STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	475014	A. Building B. Wing	12/17/2025

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations and interviews, the facility failed to provide a safe, clean, comfortable, and homelike environment regarding construction debris and resident room equipment maintenance and repair on 1 of 4 units (Second Floor).Findings include:1. Per observation on 12/15/2025 at approximately 2:10 PM, a white/grey powder like substance was on the code cart, wound care/treatment cart, and the precaution supply carts. Per interview on 12/15/2025 at approximately 2:30 PM with the LPN on the Second floor, they confirmed the code cart, wound care cart, and precaution supply carts were dusty with white/grey powder and needed to be cleaned. Per interview with 12/15/2025 at 3:09 PM with the Director of Nursing (DON), she confirmed there was dust on the code cart, suction machine, precaution supply carts, and treatment cart containing construction dust and that they all needed to be cleaned. During observation of the Second floor on 12/17/25 at 9:41 AM, Hoyer lifts, a mechanical device used to lift and transfer residents with limited mobility safely, were observed with dust-like material that had a white powder look on the base of the equipment. Per interview on 12/17/2025 at 9:57 AM with the Infection Preventionist, Director of Nursing (DON), and the Regional Nurse Consultant, they confirmed the debris seen on the Second floor. During the observation of the Second floor on 12/17/25 at 11:28 AM, the Regional Nurse Consultant acknowledged that the Hoyer lifts required cleaning due to construction dust and reported that housekeeping was working on it. During an interview on 12/17/25 at 12:19 PM with the Assistant Administrator and the DON, the Assistant Administrator described the debris as construction particles and dust produced during sanding and wall preparation for wallpaper. During an interview on 12/17/25 at 1:40 PM with a maintenance person and the Second floor LPN, both confirmed that the kitchenette hood had a buildup of debris and had not been cleaned. According to the Centers for Disease Control and Prevention (2023, CDC) when the environment is disturbed such as by producing dust airborne infections can be released into the air which can cause healthcare associated infections. (continued on next page)

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

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

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