45 AM all four residents discussed that they get snacks only if the kitchenettes have the food. They discussed that kitchenettes do not always have food stocked for snacks. 3. Per observation on 12/15/25, starting at 11:27, the kitchenettes on each unit were observed. There were no salads (chicken, egg, or tuna salad) on any unit, and the kitchenettes were minimally stocked with snack food including bread, potato chips, and a small number of crackers. (continued on next page)

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	475014	A. Building B. Wing	12/17/2025

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

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F 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Per interview on 12/17/2025 at 12:03 PM, the Kitchen Manager stated that meals are served between 8 AM and 5 PM on the first unit, and 9 AM and 6 PM on the last unit (making it 15 hours between dinner and breakfast). He explained that the kitchen staff are responsible for stocking the snacks on the units. When asked what should be available to residents as a substantial snack, he said that each unit should have a minimum of two salad options, like chicken salad or egg salad to make sandwiches, and other snack options.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observations and interviews, the facility failed to store food in a safe, sanitary condition. This has the potential to impact all residents. Findings include: 1. On 12/15/2025 at 10:55 AM, a tour of the kitchen as conducted with the Kitchen Manager (KM) and Registered Dietician. The following observation was made: The walk-in freezer had multiple boxes stacked directly on the floor of the cooler, blocking access to most of the food on the shelves. The KM explained that the boxes should be put on crates and should not be on the freezer floor directly.Per observation on 12/16/2025 at 8:12 AM, the walk-in freezer had multiple boxes stacked directly on the floor of the cooler.Per interview on 12/16/2025 at 8:14 AM, the Kitchen Manager stated that the freezer was organized yesterday after our initial observation and boxes shouldn't be on the freezer floor.2. On 12/15/25, starting at 11:27 AM, the following observations were made of all four unit kitchenettes:Second floor The microwave was covered in a large white smear; The cabinets were lined with what looked like cracker crumbs and contained a hot chocolate bag open to the air, a loaf of gluten free bread with no date, an open bag of chips with no date, and a regular loaf of bread with no date; The refrigerator had two undated take out containers, a jar of brown celery, chicken stock dated 10/15/25, and the inside doors were lined with a yellow substance; The freezer had two loaves of undated bread with a brown substance on the bags; The coffee station had a bag of brown sugar, open to air with no date.Third floor The cabinets contained three loaves of bread with significant green mold and five additional undated loaves of bread, an open jar of grape jelly 48 oz that read refrigerate after open, an open bag of chips with no date; The refrigerator had an unlabeled container of soup, a large bag of hot dogs open to air with no date, a greasy undated subway bag, an undated take out bag, a container of raviolis with a use by date of 12/8/25, prune juice with a use by date of 10/16/25. Per interview with the Unit Manager, she said that it is not good about the moldy bread, and explained that all food in the refrigerator should be marked with names and dates and it wasn't. Fourth floor The cabinets contained one loaf of undated bread; The refrigerator had two unlabeled take out containers.Fifth floor The cabinets contained five undated loaves of bread; The freezer had an unlabeled bag of ground beef; The refrigerator had eight take out containers with no dates or names and two Ziploc bag containing soup like food with no labels.Per interview with the Director of Nursing, she explained that the policy was to have all food items labeled and dated and confirmed that none of the food listed above should be in the refrigerator. Per interview on 12/17/2025 at 9:55 AM, the Kitchen Manager confirmed that all food in the kitchenettes, including bread, should be labeled with the resident's name (if applicable) and the dates that the food was open and expires.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, the facility failed to implement infection control practices designed to provide a safe and sanitary environment for 1 of 4 units (Second floor) and ensure infection control measures were followed to prevent the transmission of diseases and infections for one randomly sampled resident (Resident #14). Findings include: 1. Per observation on 12/15/2025 at approximately 2:10 PM, a white/grey powder like substance was on the code cart, wound care/treatment cart, and the precaution supply carts. Per interview on 12/15/2025 at approximately 2:30 PM with the LPN on the Second floor, they confirmed the code cart, wound care cart, and precaution supply carts were dusty with white/grey powder and needed to be cleaned. Per interview with 12/15/2025 at 3:09 PM with the Director of Nursing (DON), she confirmed there was dust on the code cart, suction machine, precaution supply carts, and treatment cart containing construction dust and that they all needed to be cleaned. During observation of the Second floor on 12/17/25 at 9:41 AM, Hoyer lifts, a mechanical device used to lift and transfer residents with limited mobility safely, were observed with dust-like material that had a white powder look on the base of the equipment. Per interview on 12/17/2025 at 9:57 AM with the Infection Preventionist, Director of Nursing (DON), and the Regional Nurse Consultant, they confirmed the debris seen on the Second floor. During the observation of the Second floor on 12/17/25 at 11:28 AM, the Regional Nurse Consultant acknowledged that the Hoyer lifts required cleaning due to construction dust and reported that housekeeping was working on it. During an interview on 12/17/25 at 12:19 PM with the Assistant Administrator and the DON, the Assistant Administrator described the debris as construction particles and dust produced during sanding and wall preparation for wallpaper. During an interview on 12/17/25 at 1:40 PM with a maintenance person and the Second floor LPN, both confirmed that the kitchenette hood had a buildup of debris and had not been cleaned. According to the Centers for Disease Control and Prevention (2023, CDC) when the environment is disturbed such as by producing dust airborne infections can be released into the air which can cause healthcare associated infections. 2. Per observation on 12/15/2025 at 11:07 AM, a resident in room [ROOM NUMBER] had been discharged earlier that morning. The mattress was noted to have had a brown discoloration in the middle. The protective lining in the center of the mattress was a lighter blue than the rest of the mattress with the edges appearing chipped. There were two pillows observed with holes in the protective/plastic covering. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Per interview on 12/15/2025 at 1:09 PM with a Licensed Practical Nurse (LPN) on the Second floor, s/he confirmed the mattress was compromised as noted above, and that there was a brown stain to the mattress where the top layer was worn, and that both pillows had holes in them. Per observation on 12/15/2025 at approximately 2:32 PM, room [ROOM NUMBER] appeared to have been cleaned and the bed containing the identified compromised mattress was noted to be made and ready for use. The bed linens were removed from one side of the mattress revealing the compromised mattress observed earlier in the day as noted above. The pillows noted above were on the bed with pillow cased in place. Per interview with a Housekeeping Staff who was finishing up in room [ROOM NUMBER], they confirmed the room had been terminally cleaned and the mattress/bed was ready for a new resident. The Housekeeping Staff was shown the mattress/bed and asked if the mattress was safe to use for a new resident and the Housekeeping Staff said she didn't know but it was re-made and ready for a new resident. Per interview on 12/15/2025 at 2:43 PM with the Administrator (ADM), she confirmed that the mattress was not appropriate for resident use in the above noted condition, it was compromised and could not properly be cleaned in that condition and needed to be thrown away. Per interview on 12/17/2025 at 8:11 AM with the Housekeeping Manager, he confirmed if a mattress cover is compromised it should be reported and removed from use and stated he was mortified by the condition of the mattress found in one of the resident rooms that was being terminally cleaned, thorough cleaning of a room after use in healthcare environments to control the spread of infections, and he wouldn't put a resident on a mattress I wouldn't sleep on myself. He confirmed that staff should contact the Administrator or Assistant Administrator for a replacement when equipment is worn out, damaged, or broken. Per interview on 12/17/2025 at 9:57 AM with the Infection Preventionist, Director of Nursing (DON), and the Regional Nurse Consultant, they confirmed that equipment that cannot be disinfected shouldn't remain in use for residents. When there are worn-out, damaged, or broken items, staff are expected to use TELS (the online platform for building maintenance) or contact the Assistant Administrator to request a replacement. Review of facility policy titled Care, Cleaning and Storage of Equipment, last reviewed 2/2025, states Equipment found to be in disrepair.should be reported to the supervisor on the day it is noted. 3. Per interview on 12/17/25 at 1:30 PM with the Second floor LPN, confirmed that an out-of-service medication cart was missing a sharps container, a special puncture-proof container used for the safe disposal of needles, syringes, and other sharp medical items. In the designated location for the sharps container, there was a used butterfly needle, a device with a small needle attached to flexible wings, used for drawing blood or administering fluids. Additionally, she noted dust-like debris was present on the suspension wires for the partitions at the nurses' station and on the activity cart. During a 12/17/25 interview at 1:46 PM, the Unit Manager for the Second floor confirmed that an out-of-service medication cart contained a used needle and lancet that had not been disposed of in the required sharps container. (continued on next page)

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