



Department of Disabilities, Aging and
Independent Living
Division of Licensing and Protection
280 State Drive/HC 2 South
Waterbury, VT 05671-2060
www.dlp.vermont.gov

[phone] 802-241-0344
[fax] 802-241-0343

AGENCY OF HUMAN SERVICES

January 22, 2026

Ms. April Furlow, Administrator
Premier Rehab and Healthcare at Burlington
300 Pearl Street
Burlington, VT 05401

Provider ID #: 475014

Dear Ms. Furlow:

Enclosed is a copy of your acceptable plans of correction for the recertification survey conducted on **December 17, 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,

A handwritten signature in dark ink that reads "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: 475014	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 12/17/2025
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NAME OF PROVIDER OR SUPPLIER Premier Rehab and Healthcare at Burlington	STREET ADDRESS, CITY, STATE, ZIP CODE 300 Pearl Street , Burlington, Vermont, 05401
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E0000	Initial Comments The Division of Licensing and Protection conducted an onsite, unannounced survey of the facility's emergency preparedness program on 12/17/2025 during an annual re-certification survey. There were no regulatory violations related to emergency preparedness as a result of this survey.	E0000		
F0000	INITIAL COMMENTS The Division of Licensing and Protection conducted an unannounced, onsite recertification survey on 12/15/25 through 12/17/25 to determine compliance with 42 CFR Part 483 requirements for Long Term Care Facilities. Three complaints (#152878, #154078, and #154071) and two facility reported incidents (#2648033, and #154202) were also investigated. The following regulatory violations were identified:	F0000		
F0584 SS = D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft.	F0584	F584 Safe/Clean/Comfortable/Homelike Environment - The second-floor code carts, treatment carts, mechanical lift, precautions supplies, and kitchenette hood were cleaned and cleared of construction debris (dust). The Mattress in room 209 was removed and discarded. - A FWA was performed validating that the code carts, treatment carts, mechanical lift, precautions supplies, and kitchenette hoods do not have dusty on them and that mattresses have no signs of wear. - The Staff Development Coordinator (SDC) or designee provided education on the policy safe and homelike environment specifically keeping resident care equipment clean from dust and replacing a mattress when there are signs of wear. - The SDC or Designee will perform observations weekly validating that the code carts, treatment carts, mechanical lift, precautions supplies, and kitchenette hoods do not have dust on them and that mattresses have no signs of wear. - The Administrator is responsible for overseeing this process. The results of these audits will be brought to the QAPI committee for further review and recommendation ensuring substantial compliance has been achieved for 3 months. Corrective action date: 01/16/2026	

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 NHA	(X6) DATE 01/16/2026
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F0584 SS = D	Continued from page 1 §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is NOT MET as evidenced by: Based on observations and interviews, the facility failed to provide a safe, clean, comfortable, and homelike environment regarding construction debris and resident room equipment maintenance and repair on 1 of 4 units (Second Floor). Findings include: 1. Per observation on 12/15/2025 at approximately 2:10 PM, a white/grey powder like substance was on the code cart, wound care/treatment cart, and the precaution supply carts. Per interview on 12/15/2025 at approximately 2:30 PM with the LPN on the Second floor, they confirmed the code cart, wound care cart, and precaution supply carts were "dusty" with white/grey powder and needed to be cleaned. Per interview with 12/15/2025 at 3:09 PM with the Director of Nursing (DON), she confirmed there was dust on the code cart, suction machine, precaution supply carts, and treatment cart containing "construction dust" and that they all needed to be cleaned. During observation of the Second floor on 12/17/25 at	F0584	Tag F 584 POC accepted on 1/22/26 by J. Wilder/S. Stem	

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F0584 SS = D	Continued from page 2 9:41 AM, Hoyer lifts, a mechanical device used to lift and transfer residents with limited mobility safely, were observed with dust-like material that had a white powder look on the base of the equipment. Per interview on 12/17/2025 at 9:57 AM with the Infection Preventionist, Director of Nursing (DON), and the Regional Nurse Consultant, they confirmed the debris seen on the Second floor. During the observation of the Second floor on 12/17/25 at 11:28 AM, the Regional Nurse Consultant acknowledged that the Hoyer lifts required cleaning due to construction dust and reported that housekeeping was "working on it." During an interview on 12/17/25 at 12:19 PM with the Assistant Administrator and the DON, the Assistant Administrator described the debris as construction "particles" and "dust" produced during sanding and wall preparation for wallpaper. During an interview on 12/17/25 at 1:40 PM with a maintenance person and the Second floor LPN, both confirmed that the kitchenette hood had a buildup of debris and had not been cleaned. According to the Centers for Disease Control and Prevention (2023, CDC) when the environment is disturbed such as by producing dust airborne infections can be released into the air which can cause healthcare associated infections. 2. Per observation on 12/15/2025 at 11:07 AM, a resident in room 209 had been discharged earlier that morning. The mattress was noted to have had a brown discoloration in the middle. The protective lining in the center of the mattress was a lighter blue than the rest of the mattress with the edges appearing chipped. There were two pillows observed with holes in the protective/plastic covering. Per interview on 12/15/2025 at 1:09 PM with a Licensed Practical Nurse (LPN) on the Second floor, s/he confirmed the mattress was compromised as noted above, and that there was a "brown stain" to the mattress where the top layer was worn, and that both pillows had holes in them. Per observation on 12/15/2025 at approximately 2:32 PM, room 209 appeared to have been cleaned and the bed containing the identified compromised mattress was noted to be made and ready for use. The bed linens were removed from one side of the mattress revealing the	F0584		

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F0584 SS = D	Continued from page 3 compromised mattress observed earlier in the day as noted above. The pillows noted above were on the bed with pillow cased in place. Per interview with a Housekeeping Staff who was finishing up in room 209, they confirmed the room had been terminally cleaned and the mattress/bed was ready for a new resident. The Housekeeping Staff was shown the mattress/bed and asked if the mattress was safe to use for a new resident and the Housekeeping Staff said she didn't know but it was re-made and ready for a new resident. Per interview on 12/15/2025 at 2:43 PM with the Administrator (ADM), she confirmed that the mattress was not appropriate for resident use in the above noted condition, it was compromised and could not properly be cleaned in that condition and needed to be thrown away. Per interview on 12/17/2025 at 8:11 AM with the Housekeeping Manager, he confirmed if a mattress cover is compromised it should be reported and removed from use and stated he was "mortified" by the condition of the mattress found in one of the resident rooms that was being terminally cleaned, thorough cleaning of a room after use in healthcare environments to control the spread of infections, and he "wouldn't put a resident on a mattress I wouldn't sleep on myself." He confirmed that staff should contact the Administrator or Assistant Administrator for a replacement when equipment is worn out, damaged, or broken. Per interview on 12/17/2025 at 9:57 AM with the Infection Preventionist, Director of Nursing (DON), and the Regional Nurse Consultant, they confirmed that equipment that cannot be disinfected shouldn't remain in use for residents. When there are worn-out, damaged, or broken items, staff are expected to use TELS (the online platform for building maintenance) or contact the Assistant Administrator to request a replacement. Review of facility policy titled "Care, Cleaning and Storage of Equipment", last reviewed 2/2025, states "Equipment found to be in disrepair...should be reported to the supervisor on the day it is noted."	F0584		
F0610 SS = D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must:	F0610	F610 Investigate/Prevent/Correct Alleged Violation The facility has effective measures in place to ensure that further potential abuse does not occur while investigating an allegation of abuse, including for resident #73	

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F0610 SS = D	Continued from page 4 §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is NOT MET as evidenced by: Based on record review and interview the facility failed to put effective measures in place to ensure that further potential abuse does not occur while investigating an allegation of abuse for one of three sampled residents (Resident #73). Findings include: Per review of Resident #73's medical record, s/he had a BIMS [Brief Interview of Mental Status] score of 13 as of 9/26/25, indicating s/he is not cognitively impaired. S/he has medical diagnoses of COPD [Chronic Obstructive Pulmonary Disease], anxiety disorder, MDD [Major Depressive Disorder], and Wernicke's encephalopathy [a disease that is caused from a low level of thiamine]. Resident #73 is independent with ADLs [Activities of Daily Living] and hygiene. Per record review of a progress note written on 10/21/25 at 2:39 PM states, "Resident is being monitor on accusation of abuse from staff. No interaction with accused staff noted in this shift. Resident is pleasant to work with today. No c/o [complaints of] of accusation from staff reported today. POC [plan of care] continued." Per record review, the alleged incident occurred on 10/20/25. The final investigation was submitted on 10/24/25. Per the facility's initial report dated 10/21/25 states, "[Resident #73] says [s/he] was walking in the hallway on [his/her] unit late in the evening last night when [LNA#1] "yelled" at [him/her] and told [him/her] to go back to [his/her] room. When [Resident #73] told [LNA#1] no [Resident #73] says that [LNA#1]	F0610	- A FWA was performed on all allegations of potential abuse in the last 90 days validating that an accused person for the allegation is removed from the facility until the investigation is complete. - The Vice President of Clinical Operations Provided Education to the Administrator and Director of Nursing on the policy, Abuse, Neglect and Exploitation specifically ensuring all residents are protected from physical, psychological harm, as well as additional potential abuse during and after investigation by removing them from the facility during investigation. - The Administrator will track and validate that with all allegations of potential abuse an accused person for the allegation is removed from the facility until the investigation is complete. - The Administrator is responsible for overseeing this process. The results of these audits will be brought to the QAPI committee for further review and recommendation ensuring substantial compliance has been achieved for 3 months. Corrective action date: 01/16/2026 Tag F 610 POC accepted on 1/22/26 by J. Wilder/S. Stem	

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F0610 SS = D	Continued from page 5 walked up behind [him/his] and made [him/her] fall onto [his/her] face in the hallway. [S/he] says [s/he] then walked into [his/her] room and [LNA#1] told [him/her] to go to bed. [Resident #73] got into bed and [LNA#1] told [him/her] to roll over. [Resident #73] told him no and [LNA#1] put his hands on the mattress and started "bouncing [him/her] like a child" [Resident #73] continues on to say that [LNA#2] does this as well." An interview was conducted with Resident #73 on 12/15/25 at 11:11 AM. Per Resident #73, LNA [Licensed Nursing Assistant] #1 stated, "Get back to your room" as the resident was in the hall. S/he stated the LNA "pushed me because I wasn't go[ing] fast enough." Resident #73 stated s/he landed face down in the hallway. Resident #73 stated LNA#1 then grabbed him/her and started bouncing him/her off the bed. Resident #73 stated s/he kicked the staff member in the face. Resident #73 stated s/he has not seen the LNA lately, stating, "I asked for that. He's not on this floor anyway." Per record review of the facility's internal investigation states, "Both male caregivers have been moved to work on other units to prevent any further concerns." Per record review of the schedules during the investigation from 10/20/25 to 10/24/25, LNA#1 worked 10/20/25, 10/21/25, 10/23/25 and 10/24/25. LNA#2 worked on 10/21/25, 10/22/25, 10/23/25, and 10/24/25. Per record review of the facility's "Abuse, Neglect, and Exploitation" policy [last revised 9/2024] states, "VI. Protection of Resident The facility will make efforts to ensure all residents are protected from physical and psychosocial harm, as well as additional abuse, during and after the investigation. Examples include but are not limited to:...D .Room or staffing changes, if necessary, to protect the resident(s) from the alleged perpetrator." An interview was conducted with the Administrator on 12/16/25 at 4:09 PM. The Administrator confirmed LNA#1 and LNA#2 were not removed from the facility during the investigation.		F0610				
F0684 SS = G	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a		F0684	F684 Quality of Care Resident #14 was discharged from the facility on 12/28/2025			

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F0684 SS = G	Continued from page 6 resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is NOT MET as evidenced by: Based on record review and interview, the facility failed to provide care to a resident with a wound vac (wound vacuum; a negative pressure pump that helps a wound heal faster by removing fluid and infection-causing bacteria with suction) in accordance with their facility policy for 1 of 1 sampled residents (Resident #14). The facility did not have a care plan or physician orders and evidence of monitoring in accordance with facility policy for the wound vac until 11/27/25, 22 days later, did not maintain a wound vac or following wound treatment orders after wound vac was removed on 11/13/25, and did not provide necessary education and ensure staff were competent to provide care to a resident with a wound vac. As a result, Resident #14 developed an infection requiring hospitalization and two surgical interventions. Findings include: Per record review, Resident #14 was admitted to the facility on 10/21/25 for rehabilitation services after a left hip replacement. A Transition of Care report from the sending hospital dated 10/21/25 reads, "Patient is at high risk for developing post-operative infection." Resident #14's cognition was assessed on 11/29/25 with a BIMS (Brief Interview for Mental Status) score of 15 indicating cognitive intactness. Resident #14 has the following care plans: "[Resident #14] is at risk for an infection related to: recent hospitalization, post surgery, SAR [sub acute rehab] placement," created on 10/21/25, and "[Resident #14] has actual non-pressure skin impairment/s present R/T [related to] Surgical site," created on 10/22/25, with an intervention for "Treatment as ordered to the wound," created on 10/22/25. Per interview on 12/16/25 at 8:55 AM, Resident #14 explained that s/he really wants to go back home and is very frustrated that s/he can't because s/he has to go back for another hip surgery- a revision to his/her hip due to an infection. S/He explained that s/he had a wound vac on the surgical hip and there was a period of time that it wasn't on when it should have been. S/He stated that it got "full" and stopped working. S/He said that there was an issue with the wound vac supplies, and the staff didn't know what to do with it, so they stopped using it.	F0684	- A FWA was performed validating that all current residents with a wound Vac have a physician's order in place that includes the desired pressure setting, continuous or intermittent therapy, frequency of dressing change, and monitoring for function/setting every shift, a care plan indicating Wound Vac interventions and monitoring, replacement cartridges are in supply, and that orders for any additional wound care are followed following a wound Vac removal - The SDC or designee provided education to licensed nurses on the policy negative pressure wound therapy specifically, that physician's order are in place that includes the desired pressure setting, continuous or intermittent therapy, frequency of dressing change, and monitoring for function/setting every shift, a care plan indicating Wound Vac interventions and monitoring, and that orders for any additional wound care are followed. The Regional Nurse Provided Education to the Director of Nursing regarding cartridges supply when the facility has a resident on a wound Vac - The Director of Nursing of designee will perform weekly audits on resident with wound Vacs validating, they have a physician's order in place that includes the desired pressure setting, continuous or intermittent therapy, frequency of dressing change, and monitoring for function/setting every shift, a care plan indicating Wound Vac interventions and monitoring, replacement cartridges are in supply, and that orders for any additional wound care are followed - The Director of Nursing is responsible for overseeing this process. The results of these audits will be brought to the QAPI committee for further review and recommendation ensuring substantial compliance has been achieved for 3 months. Corrective action date: 01/16/2026 Tag F 684 POC accepted on 1/22/26 by J. Wilder/S. Stem	

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F0684 SS = G	Continued from page 7 Facility policy titled "Negative Pressure Wound Therapy [NPWT]," revised 2/2025, reads, "1. Negative pressure wound therapy will be provided in accordance with physician orders, including the desired pressure setting, continuous or intermittent therapy, and frequency of dressing change... 7. Use and application of the therapy shall be accordance with manufacturer's recommendations... 9. Monitoring throughout the use of NPWT shall include, but is not limited to, the following: a. pain associated with the therapy; b. device setting is functioning properly; c. settings are prescribed; d. troubleshooting of any alarms, in accordance with pump/product specifications; e. response of the therapy, including wound characteristics and progress towards healing." Per record review a change in condition form dated 11/4/25 reads "Increased drainage to L hip surgical incision site." Resident #14 was sent to the Emergency Department (ED). A 11/4/25 orthopedic survey consultation note reveals that Resident #14 presents with incisional drainage from his/her left hip. A Prevena wound vacuum was placed with intent for it to remain until scheduled outpatient follow up [11/10]. Per record review, on return from the hospital on 11/5/25, Resident #14's care plan was not revised to include interventions related to the wound vac or wound vac monitoring, and did not have physician orders for the wound vac. There is no evidence that his/her wound vac was monitored in accordance with facility policy. Per interview on 12/16/25 at 3:04 PM, the Unit Manager explained that Resident #14 had multiple wound vacs placed since s/he was first admitted and she was not familiar with the type of wound vacs that s/he had. She was unable to find physician orders or care plan for the wound vac placed on 11/4/25. A 11/10/25 orthopedic note regarding a scheduled outpatient follow up reads "overall incision healing well with 2 very small areas with ongoing serous draining, centrally and superiorly. Prevena wound vacuum sponger was replaced in clinic, well-tolerated. We stressed the importance of keeping the incision dry. I reviewed a prosthetic joint infection would require multiple surgeries including possible an explant and another revision. Plan: Maintain Prevena wound VAC for 5 days, then 3 times daily dry dressing changes." A 11/10/25 nursing note states "Resident came back from Ortho appt with new orders as followed: wound vac for 5	F0684		

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F0684 SS = G	Continued from page 8 days then TID [three times a day] dry dressing changes." A physician order starting 11/10/25 reads "Keep wound vac in place for 5 days every shift until 11/15/2025," but does not include desired pressure settings. Resident #14's care plan was not revised to include interventions related to the wound vac or wound vac monitoring, and there is no evidence that his/her wound vac was monitored in accordance with facility policy. A 11/11/25 Advance Practice Registered Nurse (APRN) note reveals that Resident #14's hip wound incision was cultured and found to have MRSA (methicillin resistant staph aureus). The resident did not show signs of infection. A wound vac was applied and is to stay in place until 11/15/25 then "will get 3 times a day dry due to [sic] dressing changes and instructed to keep wound dry." Review of the Treatment Administration Record (TAR), the wound vac was marked as "administered" only for three days, on 11/10/25 through 11/12/25. A 11/13/25 nursing note reads "Wound vac removed due to the cartridge being full and not having a replacement cartridge and leaking on the bed from the wound. Wet to dry dressing applied." A 11/13/25 progress note reads, "advised by day shift nurse that the wound vac clogged on the prior night shift and was removed, wet to dry dressing was put in place." Per review of the TAR, Resident #14 only received once a day dressing changes on 11/14/25 until 11/16/25. A 11/18/25 UM note reads "Wound noted to have increased drainage which is more thick. Dressing are needed to be changed more frequently than daily." Resident #14 was sent to the ED. A 11/25/25 Transition of Care report reveals that Resident #14 had both a surgical site and joint infection and had hip revision surgery on 11/19/15. Resident #14 was discharged back to the facility on 11/25/25 with another wound vac. Per record review, on return to the facility, Resident #14's care plan was revised to include information regarding the wound vac and physician orders were placed with the desired settings, 22 days after the resident had first had a wound vac at the facility.	F0684		

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NAME OF PROVIDER OR SUPPLIER Premier Rehab and Healthcare at Burlington	STREET ADDRESS, CITY, STATE, ZIP CODE 300 Pearl Street , Burlington, Vermont, 05401
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F0684 SS = G	Continued from page 9 A 12/12/25 Hospital Nurse Practitioner note reveals that Resident #14 is scheduled for another hip revision surgery on 12/17/25 due to persistent drainage and s/he "is discouraged about this." There was no evidence that staff had the required training and competencies to care for Resident #14's wound vac at any point of his/her stay. Per employee education file review, 3 of 3 licensed nursing staff that cared for Resident #14 while s/he had a wound vac did not have wound vac training or competencies. See F726 for more information. Per interview on 12/17/25 at 11:24 AM, the Director of Nursing confirmed that Resident #14's care plan did not include wound vac until later in November, s/he did not have physician orders for the wound vac when s/he first got it, did not have orders or interventions to monitor the wound vac until later in November. She stated that the wound vac supplies were not available when it was removed on 11/13/25 and that the order for a dry dressing three times a day was not put in place. She confirmed that education and competencies were not provided to staff for wound vacs.	F0684		
F0698 SS = D	Dialysis CFR(s): 483.25(l) *483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is NOT MET as evidenced by: Based on interview and record review, the facility failed to ensure a resident who required dialysis received services consistent with professional standards of practice for one of two residents (Resident #106). Findings include: Facility policy titled "Hemodialysis" revised on 9/25, states "The facility will assure that each resident receives care and services for the provision of hemodialysis consistent with professional standards of practice. This will include: The ongoing assessment of the resident's condition and monitoring for complications before and after dialysis treatments received at a certified dialysis facility... ongoing assessment and oversight of the resident before, during	F0698	F698 Dialysis - Resident #106 is receiving Dialysis services consistent with professional standards of practice - A FWA was performed over the last 30 days on all current residents that are receiving dialysis services validating that dialysis communication records are being filled out before dialysis, after dialysis by the dialysis facility (or through verbal means that is documented in medical records) and after returning. - The SDC or designee will provide education to licensed nurses on the policy Hemodialysis specifically filling out the dialysis communication log completely before and after dialysis as well as validating communication from the dialysis facility on communication log or through verbal communication that is then documented in the medical record - The Director of Nursing will perform weekly audits of residents that are receiving dialysis services validating that dialysis communication records are being filled out before dialysis, after dialysis by the dialysis facility (or through verbal means that is documented in medical records) and after returning.	

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F0698 SS = D	Continued from page 10 and after dialysis treatments... Ongoing communication and collaboration with the dialysis facility regarding dialysis care and services." Per review of the medical record for Resident #106, it revealed the resident has medical diagnosis that include end stage renal disease, dependence on renal dialysis, type 2 diabetes mellitus, anemia in chronic kidney disease, pulmonary hypertension, generalized edema, chronic obstructive pulmonary disease, insomnia, and chronic diastolic heart failure. Per review of Resident #106's physician orders, the resident is scheduled for dialysis treatments on Tuesdays, Thursdays, and Saturdays. Per record review of Resident #106's Hemodialysis Communication Record, there are 23 dates where the communication log is not filled out completely by either the facility, the dialysis center, or both since 8/19/25. Per interview with a nurse on 12/17/25 at approximately 2:10 PM, she confirmed that the facility staff should be completing the before and after dialysis treatment assessments which include assessing for bruit, thrill, blood pressure, temperature, pulse, time of last meal, diet, and the patient's general condition and that this wasn't completed for 12/16/25. She also confirmed that the dialysis center should complete the middle section of the Hemodialysis Communication Record. Per interview on 12/17/25 at 2:27 PM, the Director of Nursing (DON) confirmed that the Hemodialysis Communication Record was not being filled out completely by the facility and by the dialysis center and that they should be filled out completely. The DON confirmed that the nursing staff should be assessing Resident #106's condition before they leave the facility, ensuring that the dialysis center completes their portion of the documentation on return to the facility, and that on Resident #106's return to the facility, nursing staff assesses their condition and documents that in the Hemodialysis Communication Record. The DON revealed the Unit Manager should be ensuring the Hemodialysis Communication Record is filled out by the facility, and dialysis center, and the dialysis center should be contacted when the documentation is incomplete.	F0698	- The Director of Nursing is responsible for overseeing this process The results of these audits will be brought to the QAPI committee for further review and recommendation ensuring substantial compliance has been achieved for 3 months. Corrective action date: 01/16/2026 Tag F 698 POC accepted on 1/22/26 by J. Wilder/S. Stem	
F0726 SS = G	Competent Nursing Staff CFR(s): 483.35(a)(3)(4)(d) §483.35 Nursing Services The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable	F0726	F726 Competent Nursing Staff - All Licensed Nurses have been assessed for wound Vac education and competency. - A FWA was performed validating that all Licensed Nurses were assessed for wound Vac education and Competency	

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F0726 SS = G	Continued from page 11 physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.71. §483.35(a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. §483.35(a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs. §483.35(d) Proficiency of nurse aides. The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. This REQUIREMENT is NOT MET as evidenced by: Based on record review and interview, the facility failed to provide necessary education and ensure staff were competent to provide care to a resident with a wound vac (wound vacuum; a negative pressure pump that helps a wound heal faster by removing fluid and infection-causing bacteria with suction) for 3 of 3 sampled licensed nurses providing care to Resident #14. As a result, Resident #14 developed an infection requiring hospitalization and two surgical interventions. Findings include: Per record review, Resident #14 was admitted to the facility on 10/21/25 for rehabilitation services after a left hip replacement. Resident #14's cognition was assessed on 11/29/25 with a BIMS (Brief Interview for Mental Status) score of 15 indicating cognitive intactness. Per interview on 12/16/25 at 8:55 AM, Resident #14 explained that s/he really wants to go back home and is very frustrated that s/he can't because s/he has to go back for another revision to his/her hip due to an	F0726	- The VP of Clinical Operations has provided education to the DNS on the staff competency plan, including ensuring employees meet the appropriate competencies for Wound Vacs - The SDC or designee will perform audits for each licensed nurses upon hire ensuring that they have received education and competency for wound Vacs - The DNS is responsible for overseeing this process. The results of this audit will be brought to the QAPI for review and recommendations for 3 months ensuing substantial compliance is achieved. Corrective action date: 01/16/2026 Tag F 726 POC accepted on 1/22/26 by J. Wilder/S. Stem	

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F0726 SS = G	Continued from page 12 infection. S/he explained that s/he had a wound vac (wound vacuum; a negative pressure pump that helps a wound heal faster by removing fluid and infection-causing bacteria with suction) on the surgical hip and here was a period of time that it wasn't on when it should have been. S/He stated that it got "full" and stopped working. S/He said that there was an issue with the wound vac supplies, and the staff didn't know what to do with it, so they stopped using it. Per record review and interview, Resident #14 had a wound vac placed on his/her left hip surgical site on 11/4/25 due to drainage. Resident #14 required hip revision surgery on 11/19/25 due to an infection. Resident #14 did not have a care plan or physician orders and evidence of monitoring in accordance with facility policy for the wound vac until 11/27/25, 22 days later. See F684 for more information. Per interview on 12/16/25 at 3:04 PM, the Unit Manager explained that Resident #14 had multiple wound vacs placed since s/he was first admitted and she was not familiar with the type of wound vacs that s/he had. Education files for 3 licensed nursing staff that cared for Resident #14 while s/he had a wound vac were reviewed. 3 of 3 licensed nursing staff did not have wound vac training or competencies. Per interview on 12/17/25 at 11:24 AM, the Director of Nursing confirmed that education and competencies were not provided to staff for wound vacs. Review of the Facility Assessment, dated 10/6/25, reveals that the facility has determined it can care for residents who have major joint replacements and wounds. A section titled "Information About Our Staff Training/Education and Competencies" describes the skills and competencies required to meet resident needs and reads, "We identified four categories of competencies: knowledge, assessment, pharmacological/treatment/care considerations, and technical/hands-on skills. Refer to the worksheet 'Facility Education/Staff Competencies Necessary to Care for Resident Population.' The worksheet identifies which staff require certain competencies and skill sets, and the frequency of education. See also 'Staff Development Training Plan.'" Per interview on 12/17/25 at 1:20 PM, the Nurse Educator confirmed that there had been no education provided to staff for wound vacs. During this interview, the facility assessment was reviewed with		F0726				

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F0726 SS = G	Continued from page 13 the Nurse Educator. She was unfamiliar with the education and competency worksheet and the staff development training plan that the facility assessment referred to.	F0726		
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 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 interview, record review, and observation, the facility failed to safely store locked medications for 1 of 7 medication carts. Findings include: During observations on the second floor on 12/15/25 at 10:54 AM till 11:04 AM, the medication treatment cart was observed to be unlocked. There was one Resident walking up and down the hallway. Per interview with a nurse on 12/15/25 at 11:04 AM, she confirmed that the medication treatment cart should be locked and then locked the cart. Per review of the facility's "Medication Storage" policy reviewed 9/24, it states "... All drugs and biologicals will be stored in locked compartments (i.e., medication carts, cabinets, drawers, refrigerators, medication rooms)."	F0761	F761 Labeling of drugs and Biologicals - The second-floor medication cart is locked when not under direct observation of the person administering the medications - A FWA was performed validating that all medications carts are locked when they're not under direct supervision of the person administering medications - The SDC or designee will provide education to licensed nurses on the policy medication storage, specifically, medications carts being locked when they're not under direct supervision of the person administering medications. - The Director of Nursing or designee will perform audits 2 times per week, validating that all medications carts are locked when they're not under direct supervision of the person administering medications - The DNS is responsible for overseeing this process. The results of this audit will be brought to the QAPI for review and recommendations for 3 months ensuing substantial compliance is achieved. Corrective action date: 01/16/2026 Tag F 761 POC accepted on 1/22/26 by J. Wilder/S. Stem	

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F0761 F801D SS = F	Qualified Dietary Staff CFR(s): 483.60(a)(1)(2) §483.60(a) Staffing The facility must employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, taking into consideration resident assessments, individual plans of care and the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.71. This includes: §483.60(a)(1) A qualified dietitian or other clinically qualified nutrition professional either full-time, part-time, or on a consultant basis. A qualified dietitian or other clinically qualified nutrition professional is one who- (i) Holds a bachelor's or higher degree granted by a regionally accredited college or university in the United States (or an equivalent foreign degree) with completion of the academic requirements of a program in nutrition or dietetics accredited by an appropriate national accreditation organization recognized for this purpose. (ii) Has completed at least 900 hours of supervised dietetics practice under the supervision of a registered dietitian or nutrition professional. (iii) Is licensed or certified as a dietitian or nutrition professional by the State in which the services are performed. In a State that does not provide for licensure or certification, the individual will be deemed to have met this requirement if he or she is recognized as a "registered dietitian" by the Commission on Dietetic Registration or its successor organization, or meets the requirements of paragraphs (a)(1)(i) and (ii) of this section. (iv) For dietitians hired or contracted with prior to November 28, 2016, meets these requirements no later than 5 years after November 28, 2016 or as required by state law. §483.60(a)(2) If a qualified dietitian or other clinically qualified nutrition professional is not employed full-time, the facility must designate a		F0761 F0801	F801 Qualified Dietary Staff - The facility has a Full time qualified Registered dietician - A FWA was performed validating that there is full-time qualified dietician or clinically qualified nutrition professional employed. - The VP of clinical services provided education with the Administrator regarding the federal requirement F801, specifically the need for a full-time qualified dietician or clinically qualified nutrition professional. - The Administrator will validate Monthly that there is a full-time qualified dietician or clinically qualified nutrition professional employed by the facility. - The Administrator is responsible for this process. The results of this audit will be brought to the QAPI for review and recommendations for 3 months ensuing substantial compliance is achieved. Corrective action date: 01/16/2026 Tag F 801 POC accepted on 1/22/26 by J. Wilder/S. Stem			

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F0801 SS = F	Continued from page 15 person to serve as the director of food and nutrition services. (i) The director of food and nutrition services must at a minimum meet one of the following qualifications- (A) A certified dietary manager; or (B) A certified food service manager; or (C) Has similar national certification for food service management and safety from a national certifying body; or D) Has an associate's or higher degree in food service management or in hospitality, if the course study includes food service or restaurant management, from an accredited institution of higher learning; or (E) Has 2 or more years of experience in the position of director of food and nutrition services in a nursing facility setting and has completed a course of study in food safety and management, by no later than October 1, 2023, that includes topics integral to managing dietary operations including, but not limited to, foodborne illness, sanitation procedures, and food purchasing/receiving; and (ii) In States that have established standards for food service managers or dietary managers, meets State requirements for food service managers or dietary managers, and (iii) Receives frequently scheduled consultations from a qualified dietitian or other clinically qualified nutrition professional. This REQUIREMENT is NOT MET as evidenced by: Per interview and record review, the facility failed to have a qualified food service director or a full-time qualified dietitian. This has the potential to impact all residents. Findings include: Per interview on 12/16/25 at 8:14 AM, the Kitchen Manager explained that he was new to the position and does not have his certification as a dietary manager or food service manager yet. Per interview on 12/17/25 at 12:15 PM, the Administrator explained that the Registered Dietician (RD) works full time between two facilities. Per review of the RD's timecard for the previous week, the RD worked 25 hours at the facility.	F0801		

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F0801 SS = F	Continued from page 16 Per interview on 12/17/25 at 12:32 PM, the RD explained that she works at the facility 3 times a week and confirmed that she does not work full-time at this facility.	F0801		
F0809 SS = F	Frequency of Meals/Snacks at Bedtime CFR(s): 483.60(f)(1)-(3) §483.60(f) Frequency of Meals §483.60(f)(1) Each resident must receive and the facility must provide at least three meals daily, at regular times comparable to normal mealtimes in the community or in accordance with resident needs, preferences, requests, and plan of care. §483.60(f)(2) There must be no more than 14 hours between a substantial evening meal and breakfast the following day, except when a nourishing snack is served at bedtime, up to 16 hours may elapse between a substantial evening meal and breakfast the following day if a resident group agrees to this meal span. §483.60(f)(3) Suitable, nourishing alternative meals and snacks must be provided to residents who want to eat at non-traditional times or outside of scheduled meal service times, consistent with the resident plan of care. This REQUIREMENT is NOT MET as evidenced by: Based on record review, observations, and interviews, the facility failed to provide substantial snacks at bedtime when there is more than 14 hours between a substantial evening meal and breakfast the following day. This has the potential to impact all residents. Findings include: 1. Per review of the medical record for Resident #106, it revealed the resident has medical diagnosis that include end stage renal disease, dependence on renal dialysis, type 2 diabetes mellitus, anemia in chronic kidney disease, pulmonary hypertension, generalized edema, chronic obstructive pulmonary disease, insomnia, and chronic diastolic heart failure. Per review of Resident #106's physician orders, the resident is scheduled for dialysis treatments on Tuesdays, Thursdays, and Saturdays.	F0809	F809 Frequency of Meals /snacks at bedtime - The facility provides substantial snacks at bedtime. - A FWA was performed validating that there are substantial snacks available for residents to eat. - The SDC or designee provided education to the dietary department regarding meal frequency and bedtime snacks, specifically when there is more than 14 hours between an evening meal and breakfast the following day, a nutritious snack is to be served at bedtime. - The Food Service Director, or designee will perform audits 3 times a week validating that there are substantial snacks available for the residents. - The Administrator is responsible for overseeing this process. The results of this audit will be brought to the QAPI for review and recommendations for 3 months ensuing substantial compliance is achieved. Corrective action date: 01/16/2026 Tag F 809 POC accepted on 1/22/26 by J. Wilder/S. Stem	

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F0809 SS = F	Continued from page 17 Per record review of Resident #106's meal intake, from the dates of 11/1/25 through 12/17/25, there are six dates where Resident #106 either had no documentation for their dinner consumption, or the documentation stated "RX" resident not available. Per interview with Resident #106 on 12/15/25 at 3:18 PM, s/he revealed that when they get back from their dialysis appointments at 9:30 PM at night, s/he doesn't always get dinner because they take his/her tray away and throw it out. Resident #106 reports this having happened three to four times. Resident #106 also reported that the always available menu the facility offers is not available after 7 or 8 PM. Resident #106 has asked for snacks when they get back, and staff have made statements like "you just want me to run around for you" to the Resident when they request a drink or food. Per interview with Resident #106 on 12/17/25 at 8:26 AM, s/he stated that they had something to eat after their dialysis appointment on 12/16/25, but that it wasn't enough. S/he also reported the food was a turkey sandwich which was saturated. They reported that they ordered out more food as the kitchen was closed and they don't have snacks available for him/her. Per observation with the Unit Manager of the snacks on Floor 2 on 12/17/25 at 10:50 AM, she revealed that there are no sandwiches in the refrigerator and that if they have them the kitchen is supposed to bring them up. The Unit Manager confirmed that there should be more snacks in the cupboard like goldfish, peanut butter sandwich crackers, pretzels, and that it was missing these items. She revealed that dietary is supposed to fill the fridge when empty and that nursing staff should be calling down if they are missing snack items. When asked about what residents have to eat at night if they are hungry, she stated that she thinks nursing staff can go into the kitchen downstairs. Per observation of the floor 3 snacks, she confirmed that there should be sandwiches in the fridge available for residents. She confirmed that there was no peanut butter crackers or jelly in the cupboards. Per interview with the Kitchen Manager on 12/17/25 at 11:19 AM, they reported that the kitchen closes at around 7:45 PM to 8 PM and that there isn't an option for residents to have hot food at night. The Kitchen Manager stated that the units have peanut butter and	F0809		

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F0809 SS = F	Continued from page 18 jelly all the time and that they are working on getting sandwich fillings up there so they can make the resident a sandwich on the floor. The Kitchen Manager also revealed that it is the kitchens responsibility to keep the snacks stocked and that the evening cook is supposed to check all the snacking supplies or that nursing is supposed to call them. He confirmed that they do not keep track of what is stocked upstairs for snacks. The Kitchen Manager also stated after 7:45 PM, whatever is on the units for snacks are the options that residents have like pudding, fudge rounds, and saltines. When asked if those items constitute a meal, he confirmed that those are not dinner meals and that the kitchen is closed so there are no meal options for residents overnight. Additionally, he confirmed that the menu does say always available, but it is not always available once the kitchen is closed. Per interview with the kitchen manager on 12/17/25 at 12:21 PM, he reported that nursing staff have access to the kitchen but he doesn't know if they are allowed to go into the kitchen. Per interview with an LNA on 12/17/25 at 1:53 PM, she reported that she frequently cares for Resident #106. The LNA confirmed that they don't bring sandwiches and put them in the refrigerator and she confirmed that there are no meal alternatives after 8 PM. When asked if she could go into the kitchen if a resident wanted something different after the kitchen is closed, she reported that she has never done that before and wasn't sure if she was allowed to. The LNA also confirmed that nursing staff aren't consistently documenting Resident #106's meal intake on the evening shifts and that they should be documenting Resident #106's meal intake after they get back from dialysis. Per interview with LNA #2 on 12/17/25 at 1:47 PM, she confirmed that they don't have a meal replacement option for residents who want a meal after 8 PM and that they never have sandwiches stocked on the unit. When asked if she has ever gone to the kitchen to get a resident food, she stated that she has never had to. Per interview with the Director of Nursing on 12/17/25 at 2:37 PM, she confirmed that the staff should be documenting how much Resident #106 eats when they get back from their dialysis appointments and that they weren't always doing that. She confirmed that nursing staff should not be coding "RX" (Resident not	F0809		

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F0809 SS = F	Continued from page 19 Available) for dinner on the days Resident #106 goes out for dialysis and then comes back. 2. An interview was conducted with four residents (Resident #59, #104, #83, and #99) on 12/17/25 at 10:27 AM during a resident council task. Resident #59 has a BIMS [Brief Interview of Mental Status] score of 14 as of 12/2/25, indicated s/he is cognitively intact. Resident #104 has a BIMS of 15 as of 10/23/25 indicating they are cognitively intact. Resident #83 has a BIMS of 15 as of 10/13/25 indicating s/he is cognitively intact. Resident # 99 has a BIMS of 14 as of 10/24/25 indicating they are cognitively intact. At 10:45 AM all four residents discussed that they get snacks only if the kitchenettes have the food. They discussed that kitchenettes do not always have food stocked for snacks. 3. Per observation on 12/15/25, starting at 11:27, the kitchenettes on each unit were observed. There were no salads (chicken, egg, or tuna salad) on any unit, and the kitchenettes were minimally stocked with "snack" food including bread, potato chips, and a small number of crackers. Per interview on 12/17/2025 at 12:03 PM, the Kitchen Manager stated that meals are served between 8 AM and 5 PM on the first unit, and 9 AM and 6 PM on the last unit (making it 15 hours between dinner and breakfast). He explained that the kitchen staff are responsible for stocking the snacks on the units. When asked what should be available to residents as a substantial snack, he said that each unit should have a minimum of two salad options, like chicken salad or egg salad to make sandwiches, and other snack options.	F0809		
F0812 SS = F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s) 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations.	F0812	F812 Food Procurement, store/prepare/serve-Sanitary The Boxes in the freezer walk-in in the kitchen was removed directly from the floor. The second floor Kitchenette's microwave, refrigerator and cabinets were cleaned. Any food items that had been opened and undated, expired food, moldy bread, items that needed to be refrigerated after opening that were left at room temperature in the kitchenettes on the second, fourth and fifth floors have been discarded.	

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F0812 SS = F	Continued from page 20 (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is NOT MET as evidenced by: Based on observations and interviews, the facility failed to store food in a safe, sanitary condition. This has the potential to impact all residents. Findings include: 1. On 12/15/2025 at 10:55 AM, a tour of the kitchen as conducted with the Kitchen Manager (KM) and Registered Dietician. The following observation was made: The walk-in freezer had multiple boxes stacked directly on the floor of the cooler, blocking access to most of the food on the shelves. The KM explained that the boxes should be put on crates and should not be on the freezer floor directly. Per observation on 12/16/2025 at 8:12 AM, the walk-in freezer had multiple boxes stacked directly on the floor of the cooler. Per interview on 12/16/2025 at 8:14 AM, the Kitchen Manager stated that the freezer was organized yesterday after our initial observation and boxes shouldn't be on the freezer floor. 2. On 12/15/25, starting at 11:27 AM, the following observations were made of all four unit kitchenettes: Second floor The microwave was covered in a large white smear; The cabinets were lined with what looked like cracker crumbs and contained a hot chocolate bag open to the air, a loaf of gluten free bread with no date, an open bag of chips with no date, and a regular loaf of bread with no date; The refrigerator had two undated take out containers, a jar of brown celery, chicken stock dated 10/15/25, and the inside doors were lined with a yellow substance; The freezer had two loaves of undated bread with a brown substance on the bags; The coffee station had a bag of brown sugar, open to air with no date. Third floor The cabinets contained three	F0812	- A FWA was performed validating that there are no items stored on the floor in the kitchen walk-in freezer, Kitchenettes have clean microwaves, refrigerators and cabinets, food items are labeled, dated, not expired or moldy, and food items that need refrigerating after opening are not left at room temperature. - The SDC or designee provided education on the policy, food procurement, specifically Storage of food must be done in a manner that helps prevent deterioration or contamination of the food including labeling/dating food items and discarding when expired. - The Food Service Director or Designee will perform audits 3 times a week validating that there are no items stored on the floor in the kitchen walk-in freezer, Kitchenettes have clean microwaves, refrigerators and cabinets, food items are labeled, dated, not expired or moldy, and food items that need refrigerating after opening are not left at room temperature. - The Administrator is responsible for overseeing this process. The results of this audit will be brought to the QAPI for review and recommendations for 3 months ensuing substantial compliance is achieved. Corrective action date: 01/16/2026 Tag F 812 POC accepted on 1/22/26 by J. Wilder/S. Stem	

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F0812 SS = F	Continued from page 21 loaves of bread with significant green mold and five additional undated loaves of bread, an open jar of grape jelly 48 oz that read "refrigerate after open," an open bag of chips with no date; The refrigerator had an unlabeled container of soup, a large bag of hot dogs open to air with no date, a greasy undated subway bag, an undated take out bag, a container of raviolis with a use by date of 12/8/25, prune juice with a use by date of 10/16/25. Per interview with the Unit Manager, she said that it is "not good" about the moldy bread, and explained that all food in the refrigerator should be marked with names and dates and it wasn't. Fourth floor The cabinets contained one loaf of undated bread; The refrigerator had two unlabeled take out containers.Fifth floor The cabinets contained five undated loaves of bread; The freezer had an unlabeled bag of ground beef; The refrigerator had eight take out containers with no dates or names and two Ziploc bag containing soup like food with no labels.Per interview with the Director of Nursing, she explained that the policy was to have all food items labeled and dated and confirmed that none of the food listed above should be in the refrigerator. Per interview on 12/17/2025 at 9:55 AM, the Kitchen Manager confirmed that all food in the kitchenettes, including bread, should be labeled with the resident's name (if applicable) and the dates that the food was open and expires.	F0812		
F0880 SS = E	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. 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,	F0880	F880- Infection Prevention and Control The second-floor code carts, treatment carts, mechanical lift, precautions supplies, and kitchenette hood were cleaned and cleared of construction debris (dust). The Mattress in room 209 was removed and discarded. The butterfly needle and lancet were discarded in a sharp's container. The two Ice packs were discarded from the second-floor freezer, and the freezer was disinfected. Resident #14 dressing was changed on 12/16/2025. Resident #14 had their PICC line dressing changed 12/17/2025	

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F0880 SS = E	Continued from page 22 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. §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.	F0880	- A FWA was performed validating code carts, treatment carts, mechanical lift, precautions supplies, and kitchenette hood were cleaned and cleared of construction debris (dust), that there are no ice packs in nourishment freezers, that needles/lancets are disposed of in sharps containers, and Mattresses have no signs of wear. A FWA was performed on all current residents with Picc lines and Dressing's validating that those dressings have been dated for the date of administration. - The SDC or designee provided education on the policy infection control, specifically All reusable items and equipment requiring special cleaning, disinfection, or replacement shall be cleaned/replaced per manufacture recommendations and disinfection schedule and Ice packs not being stored in food freezers. The SDC or designee provided education to licensed nurses on the policy PICC/Midline CVAD dressing changes and the policy clean dressing change, specifically dating and initialing the dressing at the time of administration. - The SDC or designee will perform weekly audits validating code carts, treatment carts, mechanical lift, precautions supplies, and kitchenette hood were cleaned and cleared of construction debris (dust), that there are no ice packs in nourishment freezers, that needles/lancets are disposed of in sharps containers, Mattresses have no signs of wear, and Picc line and wound care dressings are dated. - The Director of Nursing is responsible for overseeing this process The results of these audits will be brought to the QAPI committee for further review and recommendation ensuring substantial compliance has been achieved for 3 months. Corrective action date: 01/16/2026 Tag F 880 POC accepted on 1/22/26 by J. Wilder/S. Stem	

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F0880 SS = E	Continued from page 23 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, record review, and interview, the facility failed to implement infection control practices designed to provide a safe and sanitary environment for 1 of 4 units (Second floor) and ensure infection control measures were followed to prevent the transmission of diseases and infections for one randomly sampled resident (Resident #14). Findings include: 1. Per observation on 12/15/2025 at approximately 2:10 PM, a white/grey powder like substance was on the code cart, wound care/treatment cart, and the precaution supply carts. Per interview on 12/15/2025 at approximately 2:30 PM with the LPN on the Second floor, they confirmed the code cart, wound care cart, and precaution supply carts were "dusty" with white/grey powder and needed to be cleaned. Per interview with 12/15/2025 at 3:09 PM with the Director of Nursing (DON), she confirmed there was dust on the code cart, suction machine, precaution supply carts, and treatment cart containing "construction dust" and that they all needed to be cleaned. During observation of the Second floor on 12/17/25 at 9:41 AM, Hoyer lifts, a mechanical device used to lift and transfer residents with limited mobility safely, were observed with dust-like material that had a white powder look on the base of the equipment. Per interview on 12/17/2025 at 9:57 AM with the Infection Preventionist, Director of Nursing (DON), and the Regional Nurse Consultant, they confirmed the debris seen on the Second floor. During the observation of the Second floor on 12/17/25 at 11:28 AM, the Regional Nurse Consultant acknowledged that the Hoyer lifts required cleaning due to construction dust and reported that housekeeping was "working on it." During an interview on 12/17/25 at 12:19 PM with the Assistant Administrator and the DON, the Assistant Administrator described the debris as construction "particles" and "dust" produced during sanding and wall preparation for wallpaper.	F0880		

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F0880 SS = E	Continued from page 24 During an interview on 12/17/25 at 1:40 PM with a maintenance person and the Second floor LPN, both confirmed that the kitchenette hood had a buildup of debris and had not been cleaned. According to the Centers for Disease Control and Prevention (2023, CDC) when the environment is disturbed such as by producing dust airborne infections can be released into the air which can cause healthcare associated infections. 2. Per observation on 12/15/2025 at 11:07 AM, a resident in room 209 had been discharged earlier that morning. The mattress was noted to have had a brown discoloration in the middle. The protective lining in the center of the mattress was a lighter blue than the rest of the mattress with the edges appearing chipped. There were two pillows observed with holes in the protective/plastic covering. Per interview on 12/15/2025 at 1:09 PM with a Licensed Practical Nurse (LPN) on the Second floor, s/he confirmed the mattress was compromised as noted above, and that there was a "brown stain" to the mattress where the top layer was worn, and that both pillows had holes in them. Per observation on 12/15/2025 at approximately 2:32 PM, room 209 appeared to have been cleaned and the bed containing the identified compromised mattress was noted to be made and ready for use. The bed linens were removed from one side of the mattress revealing the compromised mattress observed earlier in the day as noted above. The pillows noted above were on the bed with pillow cased in place. Per interview with a Housekeeping Staff who was finishing up in room 209, they confirmed the room had been terminally cleaned and the mattress/bed was ready for a new resident. The Housekeeping Staff was shown the mattress/bed and asked if the mattress was safe to use for a new resident and the Housekeeping Staff said she didn't know but it was re-made and ready for a new resident. Per interview on 12/15/2025 at 2:43 PM with the Administrator (ADM), she confirmed that the mattress was not appropriate for resident use in the above noted condition, it was compromised and could not properly be cleaned in that condition and needed to be thrown away. Per interview on 12/17/2025 at 8:11 AM with the Housekeeping Manager, he confirmed if a mattress cover		F0880				

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F0880 SS = E	Continued from page 25 is compromised it should be reported and removed from use and stated he was "mortified" by the condition of the mattress found in one of the resident rooms that was being terminally cleaned, thorough cleaning of a room after use in healthcare environments to control the spread of infections, and he "wouldn't put a resident on a mattress I wouldn't sleep on myself." He confirmed that staff should contact the Administrator or Assistant Administrator for a replacement when equipment is worn out, damaged, or broken. Per interview on 12/17/2025 at 9:57 AM with the Infection Preventionist, Director of Nursing (DON), and the Regional Nurse Consultant, they confirmed that equipment that cannot be disinfected shouldn't remain in use for residents. When there are worn-out, damaged, or broken items, staff are expected to use TELS (the online platform for building maintenance) or contact the Assistant Administrator to request a replacement. Review of facility policy titled "Care, Cleaning and Storage of Equipment", last reviewed 2/2025, states "Equipment found to be in disrepair... should be reported to the supervisor on the day it is noted." 3. Per interview on 12/17/25 at 1:30 PM with the Second floor LPN, confirmed that an out-of-service medication cart was missing a sharps container, a special puncture-proof container used for the safe disposal of needles, syringes, and other sharp medical items. In the designated location for the sharps container, there was a used butterfly needle, a device with a small needle attached to flexible "wings," used for drawing blood or administering fluids. Additionally, she noted dust-like debris was present on the suspension wires for the partitions at the nurses' station and on the activity cart. During a 12/17/25 interview at 1:46 PM, the Unit Manager for the Second floor confirmed that an out-of-service medication cart contained a used needle and lancet that had not been disposed of in the required sharps container. 4. Per observation on 12/16/2025 at approximately 11:30 AM of the second-floor kitchenette, two ice packs were identified in the freezer. Each ice pack had a resident's first and last name written on them. Per interview on 12/16/2025 at 1:20 PM with the Licensed Practical Nurse (LPN) on the Second floor, they confirmed the two ice packs observed in the kitchenette refrigerator freezer are used for a resident who recently had surgery to address topical	F0880		

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F0880 SS = E	Continued from page 26 pain relief. The LPN confirmed the topical ice packs are specific to one resident and should not be stored in a refrigerator/freezer that is used for food storage. Per interview with the DON on 12/16/2025 at 1:24 PM, she stated they did not know where the ice packs came from or why they were in the freezer. S/he confirmed that the ice packs identified in the freezer should not be stored in a refrigerator/freezer where food is kept. 5. On 12/16/25 at 1:39 PM, wound care was observed for Resident #14. Resident #14's left hip surgical dressing did not have a date to indicate the day it was last changed. Resident #14 was observed to have a PICC line (Peripherally Inserted Central Catheter; a long term IV site) on his/her right arm. This dressing also did not have a date to indicate the day it was last changed. Per interview with the Licensed Practical Nurse performing the dressing change, she confirmed that Resident #14's surgical dressing and PICC line dressing were not labeled with dates and should be. Reference: Centers for Disease Control and Prevention (CDC). (2023, December 21). C. Air. https://www.cdc.gov/infection-control/hcp/environmental-control/air.html Plan of correction accepted on 1/22/2026 <i>Jason D. Wilder</i>		F0880				