VERMONT

Department of Disabilities, Aging and Independent Living
Division of Licensing and Protection
280 State Drive/HC 2 South
Waterbury, VT 05671-2060
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AGENCY OF HUMAN SERVICES

September 30, 2025

Mr. Mark Moyer, Administrator
Premier Rehab and Healthcare at Berlin
98 Hospitality Drive
Barre, VT 05641

Provider ID #: 475020

Dear Mr. Moyer:

Enclosed is a copy of your acceptable plans of correction for the recertification survey conducted on **August 6, 2025.** Please post this document in a prominent place in your facility.

We may follow up to verify that substantial compliance has been achieved and maintained. If we find that your facility has failed to achieve or maintain substantial compliance, remedies may be imposed.

Sincerely,

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

Enclosure

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 475020	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/06/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E0000	Initial Comments The Division of Licensing and Protection conducted an onsite, unannounced survey of the facility's emergency preparedness program on 8/6/2025 during an annual recertification survey. There were regulatory violations related to emergency preparedness as a result of this survey.	E0000		
E0039 SS = F	EP Testing Requirements CFR(s): 483.73(d)(2) §416.54(d)(2), §418.113(d)(2), §441.184(d)(2), §460.84(d)(2), §482.15(d)(2), §483.73(d)(2), §483.475(d)(2), §484.102(d)(2), §485.68(d)(2), §485.542(d)(2), §485.625(d)(2), §485.727(d)(2), §485.920(d)(2), §491.12(d)(2), §494.62(d)(2). *[For ASCs at §416.54, CORFs at §485.68, REHs at §485.542, OPO, "Organizations" under §485.727, CMHCs at §485.920, RHCs/FQHCs at §491.12, and ESRD Facilities at §494.62]: (2) Testing. The [facility] must conduct exercises to test the emergency plan annually. The [facility] must do all of the following: (i) Participate in a full-scale exercise that is community-based every 2 years; or (A) When a community-based exercise is not accessible, conduct a facility-based functional exercise every 2 years; or (B) If the [facility] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required community-based or individual, facility-based functional exercise following the onset of the actual event. (ii) Conduct an additional exercise at least every 2 years, opposite the year the full-scale or functional	E0039	Please see attachment **Tag E0039 POC accepted on 9/29/25 by G. Prefontaine/S. Stem**	9/11/25

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 reverse for further 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
Mark L. Moyer	Administrator	8/29/25

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E0039 SS = F	Continued from page 1 exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [facility's] emergency plan, as needed. *[For Hospices at 418.113(d):] (2) Testing for hospices that provide care in the patient's home. The hospice must conduct exercises to test the emergency plan at least annually. The hospice must do the following: (i) Participate in a full-scale exercise that is community based every 2 years; or (A) When a community based exercise is not accessible, conduct an individual facility based functional exercise every 2 years; or (B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospital is exempt from engaging in its next required full scale community-based exercise or individual facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or a facility based functional exercise; or (B) A mock disaster drill; or	E0039		

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E0039 SS = F	Continued from page 2 (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (3) Testing for hospices that provide inpatient care directly. The hospice must conduct exercises to test the emergency plan twice per year. The hospice must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual facility-based functional exercise; or (B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospice is exempt from engaging in its next required full-scale community based or facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop led by a facilitator that includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the hospice's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the hospice's emergency plan, as needed. *[For PRFTs at §441.184(d), Hospitals at §482.15(d), CAHs at §485.625(d):] (2) Testing. The [PRTF, Hospital, CAH] must conduct	E0039		

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E0039 SS = F	Continued from page 3 exercises to test the emergency plan twice per year. The [PRTF, Hospital, CAH] must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or (B) If the [PRTF, Hospital, CAH] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an [additional] annual exercise or and that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, a facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the [facility's] emergency plan, as needed. *[For PACE at §460.84(d):] (2) Testing. The PACE organization must conduct exercises to test the emergency plan at least annually. The PACE organization must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or (B) If the PACE experiences an actual natural or man-made emergency that requires activation of the	E0039		

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E0039 SS = F	Continued from page 4 emergency plan, the PACE is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the PACE's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the PACE's emergency plan, as needed. *[For LTC Facilities at §483.73(d):] (2) The [LTC facility] must conduct exercises to test the emergency plan at least twice per year, including unannounced staff drills using the emergency procedures. The [LTC facility, ICF/IID] must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise. (B) If the [LTC facility] facility experiences an actual natural or man-made emergency that requires activation of the emergency plan, the LTC facility is exempt from engaging its next required a full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following:	E0039	Type text here	

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E0039 SS = F	Continued from page 5 (A) A second full-scale exercise that is community-based or an individual, facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [LTC facility] facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [LTC facility] facility's emergency plan, as needed. *[For ICF/IIDs at §483.475(d)]: (2) Testing. The ICF/IID must conduct exercises to test the emergency plan at least twice per year. The ICF/IID must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or. (B) If the ICF/IID experiences an actual natural or man-made emergency that requires activation of the emergency plan, the ICF/IID is exempt from engaging in its next required full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency	E0039		

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E0039 SS = F	Continued from page 6 plan. (iii) Analyze the ICF/IID's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the ICF/IID's emergency plan, as needed. *[For HHAs at §484.102] (d)(2) Testing. The HHA must conduct exercises to test the emergency plan at least annually. The HHA must do the following: (i) Participate in a full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise every 2 years; or. (B) If the HHA experiences an actual natural or man-made emergency that requires activation of the emergency plan, the HHA is exempt from engaging in its next required full-scale community-based or individual, facility based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the HHA's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the HHA's emergency plan, as needed. *[For OPOs at §486.360]	E0039		

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E0039 SS = F	Continued from page 7 (d)(2) Testing. The OPO must conduct exercises to test the emergency plan. The OPO must do the following: (i) Conduct a paper-based, tabletop exercise or workshop at least annually. A tabletop exercise is led by a facilitator and includes a group discussion, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. If the OPO experiences an actual natural or man-made emergency that requires activation of the emergency plan, the OPO is exempt from engaging in its next required testing exercise following the onset of the emergency event. (ii) Analyze the OPO's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the [RNHCI's and OPO's] emergency plan, as needed. *[RNCHIs at §403.748]: (d)(2) Testing. The RNHCI must conduct exercises to test the emergency plan. The RNHCI must do the following: (i) Conduct a paper-based, tabletop exercise at least annually. A tabletop exercise is a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (ii) Analyze the RNHCI's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the RNHCI's emergency plan, as needed. This STANDARD is NOT MET as evidenced by: Based on interview and record review, the facility failed to conduct exercises to test the emergency plan at least twice per year. Findings include: Per record review of the facility's emergency preparedness program, there was no documentation of community-based exercises for the past year. Per interview on 8/6/2025 at approximately 4:22 PM, the Administrator and the Maintenance Director confirmed that they had not done a community-based exercise this year and the last one was done in February of 2024.	E0039		

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E0039 ~~F0000~~ SS=F	INITIAL COMMENTS The Division of Licensing and Protection conducted an unannounced, onsite recertification survey and investigation of [3] complaint(s) and [2] facility reported incidents, including reports # 163004,163026,163031,163032,163046, from 8/4/2025 through 8/6/2025 to determine compliance with 42 CFR Part 483 requirements for Long Term Care Facilities. Deficiencies were cited as a result of this survey.	E0039 F0000		
F0554 SS = D	Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7) §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is NOT MET as evidenced by: Per observation, interview, and record review, the facility failed to determine whether it is clinically appropriate for residents to self-administer medications for one of one sampled resident (Resident #43). This is a repeat deficiency for this facility, with violations cited during the previous thee recertification surveys, dated 2/6/25, 8/19/24, and 3/01/24. Findings include: Per review of the facility policy titled “Medication Administration” reviewed on 3/2025, “Medication are administered by licensed nurses or other staff who are legally authorized to do so in this state, as ordered by the physician and in accordance with professional standards of practice… Observe resident consumption of medication”. Per record review, Resident #43 has a medical condition called dysphagia, a condition that causes difficulty swallowing. Additionally, the physicians order page in the Electronic Health Record (EHR) revealed Resident #43 does not have orders for self-administration of medications. Per observation on 8/4/2025 at approximately 10:40am, Resident #43 had a pill in a small medicine cup with pudding left on his/her bedside table. There was no nursing staff in the room. Per interview with Licensed Nurse #1 assigned to the medication cart on 8/4/2025 at approximately 10:45am, they confirmed that the medications were left at the	F0554	Please see attachment **Tag F0554 POC accepted on 9/29/25 by G. Prefontaine/S. Stem**	9/11/25

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F0554 SS = D	Continued from page 9 bedside and that he/she shouldn't have left them there. The nurse said that in the medication cup there were crushed medications along with a medication that was not crushed, a pill called Protonix (also known as Pantoprazole as stomach acid reducer used to treat acid reflux) that cannot be crushed.	F0554		
F0689 SS = D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is NOT MET as evidenced by: Based on interview and record review the facility failed to provide adequate supervision to prevent a resident from eloping from a facility for 1 of 3 Residents (Resident #45). Findings include: Per record review of Resident #45's Care Plan, this resident was assessed as an elopement risk upon admission to this facility and has had a Wander Guard on his/her right ankle since admission. The Wander Guard was initiated on 3/7/25. The Care Plan does not indicate interventions related to wandering or for supervision for this resident. This resident has diagnoses of impaired cognitive function, restlessness and agitation and traumatic brain injury. Per review of an Incident Report, Resident #45's eloped on 4/7/25,. The document shows Resident #45 was unable to be located on the facility campus on 4/17/25 at 7:15PM. S/he was located at approximately 7:35PM on the property adjacent to the facility which is located down a hill from the facility. Per record review [SS1] of a 4/18/25 progress note, Resident #45 was transported by Emergency Medical Services from the adjacent property to the hospital where she/he had x-rays done because s/he complained that their head and both knees hurt. Both knees had scrapes on them. The resident said s/he had fallen while walking down the hill between the facility and	F0689	Please see attachment **Tag F0689 POC accepted on 9/29/25 by G. Prefontaine/S. Stem**	9/11/25

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F0689 SS = D	Continued from page 10 the adjacent property. Per interview on 8/5/25 at approximately 3:30PM with Resident #45, s/he explained how s/he had excited the building without being noticed. S/he removed the window and the screen in an empty room. S/he then climbed out the window to go for a “toddle around” with a plan to go to Northfield because s/he wanted to go home. Per interview with Licensed Practical Nurse (LPN) #1 on 8/6/25 at 11:00AM, s/he stated that s/he was part of the search team for Resident #45. S/he and two other staff members found the resident at the Hair Salon down the hill from this facility. S/he stated that the resident was able to tell her/him what had happened and that his/her head and knee hurt. S/he confirmed that Emergency Medical Services was present when s/he arrived and that the resident was taken to the hospital by EMS to be assessed. Per interview on 8/6/25 at 10:50 AM with the Director of Nursing, she stated the last time staff had “eyes on him/her” was about 6:00 PM. Resident #45 was located at the hair salon which is about 200 yards away. She also confirmed that Resident #45 had the Wander Guard on at the time s/he was found. The DON stated that it did not alarm because the resident went out a window and the windows are not alarmed. She also confirmed that Resident #45 had removed the window and the screen in an empty room that maintenance had been working in. Per observation on 8/6/25 at approximately 3:00PM Resident # 45 exited through an alarmed door while an employee was assisting another resident, in a wheelchair, through the same door, onto the unit. The employee did not stop or redirect Resident #45.	F0689		
F0761 SS = D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal	F0761	Please see attachment **Tag F0761 POC accepted on 9/29/25 by G. Prefontaine/S. Stem**	9/11/25

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0761 SS = D	Continued from page 11 laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, record review, the facility failed to ensure medications were properly stored for 1 of 7 sampled residents (Resident #43). This is a repeat deficiency for this facility, with violations cited during the previous three recertification surveys, dated 2/6/25, 8/19/24, and 3/01/24 Findings include: Per review of the facility policy titled “Medication Administration” reviewed on 3/2025, “Medication are administered by licensed nurses or other staff who are legally authorized to do so in this state, as ordered by the physician and in accordance with professional standards of practice… Observe resident consumption of medication.” Per review of the facility policy titled "Medication Storage" reviewed on 3/2025, "During a medication pass, medications must be under the direct observation of the person administering medications or locked in the medication storage area/cart." Per record review, Resident #43 has a medical condition called dysphagia, a condition that causes difficulty swallowing. Additionally, the physicians order page in the Electronic Health Record (EHR) revealed Resident #43 does not have orders for self-administration of medications. Per observation on 8/4/2025 at approximately 10:40 AM, Resident #43 had a pill in a small medicine cup with pudding left on his/her bedside table. There was no nursing staff in the room. Per interview with Licensed Nurse #1 assigned to the medication cart on 8/4/2025 at approximately 10:45 AM, they confirmed that the medications were left at the	F0761		

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F0761 SS = D	Continued from page 12 bedside and that he/she shouldn't have left them there. The nurse said that in the medication cup there were crushed medications along with a medication that was not crushed, a pill called Protonix (also known as Pantoprazole as stomach acid reducer used to treat acid reflux) that cannot be crushed.	F0761		
F0804 SS = E	Nutritive Value/Appear, Palatable/Prefer Temp CFR(s): 483.60(d)(1)(2) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. This REQUIREMENT is NOT MET as evidenced by: Based on observation and interview the facility failed to provide palatable and appealing food for 10 of 19 sampled Residents (Resident #3, Resident #37, Resident #5, Resident #30, Resident #8, Resident #11, Resident #42, Resident #43, Resident #1, and Resident #27). Findings include: #1: Per interview with Resident #3 on 8/4/2025 at 11:01 AM, she/he reported that s/he has been struggling to eat the food and gags because it's so bad. Resident #3 also reported that they will heat up his/her food and it will still be cold ninety percent of the time. #2: Per interview with Resident #37 on 8/04/2025 at 11:46 AM, s/he reported that sometimes the food is not hot. #3: Per interview with Resident #5 on 8/04/2025 at 11:56 AM, s/he reported the food is "too often" cold, about 75% of the time. #4: Per interview with Resident #30 on 8/4/2025 at 2:33 PM s/he stated that the food is not always good and not like s/he is used to. #5: Per interview with Resident #8 on 8/4/2025 at 3:14 PM, the Resident reported that s/he does not eat the food provided by the facility and that the food is not healthy, so s/he has friends buy him/her food.	F0804	Please see attachment **Tag F0804 POC accepted on 9/29/25 by G. Prefontaine/S. Stem**	9/11/25

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F0804 SS = E	Continued from page 13 #6: Per interview with Resident #11 on 8/4/2025 at 4:13 PM, s/he reports that the food is often cold. #7 Per interview with Resident #42 on 8/05/2025 at 9:22 AM s/he reported that the food is cold and sometimes the food is still cold even after being heated up. #8 Per interview with Resident #43 on 8/6/2025 at 9:10 AM, s/he reported that their breakfast was cold. 9. Per interview with Resident #1 on 8/6/25 at approximately 9:00 AM, s/he stated the food is cold and there not a lot of options. S/he stated by the time it gets to us it is always cold. The meat tastes like rubber and they do not get a lot of beef options. Per Resident #1, "We are sick of fish and chicken. I'm diabetic and on dialysis and all they feed us is carbs [carbohydrates]. Snacks at night are all sugar, portions are small. We buy cold food and they throw it out after three days." 10. Per interview with Resident #27 on 8/6/25 at approximately 9:00 AM, s/he stated the food is almost always cold and there was not much of a variety. S/he discussed there were not a lot of beef options. Resident #27 stated the residents used to get waffles and breakfast sandwiches "And now we don't anymore…They don't give maple syrup, only regular syrup." 11. Per observation on 8/05/2025 at approximately 12:30 PM, lunch is being served, and the green beans look slimy, mushy, and unappetizing with a thin white sauce over them. Per observation on 8/6/2025 at 2:45 PM, the sampled test tray tasted by a surveyor, had rice that had limited taste and asparagus that was steamed soft.	F0804		
F0880 SS = D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program.	F0880	Please see attachment **Tag F0880 POC accepted on 9/29/25 by G. Prefontaine/S. Stem**	9/11/25

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F0880 SS = D	Continued from page 14 The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.	F0880		

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F0880 SS = D	Continued from page 15 §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and record review the facility failed to perform adequate hand hygiene during a dressing change for 1 of 22 sampled Residents (Resident #67). This is a repeat deficiency for this facility, with violations cited during the previous recertification survey dated 2/6/25. Findings include: Record review on 8/5/25 revealed that Resident #67 had an unstageable pressure ulcer on their coccyx (The small bone at the bottom of the spine. It is made up of 3-5 fused bones. It is also called the tailbone) and had an order for daily dressing changes. Observation on 8/5/25 at approximately 2:30 PM, a Physician's Assistant (PA) donned gloves and provided a wound assessment via visual and tactile methods, and they provided wound debridement with a disposable scalpel for Resident #67. After performing the wound assessment and wound debridement, the PA removed the soiled gloves and without sanitizing her/his hands took the disposable scalpel used to debride the residents wound and with her/his bare hand, placed the disposable scalpel inside one of the gloves s/he had removed from their hand. S/he then picked up their pen and made notes on a piece of paper. S/he then touched the inside door knob of the residents room with their bare hand, opened the door and exited the room. Per interview with the PA on 8/5/25 at approximately 2:40 PM, s/he confirmed that s/he had not washed or used hand sanitizer to clean their hands after removing their gloves. Per review of the Hand Hygiene policy it read, "6. Additional considerations: a. The use of gloves does not replace hand hygiene. If your task requires gloves, perform hand hygiene prior to donning gloves, and immediately after removing gloves."	F0880		

]E0039-F Emergency Preparedness

- The facility has a full-scale community – based exercise scheduled for 9/9/2025.
- A tabletop mock disaster drill occurred 8/13/2025.
- A schedule has been created for 2026 including a full-scale community-based exercise and a tabletop mock disaster drill.
- This schedule will be reviewed through the quarterly QAPI for scheduling and preparation.
- The Administrator is responsible for overseeing this process. The results of the quarterly review will be brought to the QAPI committee for further review and recommendation to ensure substantial compliance is achieved.

F554- Self-administration of Medications

- Resident #43 does not have any medication left at their bedside.
- A Facility Wide Audit (FWA) was completed to validate that residents who have not been assessed as being clinically appropriate to administer their own medications, do not have medications left at beside
- The SDC has provided education to all licensed nurses on the policy, self-administration of medication, focusing on not leaving medications at the beside, unless a resident has been assessed that it is clinically appropriate for them to self-administer medications.
- The DON is responsible for overseeing this process. Through 3 observations a week by the SDC or designee validating that resident do not have medications left at the bedside, unless they have been assessed to be clinically appropriate to self-administer medications.
- The results of these audits will be reviewed and brought to QAPI meeting for a total of 3 months for further review and recommendations ensuring substantial compliance is achieved.

F689 Free of Accidents Hazards/Supervision

- Resident #45 has adequate interventions and supervision in place consistent with the residents needs, goals, and care plan to prevent them from leaving the facility unattended.
- A FWA was performed on all resident who are assessed to be an elopement risk validating those residents have adequate interventions and supervision in place consistent with the resident's needs, goals and care plan to prevent them from leaving the facility unattended.
- The SDC has provided education to all staff on the policy Accidents and Supervision, specifically Implement interventions, including adequate supervision and assistive devices, consistent with a resident's needs, goals, care plan to prevent them from leaving the facility unattended.
- The DON is responsible for overseeing this process through a weekly review of the medical record of new admission/readmissions and residents newly determined to be an elopement risk due to a change in their condition validating that they have interventions

and adequate supervision based on the residents needs, goals and care plan to prevent them from leaving the facility.

- The results of these audits will be reviewed and brought to QAPI meeting for a total of 3 months for further review and recommendations ensuring substantial compliance is achieved.

F761 Labeling of Drugs and Biologicals

- Resident #43 does not have any medication stored at their bedside.
- A FWA was completed to validate medications are properly stored, including that residents who have not been assessed as being clinically appropriate to administer their own medications, do not have medications stored at beside
- The SDC or designee has provided education to all licensed nurses on the policy, labeling and storing of drugs and biologicals , focusing on not storing medications at the beside, unless a resident has been assessed that it is clinically appropriate for them to self-administer medications and they are stored in a locked compartment
- The DON is responsible for overseeing this process. Through 3 observations a week by the SDC or designee validating that resident do not have medications stored at the bedside, unless they have been assessed to be clinically appropriate to self-administer medications.
- The results of these audits will be reviewed and brought to QAPI meeting for a total of 3 months for further review and recommendations ensuring substantial compliance is achieved.

F804 Nutritive Value/Appear, Palatable/Prefer Temp

- Resident #3, 37, 5, 30, 8, 11, 42, 43, 1, 27 are receiving food and drink that is palatable appealing, and appetizing temperature
- A FWA was performed on all residents validating that they are receiving food and drink that is palatable appealing, and appetizing temperature
- The SDC provide Education to the kitchen staff on the regulation Nutritive Value/Appear, Palatable/Prefer Temp, with a focus on providing residents with food that is palatable, appealing and an appetizing temperature
- The Administrator is responsible for overseeing this process through 3 observations a week by the Food Service Director or Designee validating that residents are receiving food and drink that is palatable appealing, and appetizing temperature.
- The results of these audits will be reviewed and brought to QAPI meeting for a total of 3 months for further review and recommendations ensuring substantial compliance is achieved.

F880 Infection Prevention and Control

- The facility is performing hand hygiene during Resident #67’s dressing change.

- A FWA was performed on all residents that require a dressing change validating the facility, staff and contracted services are performing hand hygiene during the dressing change, including after removing gloves.
- The SDC has provided education to the wound care PA and nursing staff regarding the policy Hand Hygiene, specifically hand hygiene during dressing changes
- The DON is responsible for this process through weekly audits by the SDC or designee validating that the facility is performing hand hygiene with dressing changes
- The results of these audits will be reviewed and brought to QAPI meeting for a total of 3 months for further review and recommendations ensuring substantial compliance is achieved.