STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	475020	A. Building B. Wing	05/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Premier Rehab and Healthcare at Berlin	98 Hospitality Drive Barre, VT 05641

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review, the facility failed to notify the resident's power of attorney (POA) of a change in condition on 3/14/25, related to a new pressure ulcer identified on his/her sacrum for 1 resident in the sample of 7 (Resident #1). This is a repeat deficiency for this facility, with violations cited during two previous recertification surveys, dated 2/6/25 and 3/1/24. Findings include: Per review of Resident #1's medical record, s/he was admitted to the facility with a diagnosis of failure to thrive and a history of pelvic fracture on 1/27/25. A nursing assessment dated [DATE] identified Resident #1 as a high risk for pressure injury with a Braden score of 12. Per the admission assessment dated [DATE], s/he was frequently incontinent of urine and bowel, and dependent for care, including repositioning. Per Resident #1's MDS assessment dated [DATE] there was no evidence of a pressure injury upon admission. According to the medical record, Resident #1 developed a stage 2 pressure injury to his/her sacrum. A stage 2 pressure injury is described as a Partial-thickness loss of skin with exposed dermis. The wound bed is viable, pink or red, moist, and may also present as an intact or ruptured serum-filled blister The area was identified on 3/14/25 by the Advanced Practice Registered Nurse (APRN). There is no evidence in the Resident #1's medical record that their POA was notified of the new pressure ulcer. A 3/31/25 APRN visit note reveals that Resident #1 reveals that Resident #1's pressure ulcer worsened to an unstageable pressure ulcer an unstageable pressure injury is described as Full-thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because it is obscured by slough or eschar. (NPIAP, 2025) Per the facility policy last revised 8/2024 titled Notification of Change, The facility must inform the resident, consult with the resident's physician and /or notify the resident's family member or legal representative when there is a change requiring such notification . Circumstances requiring a notification include . a need to alter treatment including new treatment. Per interview on 5/1/25 at 7:30 AM, with Resident #1's POA, s/he stated that s/he was not notified of concerns related to a stage 2 pressure injury on his/her sacrum that was identified on 3/14/25. S/he stated that no one at the facility had notified them of a treatment plan for the pressure injury or that the area was deteriorating. She stated the first notification of the pressure injury was on 4/1/25. (continued on next page)

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Per an interview with the Director of Nursing (DON) on 4/29/25 at 8:30 AM, the DON confirmed she was not notified or aware that Resident #1 had a stage 2 pressure injury on his/her sacrum and stated she had not completed a change of condition or notification to the family on 3/14/25 when it was found by the APRN. Per the medical record Resident #1's family was not notified of a new pressure injury to Resident #1's sacrum until after 3/31/25 when it deteriorated to an unstageable pressure injury with necrosis. Reference: http://www.npuap.org/resources/educational-and-clinical-resources/npuap-pressure-ulcer-stagescategories/

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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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, observation, and record review, the facility failed to revise the care plan for 3 residents out of 7 sampled (Resident #1, #2, and #3) related to skin, wounds, including pressure prevention interventions and care planning for actual pressure injury. This is a repeat deficiency for this facility, with this violation cited during a previous recertification survey dated 8/19/24. Findings include: 1. Per review of Resident #1's medical record, s/he was admitted to the facility with a diagnosis of failure to thrive and a history of pelvic fracture on 1/27/25. On 1/27/25, a nursing assessment revealed a 12 on the Braden scale for predicting pressure risk, identifying Resident #1 as a high risk for pressure injury. On admission, Resident #1 was assessed to be frequently incontinent of urine and bowel, and dependent for care, including repositioning. Per Resident #1' admission minimum data set (MDS; a comprehensive assessment of each resident's functional capabilities) submitted on 2/10/25 by the MDS coordinator, Resident #1 had no pressure injuries at time of admission on [DATE]. Per review of Resident #1's care plan, initiated on 1/27/25, s/he requires assist to complete ADL's [activities of daily living] R/T [related to] impaired mobility, incontinence, and pain. Per the care plan, s/he was dependent for all mobility and identified as at risk for a pressure injury and had interventions that included weekly skin check, and non-specific interventions including treatments for prevention of skin breakdown. No interventions were added to his/her care plan to turn and reposition. Per record review, a provider note written on 2/17/25 by the Advanced Practical Registered Nurse (APRN) reads [Resident #1] is seen today for noted wounds to the right dorsum, left shin and self reported pain to the sacrum .Assessment & Plan: Redness of sacrum. Educated staff on proper repositioning for skin integrity. Patient may benefit from an air mattress. There was no evidence that the resident's care plan was updated at this time to include repositioning or an air mattress. An APRN progress note dated 3/14/25 reads Chief complaint: Covid-19, pressure ulcer, weakness, pain, depression, constipation . [Section titled skin] Small circular open lesion over the sacrum.[Section titled assessment and plan] Pressure injury of the sacral region, stage 2. Cleanse with wound cleanser. Apply skin prep and cover with sacral dressing. Plan to switch out bed to an air mattress . The following orders were written by the APRN on 3/15/25: Check under boarder dressing daily. Cleanse with wound cleanser and apply sacrum boarder every 3 days and PRN every day shift for pressure ulcer prevention. There was no evidence that the resident's care plan was updated at this time to include the resident's actual wound or treatment. Per interview with the Director of Nursing on 4/29/25 at approximately 4:30 PM, she confirmed that Resident #1's care plan was not updated to include interventions for turning and repositioning, or the air mattress starting on 2/17/25, and should have been. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A 3/31/25 APRN note reads Chief complaint: Acute unstageable pressure ulcer, boggy heels .[S/he] is seen today for unstageable pressure ulcer to [his/her] sacrum and new boggy heels. [S/he] originally had a small circular stage 2 to the sacrum and [s/he] was moved to an air mattress to help offload her sacrum. Today when this writer goes to see [him/her], [s/he] notes [his/her] sacrum feels worse and when this writer pulls off the dressing, there is significant drainage as well as dark skin around the wound area. Some odor . The care plan for Resident #1 was not updated until after his/her pressure areas worsened and was found to have signs of deterioration including worsening pressure injury, necrosis and drainage with odor. Facility policy titled Pressure Injury and Prevention Management, last revised 5/2022, reads, After completing a thorough assessment/evaluation, the interdisciplinary team shall develop a relevant care plan that includes measurable goals for prevention and management of pressure injuries with appropriate interventions . Evidence-based interventions for prevention will be implemented for all residents who are assessed at risk or who have pressure injury present. There is no evidence the facility followed their policy or the professional standards to prevent pressure injury, including not revising Resident #1's care plan after s/he developed a pressure injury on 3/14/25, until 3/31/25. 2. Per record review, Resident #2 had the following care plan initiated on 7/12/2024, at high risk for skin breakdown related to limited mobility, frail fragile skin, purists (itching), diabetes, and history of skin breakdown . His/her care plan includes the following interventions initiated on 8/30/23, weekly wound assessment to include measurements and description of the wound status. An APRN regulatory visit note dated 4/2/25 documented a new open area to Resident #2's left shoulder. The APRN wrote the following orders in his/her note on 4/2/25, Open wound of left shoulder, initial encounter Acute. Patient inflicted due to itching. Gently cleanse and cover with bandaid until resolved. There is no evidence that the orders were entered into the resident's medical record or a new intervention to his/her care plan. There is no evidence that the left shoulder was monitored or that the care plan was updated to include the actual skin/wound area. Per Resident #2's facility Treatment Administration Record (TAR) for April 2025, there is no evidence that an order was entered to monitor the left shoulder or to treat an open wound starting on 4/2/25. According to the TAR, the facility did have the following order: Vit A&D ointment to chest and both shoulders. Per review of the TAR, several days indicate a treatment was not given, and the area where the ointment was applied was not documented. There is no evidence that the facility treated or monitored a new open wound on Resident #2's shoulder or updated his/her care plan to include interventions for actual skin and wound to his/her left shoulder. Per interview with the Director of Nursing on 4/29/25 at approximately 4:30 PM, she confirmed that Resident #2's care plan was not updated to include a wound to the left shoulder and no new orders were entered on 4/2/25, as indicated in APRN's note. 3. Per record review, Resident #3 has diagnoses that include cerebral palsy and limited range of motion. Per observation on 5/6/25, Resident #3 has minimal use of his/her right arm and has a significant contracture of the right hand. Per review of his/her care plan, there was no evidence of interventions to prevent pressure injury to his/her contracted right hand. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Per review of the integrated wound care note dated 5/2/25, [Resident #3] is seen today a DTI to the right index finger. [S/he] does have CP (Cerebral Palsy) and tends to contract [his/her] fingers in such a way that it places pressure over bony areas, which has resulted in a small DTI [deep tissue injury] . Instructions: Gently clean and pat dry. Apply skin prep over area [and] apply foam dressing for protection. Consider finger separator from PT [physical therapy] if necessary for prevention. Per review, Resident #3's care plan does not address their right hand and pressure prevention related to contracture. Per the interview with Resident #3 on 5/6/25 at approximately 1:00 PM, s/he stated s/he is unable to use their right hand. Resident #3 is observed with his right hand lying flat on the bed; s/he was noted to have significant contracture of the right hand and a small dressing on the second finger. There was no evidence of a finger separator in his/her right hand. Resident #3 stated s/he has pain in the right arm and shoulder and hand at times. Per the Director of Nursing on 5/8/25 at 12:38 PM she stated in an email that Resident #3 has at risk for skin impairment section of the care plan that included 'impaired mobility r/t cerebral palsy' and a section for risk for alterations in functional mobility related to decrease ROM (range of motion), cerebral palsy. Per further interview, the DON stated that even though Resident #3 has limited range of motion in his right arm, s/he does not have a diagnosis of contracture of the right hand and therefore would not have a preventive care plan specific to his/her right hand.

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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 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review, the facility failed to ensure that 3 of 7 residents in the applicable sample (Resident #1, #2, and #3) received necessary treatment and services consistent with professional standards of practice to prevent or promote healing and prevent infection of a pressure injury. As a result, Resident #1 developed an unstageable pressure injury which became necrotic (death of tissue); requiring hospitalization, and resulted in death related to due to osteomyelitis and sepsis of the pressure injury. This citation is at the immediate jeopardy level due to the facility's failure to prevent and treat pressure injury resulting in infection and death of 1 resident. Findings include: 1. Per review of Resident #1's medical record, s/he was admitted to the facility with a diagnosis of failure to thrive and a history of pelvic fracture on [DATE]. On [DATE], a nursing assessment revealed a 12 on the Braden scale for predicting pressure risk, identifying Resident #1 as a high risk for pressure injury. On admission, Resident #1 was assessed to be frequently incontinent of urine and bowel, and dependent for care, including repositioning. Per review of a skin assessment completed by a licensed nurse on [DATE], there is no mention of sacral redness or documentation of the sacral area. Per admission minimum date set (MDS) (a comprehensive assessment of each resident's functional capabilities) submitted on [DATE] by the MDS coordinator, Resident #1 had no unhealed or open pressure injury at time of admission on [DATE]. Facility policy titled Pressure Injury and Prevention Management, last revised 5/2022, reads, After completing a thorough assessment/evaluation, the interdisciplinary team shall develop a relevant care plan that includes measurable goals for prevention and management of pressure injuries with appropriate interventions . Evidence-based interventions for prevention will be implemented for all residents who are assessed at risk or who have pressure injury present. Per review of Resident #1's care plan, initiated on [DATE], s/he requires assist to complete ADL's [activities of daily living] R/T [related to] impaired mobility, incontinence, and pain. Per the care plan, s/he was dependent for all mobility and identified as at risk for a pressure injury. With interventions that included weekly skin check, and non-specifics including treatments for prevention of skin breakdown. No interventions were added to his/her care plan to turn and reposition. The facility did not follow professional standards of practice or its policy for preventing pressure ulcer development. According to the National Pressure Injury Advisory Panel (NPIAP), identification of a person at risk for pressure injury and implementation of an individualized care plan should include turning and repositioning every two hours and ongoing monitoring to determine if the individual needs more frequent position changes (2024). There is no evidence that turning and repositioning was added to the care plan to prevent pressure injury, or that interventions were revised after pressure injury was identified. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	An Advanced Practical Registered Nurse (APRN) visit note dated [DATE] revealed [Resident #1] is seen today for noted wounds to the right dorsum, left shin, and self reported pain to the sacrum. Patient is at [his/her] baseline orientation, and assessment of [his/her] skin does not show any wounds or lesions. [His/Her] sacrum is noted to have blanchable redness. [S/he] requires assistance with all ADLs and transfers . Assessment & Plan: Redness of sacrum. Educated staff on proper repositioning for skin integrity. Patient may benefit from an air mattress. Per further review of the APRN progress notes dated [DATE], [DATE], she continued to document pain and sacral redness for Resident #1 and continued to request an air mattress at each visit. There is no documented evidence that the air mattress or turning and repositioning were added to his/her care plan. According to the APRN progress notes, Resident #1 complained of sacral pain on [DATE] and again on [DATE]. Per interview with the APRN by telephone on [DATE] at 2:00 PM, she stated that she was concerned that Resident #1 was a high risk for pressure injury due to lack of fatty tissue and [s/he] was so thin. She reports requesting an air mattress for him/her on [DATE] and multiple times after that. Per record review, there were no interventions added to Resident #1's care plan after this visit. Per interview with the Director of Nursing on [DATE] at approximately 4:30 PM, she confirmed that Resident #1's care plan was not updated to include interventions for turning and repositioning, or the air mattress starting on [DATE], and should have been. She further stated that on [DATE], the facility attempted to use an air mattress from storage; however, per the DON, it would not inflate. Per record review, on [DATE], nursing documented an assessment titled Skin and Wound Evaluation, there is a single photograph of Resident #1's sacrum. The photo revealed the sacrum to be red with a small dark, bruise-like area in the center of the redness. DTPI (Deep tissue pressure injury) start as an inconspicuous bruise that rapidly becomes a full-thickness and often necrotic wound, teaming with potential harm, such as sepsis and osteomyelitis, pain, and suffering (Wound International, 2021). There is no assessment of the area attached to the photo or a progress note in the medical record that provides details of the photo of his/her sacrum on [DATE]. Per interview on [DATE] at approximately 4:30 PM with the Director of Nursing (DON), stated she identified the blanchable redness to Resident #1's sacrum and took a picture of the sacral area on [DATE]. Then she asked the facility's contracted integrated wound care specialist (IWCS) to assess Resident #1's sacrum. Per telephone interview with the IWCS on [DATE] at 3:30 PM, she stated she assessed Resident 1's sacrum on [DATE] but did not write a note. Per the facility policy titled Skin Assessment, last revised 8/2024, A full body, or head-to-toe assessment will be conducted by a licensed or registered nurse upon admission/re-admission and weekly thereafter. This assessment may also be performed after a change in condition or after a newly identified pressure injury . Procedure: remove any dressings, using clean technique, unless contraindicated or ordered to remain in place, and note any findings. Note any skin conditions such as redness, bruising, rashes, blisters, skin tears, open areas, ulcers, and lesions. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Although record review shows skin assessments were completed on [DATE] and [DATE], there was no evidence that nursing evaluated Resident #1's sacrum or documented any concerns related to the area, even though redness was identified on [DATE]. Per an interview with the DON on [DATE] at 4:00 PM, she stated she was not able to complete all the skin assessments for all residents on her own. She stated she did not have unit managers or the support she needed to complete accurately for all residents. On [DATE] the APRN documented the following note for Resident #1 Chief complaint: Covid-19, pressure ulcer, weakness, pain, depression, constipation . [Section titled skin] Small circular open lesion over the sacrum.[Section titled assessment and plan] Pressure injury of the sacral region, stage 2. Cleanse with wound cleanser. Apply skin prep and cover with sacral dressing. Plan to switch out bed to an air mattress . The APRN entered the following orders on [DATE]: Check under boarder dressing daily. Cleanse with wound cleanser and apply sacrum boarder every 3 days and PRN everyday shift for pressure ulcer prevention. There is no evidence of wound measurements completed at this time for a new pressure injury on Resident #1' sacrum. Per interview with the Director of Nursing on [DATE] at 4:00 PM, she confirmed she verified the above orders for Resident #1 wound care on [DATE]; however, the order was written for pressure prevention, and the APRN did not communicate the findings with her, she did not recognize the order was for an actual wound. She stated she did not review the APRN visit notes associated with the orders written on [DATE]. She stated she didn't become aware of the sacral wound until [DATE]. Per interview with the APRN by telephone on [DATE] at 2:00 PM, she stated that on [DATE], she assessed Resident #1's sacrum and found a small blistered area that appeared to have broken open, and the top layers of skin were missing. She identified the area as a stage 2 pressure injury and entered orders into the electronic medical record to cleanse the area with wound wash and cover with a sacral dressing. Per review of the diagnosis list dated [DATE], the APRN entered the diagnosis of pressure injury stage 2 on [DATE]. Per further interview APRN stated she did not follow her process when she discovered the wound, which would be to review the findings with the nurse attending to the resident on the unit and then review with the DON. APRN also stated during interview she did not measure the area of pressure injury on [DATE]. Per facility skin assessments completed on [DATE] and on [DATE], there was no evidence that nursing evaluated Resident #1's sacrum or documented the stage 2 pressure injury identified on [DATE]. Per further interview with the DON on [DATE] at 4:00 PM she stated she did not have the staff to complete timely skin checks or to verify skin checks were being completed accurately by licensed nursing staff. Per review of Resident #1's Treatment Administration Record (TAR), Resident #1 received a dressing change on 3/16, 3/17, 3/18, 3/20, 3/21, 3/22, 3/23, 3/24, 3/25, 3/26, 3/27, 3/28, 3/29, and [DATE] without documentation of the sacral area. On [DATE], nursing documented the following progress note: Apply protective dressing to sacrum . Pt sore open to air. cleansed wound and placed a dressing over sacrum . There is no documentation of a wound evaluation during any of these dressing changes or that the DON was notified of an opening on Resident #1's sacrum. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Per review of Resident #1's treatment administration record, orders dated [DATE], there is a protective sacral border dressing ordered by the APRN, and starting on [DATE], the order is updated to include check under the dressing daily and ensure that it is in place. Several days were signed off in the TAR, however, there is no way to determine when a dressing change had been completed, and there was no wound assessment prior to [DATE] that included measurements or characteristics The medical record revealed no evidence of a wound assessment with measurements until [DATE], 17 days after the pressure injury was first diagnosed by the APRN. Per facility policy, titled Wound Care, last reviewed 5/2022, treatments will be documented on the treatment administration record or in the electronic health record, and will include effectiveness of treatment, healing progression, changes in the characteristics of the wound, including location, pressure injury stage (or level of tissue destruction if not a pressure injury), size-including shape depth and presence of tunneling, undermining and characteristic of exudate, pain, signs of infection and condition of the tissue in the wound bed including assessment of skin around the wound .Treatment decisions will be based on the characteristics of the wound, including the stage, size, exudate, presence of pain, signs of infection, wound bed, wound edge, and surrounding tissue . Interventions will be documented in the care plan and communicated to all relevant staff. The facility did not follow professional standards and policy for treating actual pressure ulcers. Per interview with the DON on [DATE] at 10:30 AM, she stated that Resident #1 should have been referred to the IWCS on [DATE] when the stage 2 pressure injury was identified. She confirmed that there should have been a wound assessment completed weekly and interventions should have been entered into the care plan on [DATE]. She stated resident did not receive a referral to the IWCS or updates to his/her care plan until [DATE] for the actual pressure injury. Per interview on [DATE] at 12:30 PM, the Medical Director explained, she had been the Medical Director at the facility since [DATE]. She was not aware that the facility had any concerns related to skin, including prevention or treatment of pressure injury. She stated that the process as she understood it was that the DON should be notified of any new wounds, and the resident should be placed on a wound tracker immediately. Assessment of a new pressure injury should include measurements and should be completed when the pressure injury is identified, and a referral to IWCS. The Physician, who was also the Medical Director at the time, stated she was not aware of Resident #1's skin issues at the time of her regulatory visit on [DATE]. She further stated she had not reviewed the APRN notes prior to her visit with Resident #1 on [DATE] and should have. An APRN progress note dated [DATE], Chief complaint: Follow-up pain, pressure ulcer, weakness, depression . [S/he] notes [s/he] has been having more generalized pain and is hoping to get [his/her] tylenol increased. [S/he] also has some pain in [his/her] pressure area.[Section titled assessment and plan] Pressure Ulcer of the Sacral Region Stage 2. Ongoing management. Cleanse with wound cleanser, apply skin prep and cover with sacral dressing. Reposition Q2 [every two hours]. Continue to use air mattress . There was no evidence of a wound assessment to include measurements of the pressure injury, on [DATE], or [DATE]. There was no revision to the care plan to include actual pressure injury until [DATE]. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	An APRN note dated [DATE] revealed Chief complaint: Acute unstageable pressure ulcer, boggy heels . [S/he] is seen today for unstageable pressure ulcer to [his/her] sacrum and new boggy heels. [S/he] originally had a small circular stage 2 to the sacrum .[His/Her] sacrum feels worse and when this writer pulls off the dressing, there is significant drainage as well as dark skin around the wound area. Some odor . Per interview on [DATE] at 7:30 AM, with Resident #1's family representative, s/he stated that s/he was not notified of concerns related to a stage 2 pressure injury on his/her sacrum that was identified on [DATE]. S/he stated that no one at the facility had notified them of a treatment plan for the pressure injury or that the area was deteriorating. S/he stated that s/he visited Resident #1 frequently and s/he complained of pain in his/her sacrum, describing a sore spot on my back. S/he stated that when Resident #1 would complain of pain in his/her sacrum s/he would use the following words, terrible, I can't stand it, my butt is on fire and would occasionally make whimpering sounds. S/he further stated that Resident #1 continued to decline and then on [DATE] noted that Resident #1 had a large amount of swelling of arms and legs and was not eating. S/he stated that s/he was complaining of a lot of pain. Then on [DATE], Resident #1 was transferred to the emergency room. An emergency room Physician's note dated [DATE] when Resident #1 arrives at the emergency department states Primary complaint 11/10 pain to known pressure injury to sacral area. Resident #1 was admitted to the hospital with a necrotic, unstageable pressure injury, which had developed to osteomyelitis (infection of the bone) and sepsis. The resident required treatment that included debridement of his/her sacrum, dressing changes, pain medication, and intravenous antibiotics. Per Resident #1's death certificate dated [DATE], s/he died of complications related to a sacral pressure injury, osteomyelitis, and sepsis. 2. Per record review, Resident #2 had the following care plan focus initiated on [DATE] at high risk for skin breakdown related to limited mobility, frail fragile skin, pruritus [itching], diabetes, and history of skin breakdown . His/her care plan includes the following interventions initiated on [DATE], weekly wound assessment to include measurements and description of the wound status. Per an APRN note dated [DATE], regulatory visit reveals that Resident #2 has a new open area to their left shoulder. The APRN wrote the following orders in his/her note on [DATE], Open wound of left shoulder, initial encounter Acute. Patient inflicted due to itching. Gently cleanse and cover with bandaid until resolved. There is no evidence that the orders were entered into the resident's medical record or a new intervention to his/her care plan. There is no evidence that the left shoulder was monitored or that the care plan was updated to include the actual skin/wound area. Per Resident #2's facility Treatment Administration Record (TAR) for [DATE], there is no evidence that an order was entered to monitor the left shoulder or to treat an open wound starting on [DATE]. According to the TAR, the facility did have the following order: Vit A&D ointment to chest and both shoulders. Per review of the TAR, several days indicate a treatment was not given, and the area where the ointment was applied was not documented. There is no evidence that the facility treated or monitored a new open wound on Resident #2's shoulder. Per facility skin assessments completed on [DATE], [DATE] and [DATE], there was no evidence that nursing evaluated Resident #2's left shoulder or documented the open wound identified on [DATE]. (continued on next page)

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	475020	A. Building B. Wing	05/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Premier Rehab and Healthcare at Berlin	98 Hospitality Drive Barre, VT 05641

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Per further interview with the DON on [DATE] at 4:00 PM, she stated she was not aware of the wound identified on [DATE] by the APRN and did not review the APRN's notes. Per the DON, the APRN attending wound rounds that week on [DATE] and did not report new findings. Per the facility wound care tracker dated [DATE], there is no evidence that Resident #2 was added to the list of new wounds in the facility. 3. Per record review, Resident #3 has diagnoses that include cerebral palsy and limited range of motion. Per observation on [DATE], Resident #3 has minimal use of his/her right arm and has a significant contracture of the right hand. Per review of his/her care plan, there was no evidence of interventions to prevent pressure injury to his/her contracted right hand. Per review of the integrated wound care note dated [DATE], [Resident #3] is seen today a DTI to the right index finger. [S/he] does have CP (Cerebral Palsy) and tends to contract [his/her] fingers in such a way that it places pressure over bony areas, which has resulted in a small DTI [deep tissue injury] . Instructions: Gently clean and pat dry. Apply skin prep over area [and] apply foam dressing for protection. Consider finger separator from PT [physical therapy] if necessary for prevention. Per review, Resident #3's care plan does not address their right hand or any new interventions for the contracure. Per the interview with Resident #3 on [DATE] at approximately 1:00 PM, s/he stated s/he is unable to use their right hand. Resident #3 is observed with his right hand lying flat on the bed; s/he was noted to have significant contracture of the right hand and a small dressing on the second finger. There was no evidence of a finger separator in his/her right hand. Resident #3 stated s/he has pain in the right arm and shoulder and hand at times. Per the Director of Nursing on [DATE] at 12:38 PM in an email stated that Resident #3 has at risk for skin impairment section of the care plan that included 'impaired mobility r/t cerebral palsy' and a section for risk for alterations in functional mobility related to decrease ROM (range of motion), cerebral palsy. Per further interview, the DON stated that even though Resident #3 has limited range of motion in his right arm, s/he does not have a diagnosis of contracture of the right hand and therefore would not have a preventive care plan specific to his/her right hand. Reference: http://www.npuap.org/resources/educational-and-clinical-resources/npuap-pressure-ulcer-stagescategories/ www.woundsinternational.com Ten top tips: mitigation deep tissue pressure injury.

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F 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure the resident's doctor reviews the resident's care, writes, signs and dates progress notes and orders, at each required visit. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review, the facility failed to ensure that physicians and other providers (as delegated to per regulation) review the residents' total program of care, including skin, pressure injury risk and prevention and treatment plan at each visit as required for 3 of 7 sampled residents (Resident's #1, #3, and #4). This is a repeat deficiency for this facility, with this violation cited during a previous recertification survey dated 8/19/24. Findings include: 1) Per review of Resident #1's medical record, s/he was admitted to the facility with a diagnosis of failure to thrive and a history of pelvic fracture on 1/27/25. On 1/27/25, a nursing assessment revealed a 12 on the Braden scale for predicting pressure risk, identifying Resident #1 as a high risk for pressure injury. Resident #1 had no pressure injuries at time of admission. A 3/14/25 Advanced Practice Registered Nurse (APRN) progress note dated 3/14/25 reveals that Resdeint #1 has a stage 2 pressure injury on their sacrum. Residnet #1's care plan was not updated to include the stage 2 pressure ulcer or treatment interventions. Per interview with the DON on 5/1/25 at 10:30 AM, she stated that Resident #1 should have been referred to the IWCS on 3/14/25 when the stage 2 pressure injury was identified. She confirmed that there should have been a wound assessment completed weekly and interventions should have been entered into the care plan on 3/14/25. She stated resident did not receive a referral to the IWCS or updates to his/her care plan until 3/31/25 for the actual pressure injury. Per review of the Physician's note for a required regulatory visit dated 3/27/25 in Resident #1's medical record, the note did not address the pressure injury to Resident #1's sacrum, and in the assessment section of the physician's note, titled skin the provider noted that exposed areas are clear with no rashes. There was no evidence that the Physican, who is also the Medical Director, addressed the pressure injury on 3/27/25 by her documentation in the medical record. During an interview on 5/1/25 at 12:30 PM, the Physician, who was also the Medical Director at the time, stated she was not aware of Resident #1's skin issues. During the interview, the Medical Director stated she had not reviewed the APRN's prior notes or discussed any concerns with her regarding Resident #1's skin or new pressure injury before she completed the regulatory visit on 3/27/25. Per interview with the Director of Nursing on 5/6/25 at approximately 2:00 PM, s/he confirmed the provider visit on 3/27/25 was a regulatory visit, and did not reflect skin, wounds, or actual pressure injury for Resident #1and did not accurately review the resident's total program of care, and it should have. 2). Per record review, Resident #3 has diagnoses that include cerebral palsy and limited range of motion. Per observation on 5/6/25, Resident #3 has minimal use of his/her right arm and has a significant contracture of the right hand. A facility skin check dated 2/7/25 identified the following skin areas: right elbow purple and redden area noted R elbow wound is new . Redden area to sacrum wound is new . Resident's skin warm and dry to touch with redness noted to the Sacrum/Groin and pressure area to the right elbow [sic]. (continued on next page)

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F 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A Physician's note dated 2/7/25, titled Recertification, revealed the following assessment by the provider related to Resident #3's skin: Skin exposed areas are clear with no rashes. There is no evidence in the written note that the provider addressed skin, or new pressure areas documented by nursing as new on 4/7/25. 3). Resident #4 was admitted to the facility on [DATE] with diagnoses that included diabetes, history of falls, weakness, and deep tissue pressure injury to his/her left knee. S/he had the following physician orders written on 3/14/25: wound care to pressure ulcer left lateral knee, 1)cleanse with wound cleanser 2) dry skin prep 3) Medi honey to wound bed 4) cover with Opti foam . A facility pressure wound assessment dated [DATE], revealed that Resident #4 was admitted with an unstageable pressure injury to his/her left knee. A Physician's note dated 3/20/25, regulatory visit titled: Admission, does not address the total plan of care for Resident #4 and does not address the actual wound and treatment for a known deep tissue injury to the left knee. The physician documented the following: Skin: exposed areas are clear with no rashes.

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. Based on interview and record review, the facility failed to ensure that licensed nurses have the specific competencies necessary to care for residents' needs as identified through resident assessments and the plan of care for 4 of 5 sampled nurses. Findings include: Per review of 5 licensed nurses' employee education files, 4 Licensed Practical Nurses (LPN) did not have evidence that they had been assessed for skin or wound assessment competencies. Per facility policy titled Staff Competency Plan, last reviewed on 8/2024, reads, It is the policy of the facility to evaluate each employee to assure they meet appropriate competencies and skills for performing their job . The knowledge and skills required among staff to meet residents' needs are determined through the facility assessment process. Evaluating competency of staff is accomplished through the facility's training program. The Facility Assessment (an assessment that determines what resources are necessary to care for the residents competently during both day-to-day operations and emergencies), dated 1/31/25, section Services and care we offer based on our resident's needs, lists: .skin integrity . [and] pressure injury prevention and care, skin care, wound care, wound care treatments (surgical, other skin wounds). Per review of the competency packet used to evaluate licensed nurses, the packet did not include skin or wound assessment competencies. Per interview on 5/6/25 at 11:35 AM, the Director of Nursing (DON) confirmed that skin and wound assessment competencies are not included in the packet. At 2:45 PM, the DON confirmed that the 4 LPNs did not have competencies related to skin and wound assessments.

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F 0841 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Designate a physician to serve as medical director responsible for implementation of resident care policies and coordination of medical care in the facility. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, and policy review, the facility failed to ensure the Medical Director assisted the facility with the implementation of resident care policies, specifically related to the total skin program at the facility, and failed to coordinate the medical care in the facility. As a result, one resident died of sepsis related to a pressure injury of the sacrum (Resident #1). This deficient practice has the potential to affect all residents at risk for skin impairment and pressure injury residing in the facility. Findings include: Per review of Resident #1's admission assessment, s/he was admitted to the facility on [DATE] and identified as a high risk for pressure injury with a score of 12. S/he did not have any skin integrity issues with his/her sacrum at the time of admission. Per review of Resident #1's care plan, initiated on [DATE], s/he was identified as at risk for a pressure injury with interventions that included weekly skin checks and nonspecific treatments for prevention of skin breakdown. No interventions were added to his/her care plan to turn and reposition, or any individualized interventions. Revision to Resident #1's care plan did not occur until [DATE]. An Advanced Practical Registered Nurse (APRN) visit note dated [DATE] revealed that Resident #1 was seen for self-reported pain to the sacrum. The note reads, [his/her] skin does not show any wounds or lesions. [His/Her] sacrum is noted to have blanchable redness. [S/he] requires assistance with all ADLs and transfers . Assessment & Plan: Redness of sacrum. Educated staff on proper repositioning for skin integrity. Patient may benefit from an air mattress. Per further review of the APRN progress notes dated [DATE], [DATE], she continued to document pain and sacral redness for Resident #1 and continued to request an air mattress at each visit. There was no evidence of new interventions to the care plan, including an air mattress or turning and repositioning. An APRN progress note dated [DATE] reveals [Section titled skin] Small circular open lesion over the sacrum. [Section titled assessment and plan] Pressure injury of the sacral region, stage 2. Cleanse with wound cleanser. Apply skin prep and cover with sacral dressing. Plan to switch out bed to an air mattress . The following orders were written by the APRN on [DATE]: Check under boarder dressing daily. Cleanse with wound cleanser and apply sacrum boarder every 3 days and PRN every day shift for pressure ulcer prevention. Per interview with the APRN by telephone on [DATE] at 2:00 PM, she stated that she was concerned that Resident #1 was a high risk for pressure injury due to lack of fatty tissue and [s/he] was so thin from time of admission. She reports requesting an air mattress for him/her on [DATE] and multiple times after that. Per interview with the APRN by telephone on [DATE] at 2:00 PM, she stated that on [DATE], she assessed Resident #1's sacrum and found a small blistered area that appeared to have broken open, and the top layers of skin were missing. Per further interview the APRN stated she did not follow her process when she discovered the wound, which would be to review the findings with the nurse attending to the resident on the unit and then review with the DON. (continued on next page)

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F 0841 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Per review of Resident #1's medical record, there was not an actual wound assessment completed of the sacral pressure injury until [DATE] by the IWCS. This was confirmed through interview on [DATE] at 4:00 PM by the Director of Nursing (DON). She explained that she didn't read the APRN's notes and didn't know there was a wound until [DATE] when it worsened to an unstageable pressure injury with necrosis. On [DATE] at 10:30 AM, the DON stated that Resident #1 did not receive a referral to the IWCS (integrated wound care specialist) or updates to his/her care plan until [DATE] for the actual pressure injury. Per interview with Resident #1 POA the resident experienced significant pain and was transferred to the hospital on [DATE]. Per review of hospital records, s/he later died on [DATE] at the hospital related to complications of a sacral pressure injury. See F 686 for more information. A Physician's note dated [DATE] titled regulatory visit, did not address concerns related to pressure injury identified at prior visits by the APRN and the assessment section of the physician's note, titled skin the provider noted that exposed areas are clear with no rashes. During an interview on [DATE] at 12:30 PM, the Physician, who was also the Medical Director at the time, stated she was not aware of Resident #1's skin issues. The Medical Director explained that she had been the medical director at the facility since [DATE]. She was unaware that the facility had any skin-related concerns, including prevention or treatment of pressure injury. She stated that the process as she understood it was that the DON should be notified of any new wounds, and the Resident should be placed on a wound tracker immediately. Assessment of a new pressure injury should include measurements and should be completed when the pressure injury is identified, and a referral to the wound specialist should be made. She was unaware that the facility was not implementing their policy related to pressure ulcer prevention and treatment. During the interview, the Medical Director she stated she had not reviewed the APRN notes or discussed any concerns with her regarding Resident #1's skin or new pressure injury before she completed the regulatory visit on [DATE]. Per facility policy for Medical Director Service, the Medical Director will coordinate medical care, including emergency treatment procedures, maintain effective liaison with attending physicians, and implement methods to keep the quality of care under constant surveillance. Monitor that the residents receive adequate services appropriate to their needs. Monitor that the resident's medical regimen is incorporated into the resident's care plan. There is no documented evidence that the MD was aware of concerns related to pressure injury, for Resident #1, or that she was coordinating the care between the residents' providers and the facility. Per further interview with the Medical Director on [DATE] at 12:30 PM, she stated she was unaware that Resident #1 had died from complications of a sacral pressure injury, sepsis, and osteomyelitis.