VERMONT

AGENCY OF HUMAN SERVICES

DEPARTMENT OF DISABILITIES, AGING AND INDEPENDENT LIVING

Division of Licensing and Protection
HC 2 South, 280 State Drive
Waterbury, VT 05671-2060
http://www.dail.vermont.gov
Survey and Certification Voice/TTY (802) 241-0480
Survey and Certification Fax (802) 241-0343
Survey and Certification Reporting Line: (888) 700-5330
To Report Adult Abuse: (800) 564-1612

March 9, 2018

Mr. Casey Keefe, Administrator
Barre Gardens Nursing And Rehab Llc
378 Prospect Street
Barre, VT 05641-5421

Dear Mr. Keefe:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **February 7, 2018.** Please post this document in a prominent place in your facility.

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

Sincerely,

Pamela M. Cota, RN
Licensing Chief

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	475037	A. BUILDING ______ B. WING ______	C 02/07/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BARRE GARDENS NURSING AND REHAB LLC	378 PROSPECT STREET BARRE, VT 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 F550	(X5) COMPLETION DATE
E 000	Initial Comments During an unannounced onsite re-certification survey 2/5-7/18, the facility was found in substantial regulatory compliance regarding emergency preparedness planning activities.	E 000	**How will the corrective action be accomplished for those residents found to have been affected by the deficient practice?** Resident #45 chair was cleaned. Residents will not be served dessert on disposable Styrofoam plates.	
F 000	INITIAL COMMENTS An unannounced onsite re-certification survey, along with the investigation of two entity self-reports, was completed by the Division of Licensing and Protection from 2/5-2/7/18. There were no findings for one of the self-reports. The following regulatory violations were identified for one self-report and the re-certification survey.	F 000	**How will the facility identify other residents having the potential to be affected by the same deficient practice?** Residents residing in the facility have the potential to be affected by the alleged deficient practice.	
F 550 SS=E	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer,	F 550	**What measures will be put in place to ensure that the deficient practice will not occur?** **Staff education on resident rights, communication between IDT members when fabric recliners appear to be soiled and regarding the use of dishes that are not disposable.** **How will the facility monitor its corrective actions to ensure that the deficient practice will not occur?** Random audits by the Administrator, DNS or designee to ensure fabric recliners are clean and disposable Styrofoam plates are not being used weekly X4 weeks and monthly X2 months or until substantial compliance is achieved. The results of the audits will be reported to the monthly QAA Committee for a minimum of three months at which time the QAA Committee will determine the continued duration of the audits. Corrective action will be completed by March 5, 2018.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [signature] Administrator

(X6) DATE: 3/1/2018

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 550	Continued From page 1	F 550	F550 POC accepted 3/1/18 JHosmerRN	PMC

Continued From page 1

discharge, and the provision of services under the State plan for all residents regardless of payment source.

§483.10(b) Exercise of Rights.
The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States.

§483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility.

§483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart.
This REQUIREMENT is not met as evidenced by:
Based on observation and confirmed by staff interview, the facility failed to ensure that 1 of 21 sampled residents was treated with respect and dignity in a manner and in an environment that promotes and enhances quality of life. The facility also failed to ensure that all residents are served meals/desserts on dishes that are not disposable. The findings include the following:

1. Per observation during the three days of survey (2/5, 2/6, and 2/7/18), Resident #45 was found to have a fabric recliner next to the bed, smeared with dried fecal material visible on the seat. The soiled chair was brought to the attention of the Director of Nurses on 2/7/18 at 7 AM, who confirmed that the chair needed

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F 550	Continued From page 2 cleaning. 2. Per observation of the noon meal on 2/5/18, residents were served cookies for dessert on disposable Styrofoam plates. Per observation of the evening meal on 2/6/18 residents were served a slice of pie for dessert on disposable Styrofoam plates. Licensed Nurse Aide staff confirm that desserts are always served on disposable Styrofoam plates unless ice-cream or pudding is being offered. The Director of the Dietary Department confirms on 2/6/18 at approximately 5:15 PM, that the facility does not have enough dessert plates. When asked if they are being ordered, h/she responded that there had been a discussion with the supervisor about month ago, but there has not been and further discussion or a conclusion determined.	F 550	**F600** **How will the corrective action be accomplished for those residents found to have been affected by the deficient practice?** **The agency LPN was terminated. Resident #35 remains at the facility with no negative impact.** **How will the facility identify other residents having the potential to be affected by the same deficient practice?** Residents residing in the facility have the potential to be affected by the alleged deficient practice. **What measures will be put in place to ensure that the deficient practice will not occur?** Staff education on facility policy for preventing abuse and neglect.	
F 600 SS=D	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion;	F 600	**How will the facility monitor its corrective actions to ensure that the deficient practice will not occur?** Random audits by the Administrator, DNS or designee to ensure residents are free from abuse and neglect weekly X4 weeks and monthly X2 months or until substantial compliance is achieved. The results of the audits will be reported to the monthly QAA Committee for a minimum of three months at which time the QAA Committee will determine the continued duration of the audits. Corrective action will be completed by March 5, 2018.	

F600 POC accepted 3/7/18 JHosmer RN/PMC

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F 600	Continued From page 3 This REQUIREMENT is not met as evidenced by: Based on record review and confirmed by staff interview, the facility failed to protect 1 of 21 applicable residents from willful mistreatment and abuse (Resident #35). The findings include the following: Facility reported information and the facility internal investigation identifies that on 1/21/18 at approximately 11:30 AM, two (2) facility Licensed Nurse Aides (LNA) identified that Resident #35 had a call light in his/her hand that was not connected to the wall unit. The call cord was resting on the floor and was not functioning as intended. The LNA staff replaced the disconnected call light and reported the situation to the Registered Nurse (RN), who immediately reported to the Administrator. The LNA staff confirmed that the Licensed Practical Nurse (LPN) assigned to that unit was overheard complaining that Resident #35 rings the bell too much and questioned if there were any broken call cords on the unit. Per the internal investigation conducted by the Administrator, the LPN was candid about knowingly placing the inoperable call bell in Resident #35's hand, "[s/he] was on the bell too much". The internal investigation also identifies that the LPN was surprised at the Administrator's questioning and unapologetic for the action taken. The LPN was as contracted employee who was terminated.	F 600		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2)	F 689		

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F 689	Continued From page 4 §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observations, interviews and record review, the facility failed to supervise 1 of 21 residents (Resident #38) sufficiently to prevent wandering and intrusion. Findings include: During observations on wing 2 on 2/6/18, Resident #38 was returned from breakfast to the area of the nurses' station by a Licensed Nurse Assistant (LNA). Both nurses and all three LNAs assigned to the wing were then engaging in medication administration or direct care while Resident #38 and Resident #50 were near the nurses' station. Resident #38, per the care plan, has behaviors of wandering, intrusion, and inappropriateness toward females. At 9:13 AM Resident #38 tried to bump the wheelchair of Resident #50 and was intercepted by the nurse who was on the way to the medication cart. Once left on his/her own, Resident #38 then proceeded to and intruded into the room of Resident #19 [who was still in bed]. The nurse came away from the medication cart and redirected Resident #38 back to the nurses' station, and returned to duties. At 9:20 AM Resident #38 again went to and intruded into the room of Resident #19; the nurse again came away from medication duties to redirect. At 9:48 AM Resident #38 tried to	F 689	F689 **How will the corrective action be accomplished for those residents found to have been affected by the deficient practice?** Resident #38 continues to reside in the facility with no negative psychosocial impact. IDT care plan review and LNA assignment sheets updated to address wandering and intrusion,. **How will the facility identify other residents having the potential to be affected by the same deficient practice?** Residents residing in the facility have the potential to be affected by the alleged deficient practice. **What measures will be put in place to ensure that the deficient practice will not occur?** **Staff education on providing adequate supervision per the plan of care to prevent wandering and intrusion.** **Staff education regarding the use of disposable Styrofoam plates.** **How will the facility monitor its corrective actions to ensure that the deficient practice will not occur?** Random audits by the Administrator, DNS or designee to ensure residents are supervised per the plan of care in order to prevent wandering and intrusion weekly X4 weeks then monthly X2 months or until substantial compliance is achieved. The results of the audits will be reported to the monthly QAA Committee for a minimum of three months at which time the QAA Committee will determine the continued duration of the audits. Corrective action will be completed by March 5, 2018.	

F689 POC accepted 3/7/18 [illegible]

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F 689	Continued From page 5 bump the wheelchair of Resident #50 again, and was redirected by the social worker who had just come to the nurses' station for a survey related task. Activity staff then removed Resident #38 to a 10:00 AM activity. It was confirmed with the clinical supervisor that there had not been an activity from 9-10 AM in the sunroom, that there were 3 nurse aids on duty instead of 4 for the 2 halls of the wing, and that the clinical supervisor was covering as the medication nurse.	F 689		
F 725 SS=E	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. 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 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 §483.70(e). §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must	F 725		

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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 725

Continued From page 6

designate a licensed nurse to serve as a charge nurse on each tour of duty.
This REQUIREMENT is not met as evidenced by:
Based on observation, review of facility assessment, and confirmed by family and staff interviews, the facility failed to have sufficient nursing staff to provide nursing and related services assuring resident safety and maintaining the highest practicable physical, mental and psychosocial well-being for each resident. Consideration for the number of residents who reside in the home, the resident assessments, individual care plans, the acuity and diagnoses of the facility population should be included in determining the number of direct care staff needed. This is a repeated citation from November, 2017. The findings include the following:

1. Per review of the facility assessment dated 1/18/18, the Nursing staffing plan is as follows:
Full time Director of Nurses-Registered Nurse (RN);
Full time Assistant Director of Nurses-RN;
2 RN/LPN on each unit (8 hours each)-RN's and LPN's are used interchangeably for both day and evening shifts and 1 nurse on each unit on the over night shift;
Direct Care Staff: 4 Licensed Nurse Aides (LNA'S) on each unit for both day and evening shifts (8 hours each) and 2 LNA's on the over night shift (8 hours each).

During the three days of survey (2/5, 2/6 and 2/7/18), the facility had numerous direct care staff calling out of work for various reasons. The staffing pattern identified was not met as follows:

F 725

F725

How will the corrective action be accomplished for those residents found to have been affected by the deficient practice?

The facility will provide sufficient nursing staff to maintain resident safety and the highest practicable physical, mental and psychosocial well-being for each resident. For residents #19, #38, #50 and #51, there were no negative outcomes as a result of the alleged deficient practice, and these residents continue to reside at the facility.

How will the facility identify other residents having the potential to be affected by the same deficient practice?

Residents residing in the facility have the potential to be affected by the alleged deficient practice.

What measures will be put in place to ensure that the deficient practice will not occur?

Nursing staffing reviewed daily as it is fluid based on acuity, call bells will be answered in a timely manner, staff encouraged to take meals and breaks according to policy, facility continues to admit and provide the highest practicable physical, mental and psychosocial well-being for all residents, staff development nurse duties completed by nursing leadership, nursing staff continues to monitor resident #51 behaviors and intervene as necessary, and nursing staff continues to monitor resident #38 behaviors and intervene as necessary.

Staff education provided on call bell response, communication between caregivers and residents, and policy on breaks and meals.

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F 725	Continued From page 7 Review of the LNA assignments for the entire building, average 9 residents each on the day and evening shifts, with the census being 74, if the staffing pattern is met. Of those 74 residents, 20 require the assistance of 2 to transfer the resident from one location to another using a mechanical lift, 8 residents require 2 assistants for transfer from one location to another, and 19 require the assistance of 1. 52 of the 74 residents require incontinent care and/or assistance with toileting. 17 of the 74 residents require 2 assistants for bathing and dressing. 2. Per interview with family members during the 3 day survey, concerns were voiced related to untimely call light answering, lack of facility staff for the management of personal care, resident preferences not being followed, lack of communication between care givers and residents, as well as lack of care plan follow through. One family reported that their relative had to wait for staff to "find the mechanical lift" to assist him/her to get out of bed. This family further reported that when it takes 2 staff to help with lifting residents in and out of bed, staff are not readily available to answer call lights in a timely fashion. During resident interviews, on 2/6/18, one resident, who wishes to be anonymous, stated that staffing was not always sufficient and reported that on several occasions a delay in answering the call light, sometimes 30-45 minutes, had resulted in episodes of incontinence. 3. During the 3 days of survey, facility staff voiced concerns related to rushing through care,	F 725	**How will the facility monitor its corrective actions to ensure that the deficient practice will not occur?** Nursing staffing, admissions and resident safety discussed daily at morning meeting and end of day meeting with staff. Random audits by the Administrator, DNS or designee on call bell response times and caregiver-resident communication weekly X4 weeks then monthly X2 months or until substantial compliance is achieved. The results of the audits will be reported to the monthly QAA Committee for a minimum of three months at which time the QAA Committee will determine the continued duration of the audits. Corrective action will be completed by March 5, 2018. F725 POC accepted 3/7/18 JHosmer RN/PNA	

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providing showers/baths in the afternoon hours, being left with only 2 LNA's on a unit between the hours of 9-11 PM, and often times their inability to have an evening meal or break. An LNA also reported during interview on 2/06/2018, that s/he was asked to interrupt personal care with which s/he was assisting a resident, in order go to another unit to take a resident outside.

4. The facility in the past 2 weeks has discharged 13 residents from the facility, but they have also admitted 12 new residents to the home, despite the staffing challenges.

5. Per interview with the Administrator on 2/7/18 at 11:15 AM, the facility is currently employing 70 % agency contracted nurses. Per interview with the Administrator, the Director of Nurses and the Regional Director of Clinical Services on 2/7/18 at approximately 1:30 PM, confirmation is made that the facility currently does not have a Staff Development Nurse. H/She is responsible for staff education, orientation and review of competencies. The Administrator confirms at this time that they will not be replacing that position, but rather sharing the responsibilities among the DNS, ADNS and Clinical Nurse Manager.

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6. During observations on wing 2 on 2/6/18, at 8:31 AM Resident #51 walked from his/her room to the unit kitchenette and took 5 ice cream cups back to his/her room. No LNA or auxiliary staff were in the area of the nurses' station, the kitchenette, the nearby sunroom, or the two halls, so the surveyor interrupted a nurse during medication administration to advise him/her of the situation. The nurse came away from medication administration duties to engage with Resident #51 regarding the 5 cups of ice cream.

7. During observations on wing 2 on 2/6/18, Resident #38 was returned from breakfast to the area of the nurses' station by a Licensed Nurse Assistant (LNA). Both nurses and all three LNAs were then engaged in medication administration or direct care while Resident #38 and Resident #50 were near the nurses' station. Resident #38, per the care plan, has behaviors of wandering, intrusion, and inappropriateness toward females. At 9:13 AM Resident #38 tried to bump the wheelchair of Resident #50 and was intercepted by the nurse who was on the way to the medication cart. Once left alone, Resident #38 proceeded to and intruded into the room of Resident #19 [who was still in bed]. The nurse came away from the medication cart and redirected Resident
#38 back to the nurses' station, then returned to duties. At 9:20 AM Resident #38 again proceeded to and intruded into the room of Resident #19; the nurse again came away from medication duties to redirect, then returned to duties. At 9:48 AM Resident #38 tried to bump the wheelchair of Resident #50 again, and was redirected by the social worker who had just

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(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
F 725	Continued From page 10 come to the nurses' station on a survey-related task. Activity staff then removed Resident #38 to a 10:00 AM activity. It was confirmed with the clinical supervisor that there had not been an activity from 9-10 AM on the unit, that there were 3 nurse aids on duty instead of 4 for the 2 halls of both wings, and that the clinical supervisor was on duty this shift as the medication nurse.	F 725		

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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

AH
"A" FORM

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER # 475037	MULTIPLE CONSTRUCTION A. BUILDING: ______ B. WING ______	DATE SURVEY COMPLETE: 2/7/2018
NAME OF PROVIDER OR SUPPLIER **BARRE GARDENS NURSING AND REHAB LLC**	STREET ADDRESS, CITY, STATE, ZIP CODE **378 PROSPECT STREET BARRE, VT**		

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 661	Discharge Summary CFR(s): 483.21(c)(2)(i)-(iv) §483.21(c)(2) Discharge Summary When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following: (i) A recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results. (ii) A final summary of the resident's status to include items in paragraph (b)(1) of §483.20, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or resident's representative. (iii) Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over-the-counter). (iv) A post-discharge plan of care that is developed with the participation of the resident and, with the resident's consent, the resident representative(s), which will assist the resident to adjust to his or her new living environment. The post-discharge plan of care must indicate where the individual plans to reside, any arrangements that have been made for the resident's follow up care and any post-discharge medical and non-medical services. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility failed to include a recapitulation of stay for 1 of 2 closed records in the sample (Resident #74); the recapitulation of stay is required to include a final summary of the resident's status and course of treatment during a stay at the facility. Findings include: Resident #74 was admitted to the facility on 10/19/17 for a short term stay for therapy. On 11/7/17, after meeting all goals, the resident was discharged home. There was no evidence during the medical record review on 2/7/18 of a summary of the resident's course of treatment during his/her stay at the facility. The Director of Nursing (DNS) confirmed on 2/7/18 @11:19 AM, that there is no discharge summary for this resident.

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is

The above isolated deficiencies pose no actual harm to the residents

031099

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F661

How will the corrective action be accomplished for those residents found to have been affected by the deficient practice?

Resident #74 no longer resides at the facility.

How will the facility identify other residents having the potential to be affected by the same deficient practice?

Residents who will be discharged from the facility have the potential to be affected by the alleged deficient practice.

What measures will be put in place to ensure that the deficient practice will not occur?

Staff education on policy regarding IDT discharge summary.

How will the facility monitor its corrective actions to ensure that the deficient practice will not occur?

Random audits by Administrator, DNS or designee to ensure residents being discharged from the facility have a discharge summary that includes a recapitulation of the resident's stay weekly X4 weeks then monthly X2 months or until substantial compliance is achieved.

The results of the audits will be reported to the monthly QAA Committee for a minimum of three months at which time the QAA Committee will determine the continued duration of the audits.

Corrective action will be completed by March 5, 2018.