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	06/22/2026

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to Identify a resident-to-resident altercation as abuse (Resident #1 and Resident #2) and failed to immediately report the incident as required. Finding include: Per record review Resident #1 has a BIMS (Brief Interview of Mental Status) of 0 which indicates significant cognitive impairment. Diagnoses for Resident #1 include major depression disorder, anxiety disorder, restlessness, agitation and history of traumatic brain injury.Per record review Resident #2 has a BIMS of 10 which indicates moderate cognitive impairment. Diagnoses for Resident #2 include cerebral infarction, major depressive disorder, adjustment disorder with anxiety, epilepsy and alcoholic polyneuropathy.Per review of the facility's 5/26/2026 incident report, on 5/23/2026 Resident #1 became angry when s/he thought Resident #2 was wearing a shirt that belonged to him/her. While a staff member was attempting to redirect Resident #1, Resident #1 turned around and willfully hit Resident #2 in the chest with a closed hand. The staff member reported the incident to the shift supervisor who determined the altercation did not signify abuse.Per review of the facility's Compliance with Reporting Allegations of Abuse/Neglect/Exploitation policy (9/2024), it states that administration or designee will be made aware of any report of abuse/neglect/exploitation so that the appropriate agencies could be notified immediately: as soon as possible, but not later than 24 hrs.Per interview with the Director of Nursing (DON) on 6/22/2026 at 11:00 AM, she stated that on 5/26/2026 she read reports from the weekend of 5/23/2026 and became aware of the resident-to-resident altercation. The DON confirmed that the shift supervisor should have called her immediately after the altercation so that the appropriate agencies could be notified within the required timeline. Based on corrective actions completed prior to the onsite survey, this citation is designated as past non-compliance. The following actions were taken by the facility: The incident was reported to [NAME], APS, the family and police on 5/26/2026The week of 5/26/2026 the DON Interviewed all staff members who were present during the incident. An interview with Resident #1 was unable to be conducted by the facility due to significant cognitive impairment.An interview with Resident #2 was conducted by the DON and s/he was not negatively affected by the incident.Social Services is scheduled to complete psycho socials with Resident #2. Supportive care (psych services) and Deer Oaks (talk therapy) have been scheduled to follow up with both residents.Education and competencies on abuse and neglect were completed for all staff by 6/5/2026.The DON reported that audits are to be completed on all units to determine understanding and compliance with abuse and neglect reporting.The supervisor on duty during the incident met with the DON and completed training/competencies on 6/5/2026.The Administrator and DON confirm that the late reporting of this incident will be included in their QAA meetings.

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