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

July 1, 2026

Ms. Jennifer Combs-Wilber, Administrator
Premier Rehab and Healthcare at Berlin
98 Hospitality Drive
Barre, VT 05641

Provider ID #: 475020

RE: Complaint Survey Findings - Past Non-Compliance

Dear Ms. Combs-Wilber:

On **June 22, 2026**, the Division of Licensing and Protection completed a complaint investigation at Premier Rehab and Healthcare at Berlin. As a result of that survey, the Division determined that at a point in time prior to the date of our visit you were not in substantial compliance with the federal regulations applicable to long-term care facilities.

Statement of Deficiencies Form CMS 2567

Enclosed is a statement of deficiency generated as a result of the survey. All references to regulatory requirements in the enclosure and in this letter are found in Title 42, Code of Federal Regulations. As the cited deficiency was corrected at the time of our visit, no plan of correction is required. Please **sign page 1 and return a signed copy of the 2567 to this office.**

Informal Dispute Resolution (IDR) Opportunity

In accordance with 42 CFR §488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. To be given such an opportunity, you are required to send your written request, along with the specific deficiencies being disputed, including an explanation of why you are disputing those deficiencies, to Pamela Cota, RN, at the Division of Licensing and Protection. Contact information is listed below. Please include if you would prefer a virtual meeting or prefer to submit information in writing for review. This request must be sent during the same ten days you have for submitting your plan of correction. You must still submit a plan of correction for all deficiencies, including those you are disputing, by the due date. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action. Please note that the following are not allowable disputes in the IDR process: scope and severity of deficiencies, unless they are immediate jeopardy level or constitute substandard quality of care; remedies imposed by CMS; survey process or inconsistency issues; or concerns about the IDR process.

A facility cannot use the IDR process to claim past noncompliance.

Email (preferred): Pamela.Cota@vermont.gov
Mailing address: Division of Licensing and Protection, attn Pamela Cota
HC 2 South, 280 State Drive
Waterbury, VT 05671-2060

Phone: (802) 241-0480

Sincerely,



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 06/22/2026

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
F0000	INITIAL COMMENTS The Division of Licensing and Protection conducted an unannounced, onsite investigation of a facility reported incident including report # 3033285 on 6/22/2026 to determine compliance with 42 CFR Part 483 requirements for Long Term Care Facilities. The following regulatory deficiency was identified:	F0000		
F0609 SS = D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §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 interview and record review the facility failed to Identify a resident-to-resident altercation as	F0609	"Past Noncompliance - no plan of correction required"	

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
Jennifer Combs-Wilber	LNHA	7/1/2026

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F0609 SS = D	Continued from page 1 abuse (Resident #1 and Resident #2) and failed to immediately report the incident as required. Finding include: Per record review Resident #1 has a BIMS (Brief Interview of Mental Status) of 0 which indicates significant cognitive impairment. Diagnoses for Resident #1 include major depression disorder, anxiety disorder, restlessness, agitation and history of traumatic brain injury. Per record review Resident #2 has a BIMS of 10 which indicates moderate cognitive impairment. Diagnoses for Resident #2 include cerebral infarction, major depressive disorder, adjustment disorder with anxiety, epilepsy and alcoholic polyneuropathy. Per review of the facility's 5/26/2026 incident report, on 5/23/2026 Resident #1 became angry when s/he thought Resident #2 was wearing a shirt that belonged to him/her. While a staff member was attempting to redirect Resident #1, Resident #1 turned around and willfully hit Resident #2 in the chest with a closed hand. The staff member reported the incident to the shift supervisor who determined the altercation did not signify abuse. Per review of the facility's Compliance with Reporting Allegations of Abuse/Neglect/Exploitation policy (9/2024), it states that administration or designee will be made aware of any report of abuse/neglect/exploitation so that the appropriate agencies could be notified immediately: as soon as possible, but not later than 24 hrs." Per interview with the Director of Nursing (DON) on 6/22/2026 at 11:00 AM, she stated that on 5/26/2026 she read reports from the weekend of 5/23/2026 and became aware of the resident-to-resident altercation. The DON confirmed that the shift supervisor should have called her immediately after the altercation so that the appropriate agencies could be notified within the required timeline. Based on corrective actions completed prior to the onsite survey, this citation is designated as past non-compliance. The following actions were taken by the facility: The incident was reported to DAIL, APS, the family and police on 5/26/2026 The week of 5/26/2026 the DON Interviewed all staff	F0609		

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F0609 SS = D	Continued from page 2 members who were present during the incident. An interview with Resident #1 was unable to be conducted by the facility due to significant cognitive impairment. An interview with Resident #2 was conducted by the DON and s/he was not negatively affected by the incident. Social Services is scheduled to complete psycho socials with Resident #2. Supportive care (psych services) and Deer Oaks (talk therapy) have been scheduled to follow up with both residents. Education and competencies on abuse and neglect were completed for all staff by 6/5/2026. The DON reported that audits are to be completed on all units to determine understanding and compliance with abuse and neglect reporting. The supervisor on duty during the incident met with the DON and completed training/competencies on 6/5/2026. The Administrator and DON confirm that the late reporting of this incident will be included in their QAA meetings.	F0609		