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

February 8, 2019

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

Dear Mr. Hallisey:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **January 9, 2019**. 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 _____	01/09/2019

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 DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments During an unannounced, on-site recertification survey, which was conducted by the Division of Licensing and Protection between 1/7-9/2018, the facility was found to be in substantial compliance with the emergency preparedness planning process.	E 000		
F 000	INITIAL COMMENTS An unannounced, on site recertification survey was conducted by the Division of Licensing and Protection between 01/07-09/2019. The following regulatory findings were identified:	F 000		
F 584 SS=E	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. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.	F 584	#1 All bathroom exhaust vents have been cleaned #2 Contaminated linens laundered and laundry aide educated #3 Wash machine filter emptied and cleaned. Clean laundry area cleaned/disinfected and laundry aide educated #4 Resident #80 oxygen tubing changed and concentrator filter cleaned #5 Resident #80 nebulizer mouthpiece/ tubing changed and bagged #6 Electrical outlet for resident #16 repaired #7 Resident #16 mattress replaced	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Shawn T. Hallisey | TITLE: Administrator | (X6) DATE: 2.6.19

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 584	Continued From page 1 §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 staff interview, the facility failed to ensure a clean, comfortable, and homelike environment. Findings include: 1. Per observation on initial tour of the facility on 1/7/19, the exhaust vents in many resident bathrooms were covered with a layer of dust/dirt. This observation was made by multiple surveyors on all units. Per interview on 1/9/19 at 2:45 PM, the Maintenance Director confirmed that the vents were taken apart and cleaned in July 2018, however the outer blades of the vent were now very dusty in many of the rooms and housekeeping had overlooked dusting them as part of the bathroom cleaning routine. 2. Per observation on 1/9/19 at 9:35 AM, a laundry service aide, while putting clean linen away, dropped a clean bed sheet on the floor. With a hand full of other sheets s/he scooped it	F 584	Residents have the potential to be affected by the alleged deficient practice. These residents will have their bathroom vents and washing machines filters cleaned, soiled linen handled appropriately, resp. equipment changed and cleaned per policy. #1 Housewide audit of bathroom exhaust vents completed to ensure are clean. Housekeeping staff will be in-serviced on bathroom exhaust vent routine cleaning schedule #2 Laundry staff in-serviced on handling soiled linen appropriately and in the correct areas #3 All washing machines audited to ensure filters are clean. Laundry staff in-serviced on cleaning washing machine filters #4 and #5 Housewide audit of all Respiratory Equipment completed to ensure changed, cleaned and maintenance provided. Licensed staff in-serviced on respiratory policies "Cleaning of Equipment" and Concentrator Maintenance" #6 Housewide audit of all electrical outlets completed to ensure no outlets exposed. All staff in-serviced on notifying maintenance when electrical outlets are exposed	

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F 584	Continued From page 2 up, contaminating the other sheets and placed them in the clean linen cart. At that time, s/he confirmed that the sheet was dirty and should not have been placed in the cart with clean linen. Per interview with the Laundry Service Director on 1/9/2019 at 10:10 AM, s/he also confirmed that the dropped sheet should not have been placed in the clean linen cart, and that the entire cart was now contaminated. 3. Per observation of the laundry area on 1/9/2019 at 9:45 AM, the two washing machine filters were filled with lint and other debris. There was a sign under the filter reading clean filter daily. Per interview with the laundry service aide at that time, s/he confirmed they should be cleaned daily, but s/he only cleans them once or twice a week. The laundry service aide also explained that after the dirty laundry is collected, it is brought down, and sorted in the clean laundry area. Per interview with the Laundry Service Director on 1/9/2019 at 10:10 AM, s/he confirmed that dirty laundry should be sorted in the dirty laundry room, not in the clean laundry area. 4. Per observation on 1/7/19 at 10:42 AM, Resident #80 was actively using oxygen therapy through an oxygen concentrator present in the room. The oxygen tubing was not labeled to indicate the last time it had been changed. The filter on the concentrator was dusty and the resident reported that he had asked the "cleaning lady" to rinse it out yesterday, s/he reported it was much worse previous to that. The Unit Nurse Manager confirmed this observation. 5. Per observation on 1/7/19 at 10:42 AM, Resident #80 had a mouthpiece and tubing	F 584	#7 Housewide audit completed of all resident mattresses to ensure they are not bottoming out needing replacement. Nursing Staff in-serviced on identifying when mattress should be reported to maintenance for replacement. #1 Random audits will be conducted by the administrator or designee of bathroom exhaust vents for cleanliness weekly for 4 weeks then monthly x2 months or until substantial compliance has been achieved. #2 Random audit will be conducted by the administrator or designee to ensure the staff handle soiled linen appropriately weekly for 4 weeks then monthly x2 months or until substantial compliance has been achieved. #3 Random audits will be conducted by the administrator or designee to ensure washing machine filters are clean weekly for 4 weeks then monthly x2 months or until substantial compliance has been achieved.	

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F 584 Continued From page 3

connected to a nebulizer machine sitting on the bedside table. The mouthpiece was not placed in a bag and was simply hanging several inches off the floor and near a male portable urinal that contained urine. The tubing was not labeled to indicate the last time it had been changed. The Unit Nurse Manager confirmed this observation.

6. Per observation on 01/08/19 at 11:35 AM, an exposed electrical outlet was noted at the head of Resident #16's bed. Per interview with the Maintenance Director on 1/8/19, s/he confirmed that the electrical outlet was exposed and that s/he had not been aware of the damaged outlet.

7. Per observation on 1/8/2019 at approximately 4:00 PM, while Resident #16 was out of bed, the mattress was noted to have a large round sunken area in the middle. When the surveyor placed their hands on the underside and the top, their fingers could be felt indicating that the mattress had bottomed out. At that time, the Director of Nurses confirmed that the mattress had bottomed out and that she was not aware of the issue.

See also F0880

F 585 Grievances
SS=B CFR(s): 483.10(j)(1)-(4)

§483.10(j) Grievances.
§483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other

F 584 #4 and #5 Random audits will be conducted by the DON/designee of residents utilizing Oxygen, Nebulizers, and/or concentrators to ensure the equipment has been maintained, changed and cleaned per policy for 4 weeks then monthly x2 months or until substantial compliance has been achieved.

#6 Random audits will be conducted by the administrator or designee on electrical outlets to ensure they are not exposed weekly for 4 weeks then monthly x2 months or until substantial compliance has been achieved.

#7 Random audits will be conducted by the DON or designee on resident mattresses to ensure they are not bottoming out weekly for 4 weeks then monthly x2 months or until substantial compliance has been achieved.

F-584 POC accepted 2/7/19 G.Coleman RN/S.Levy RN

F 585 Results to be reported to the QAPI committee for further recommendations as necessary. The Administrator will oversee this POC. Date of Compliance: 2/20/2019

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F 585	Continued From page 4 residents, and other concerns regarding their LTC facility stay. §483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph. §483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident. §483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include: (i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system; (ii) Identifying a Grievance Official who is responsible for overseeing the grievance process,	F 585	The Grievance policy and postings have been updated Residents needing to file a grievance have the potential to be affected by this alleged deficient practice. These residents will have the Grievance information available to them. The Grievance policy has been updated. The grievance official is identified and their contact information has been updated and added to the postings and they have been placed throughout the facility. All staff to be educated on the Grievance policy. Random audits will be conducted by the administrator or designee to ensure the grievance policy is posted and identifies the grievance official and their contact information weekly for 4 weeks then monthly x2 months or until substantial compliance has been achieved. Results to be reported to the QAPI committee for further recommendations as necessary. The Administrator will oversee this POC. Date of Compliance: 2/20/2019 F585 POC accepted 2/7/19 G. Coleman RN / S. Reilly RN	

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F 585	Continued From page 5	F 585		

receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations;
(iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated;
(iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law;
(v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued;
(vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and

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F 585	Continued From page 6 (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review the facility failed to establish a grievance policy that identified the grievance official and provided the grievance official's contact information for all residents. Findings include: Per review of the facility grievance policy, it read, "The facility will make information on how to file a grievance or complaint available to the resident by notifying the resident individually or with prominent postings throughout the facility to include: The required contact information of the grievance official: Name, Business Phone and address (mailings and email)." Per observation on 1/8/19, throughout the facility, the residents' rights postings did not delineate who the grievance official was and/or how to contact him/her. Per interview on 1/8/19 at 3:49 PM with the Vice President of Clinical Services, s/he confirmed that the grievance policy did not identify who the grievance official was and did not provide their contact information.	F 585		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(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	F 609		

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F 609	Continued From page 7 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 report a resident to resident altercation which resulted in physical contact (potential abuse) for 2 applicable residents (Resident #25 and Resident #75). Findings include: Per record review on 11/5/18 at approximately 4:00 PM, Resident #25 was in the dining room and s/he was slapped on the left side of the face by Resident #75. The residents were separated and Resident #25 was assessed by staff. Upon assessment, Resident #25 did not to have any noted adverse effects from the interaction. The Unit Manager, Director of Nursing, Social Worker, Physician, and family were all notified. There was	F 609	The altercation between resident #25 and #75 has been reported to the appropriate state agencies Residents involved in resident to resident altercations have the potential to be affected by this alleged deficient practice. These residents will have these altercations reported. DNS and Administrator in-serviced on regulatory guidelines for reporting resident to resident altercations to the appropriate state agencies. DNS or designee will monitor progress notes for documentation of resident to resident altercations and conduct random audits to ensure they have been reported to the appropriate state agencies weekly for 4 weeks then monthly x2 months or until substantial compliance has been achieved. Results to be reported to the QAPI committee for further recommendations as necessary. The Administrator will oversee this POC. Date of Compliance: 2/20/2019 F-609 POC accepted 2/7/19 G. Coleman RN | S. Lemyre	

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F 609	Continued From page 8 no evidence that this incident was reported to the appropriate State Agencies. Per interview on 1/9/19 at 3:45 PM with the Administrator, s/he confirmed that the incident was not reported to the appropriate State Agencies.	F 609		
F 610 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: §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 interview and record review the facility failed to thoroughly investigate a resident to resident altercation, send a summary of the investigation to the State Survey Agency, and take appropriate corrective action for 2 applicable residents (Resident #25 and Resident #75). Findings include: Per record review on 11/5/18 at approximately 4:00 PM, Resident #25 was in the dining room	F 610	The resident to resident altercation between residents #75 and #25 has been thoroughly investigated, a summary sent to the state survey agency, and corrective actions implemented. Residents involved in resident to resident altercations have potential to be affected by this alleged deficient practice. These residents will have a thorough investigation completed, a summary submitted and corrective actions implemented. DNS and Administrator in-serviced on regulatory guidelines for ensuring completion of a thorough investigation, sending a summary to the state survey agency, and taking appropriate corrective action.	

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F 610	Continued From page 9 and s/he was slapped on the left side of the face by Resident #75. The residents were separated and Resident #25 was assessed by staff. Upon assessment, Resident #25 did not to have any noted adverse effects from the interaction. The Unit Manager, Director of Nursing, Social Worker, Physician, and family were all notified. For Resident #75, there was no notation in the medical record that s/he was involved in the altercation and/or was the aggressor. Upon further record review, there was no evidence that the altercation was thoroughly investigated, a summary of the investigation was sent to the State Survey Agency,or that appropriate corrective action was taken to prevent further potential abuse. Per interview on 1/9/19 at 3:45 PM with the Administrator, s/he confirmed that the incident was not reported to the appropriate State Agencies and as a result, the incident was not investigated thoroughly, that a summary of the investigation was not sent to the State Survey Agency, and a corrective action plan was not put into place to prevent further potential abuse. S/he stated that there was no harm to either of the residents, that neither resident remembered the incident, or that they were afraid of each other.	F 610	DNS or Administrator will randomly audit resident to resident altercation incidents to ensure a thorough investigation is completed, a summary sent to the state survey agency, and corrective actions were implemented weekly for 4 weeks then monthly x2 months or until substantial compliance has been achieved. Results to be reported to the QAPI committee for further recommendations as necessary. The Administrator will oversee this POC. Date of Compliance: 2/20/2019 F-610 POC accepted 2/7/19 G. Coleman RN / S. Remy, RN	
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to--	F 657		

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F 657	Continued From page 10 (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based observation, interview, and record review the facility failed to update care plans for 2 of 20 residents in the applicable sample (Resident #5 and Resident #50). Findings include: 1. Per record review, Resident #5's care plan dated, 8/2/18, read, "Bed Mobility: requires 2 staff participation to reposition and turn in bed. Bilateral U-bars to help assist with bed mobility". Per observation of Resident #5's room on 1/8/19 at 4:19 PM, there were no bed rails and/or U-bars noted on his/her bed. Per interview on 1/9/19 at 12:38 PM with the MDS Coordinator, s/he confirmed that the resident did not have bed rails and/or U-bars on his/her bed and that the resident's care plan had not been updated.	F 657	Residents #5 and #50 have had their care plans updated. Residents with UBars and healed pressure ulcers have the potential to be affected by this alleged deficient practice. These residents will have their care plans updated Housewide audit conducted of residents with care plans for Ubars and healed pressure ulcers to ensure their care plans reflect their current care needs. Licensed staff will be in-serviced on ensuring care plans are updated for residents with Ubars and healed pressure ulcers to reflect their current care needs Random audits of care plans for residents with Ubars and healed pressure ulcers will be conducted by the DNS or designee to ensure the care plans reflect their current care needs weekly for 4 weeks then monthly x2 months or until substantial compliance has been achieved Results to be reported to the QAPI committee for further recommendations as necessary. The Administrator will oversee this POC. Date of Compliance: 2/20/2019 F-657 POC accepted 2/7/19 G. Coleman RN / S. Reny, RN	

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F 657	Continued From page 11 2. Per record review. Resident #50's care plan dated, 8/30/18, read, "Actual skin integrity impairment r/t (related to): immobility resulting in unstageable pressure ulcer to left heel." Per review of the multidisciplinary care conference notes from 12/4/18, the resident's "skin" is" intact". Per interview on 1/9/19 at 2:53 PM with the Director of Nursing, s/he confirmed that the resident did not have a pressure ulcer on his/her left heel at this time and that the resident's care plan had not been updated.	F 657		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to provide adequate supervision for 2 of 20 sampled residents, (Residents #32 & #63) Findings include: Per observation on 1/7/19 at 12:18 PM, Resident #32 was pacing around their room while yelling at their roommate, Resident #63. Resident #32 yelled "I don't want you here! I hate you, get out!" Resident #63 was asking Resident #32 why s/he did not want her/him there and Resident #32 repeated "I don't want you here! Get out!" At this time, an Occupational Therapist (OT) was walking by and entered the room. S/he asked	F 689	Residents #32 &#63 have had an incident report completed. The OT and GA have been reeducated. Residents involved in a verbal altercation have the potential to be affected by this alleged deficient practice. These residents will have these incidents reported and an investigation conducted per policy ensuring adequate supervision. A housewide audit has been completed to ensure residents involved in resident altercations have these incidents reported and an investigation conducted. Facility staff will be inserviced on the Abuse policy specific to reporting requirements.	

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F 689	Continued From page 12 Resident #32 what was wrong and Resident #32 stated "I don't want her in here, it's my room!" The OT asked Resident #32 if it would help if she closed the curtain between the two and s/he said yes. The OT then left the room. Per interview with the OT s/he confirmed that s/he had heard Resident #32 yelling at their room mate and that s/he was going to inform the nurse of the incident. On 1/7/19 at 12:25 Resident #32 was standing by Resident #63 yelling "Shut up! I don't want you here!" A Geri-Aide (GA) entered the Resident's room and asked what was wrong. Resident #32 stated I don't want this woman here! The GA stated "s/he is your room mate, s/he belongs here", Resident #32 repeated that she did not want her there and that s/he was not her roommate. The GA stated " okay, I'll go tell your nurse then." Per interview with the Unit Charge Nurse on 1/7/2018 at approximately 12:40 PM, s/he confirmed that s/he had not been notified of the incident involving the two residents by either the OT or GA.	F 689	The DNS/designee will conduct random audits of residents involved in verbal altercations to ensure these incidents have been reported and an investigation conducted weekly for 4 weeks then monthly x2 months or until substantial compliance has been achieved. Results to be reported to the QAPI committee for further recommendations as necessary. The Administrator will oversee this POC. Date of Compliance: 2/20/2019 F-689 POC accepted 2/7/19 G. Coleman RN/S. Runyi, RN	
F 756 SS=D	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the	F 756		

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F 756	Continued From page 13	F 756	Resident #61's Haldol has been discontinued Resident #16's Ativan has been discontinued Residents with PRN psychotropic medication have the potential to be affected by this alleged deficient practice. These residents will have drug irregularities reported by the pharmacist. A housewide audit of residents with md orders for prn psychotropic medications has been completed to ensure drug irregularities have been reported by the pharmacist. The consultant pharmacist has been educated on guidelines for reviewing and reporting PRN psychotropic medication irregularities. DNS or designee will randomly audit orders for PRN psychotropic medications to ensure drug irregularities have been reported by the pharmacist weekly for 4 weeks then monthly x2 months or until substantial compliance has been achieved. Results to be reported to the QAPI committee for further recommendations as necessary. The Administrator will oversee this POC. Date of Compliance: 2/20/2019 F-756 POC accepted 2/7/19 G. Coleman RN / S. Reny, RN	

facility's medical director and director of nursing, and these reports must be acted upon.
(i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug.
(ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified.
(iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record.

§483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident.
This REQUIREMENT is not met as evidenced by:
Based on interview and record review the facility pharmacist failed to report drug irregularities to the attending physician, medical director, and/or director of nursing for 2 of 7 residents in the applicable sample (Resident #16 and Resident #61). Findings include:

1. Per record review, a physician's order for Resident #61 dated, 4/6/18, read, "Haloperidol (antipsychotic medication) 2 milligram

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F 756	Continued From page 14 (mg)/milliliter (ml) concentrate-15 ml bottle-take 0.5 ml (1mg) by mouth every 6 hours as needed for agitation or hallucinations". The pharmacist reviewed Resident #61's medication regimen on, 4/19/18, 5/18/18, 6/18/18, 7/16/18, 8/17/18, 9/18/18, 10/15/18, 11/9/18, 12/7/18, and 1/7/19. There was no evidence that the pharmacist reported that the Haloperidol order was outdated; and should have been renewed 14 days from the order date. Per interview on 1/9/19 at 6:12 PM with the Director of Nursing, s/he confirmed that there were no irregularities noted from the pharmacist for the Haloperidol and that the physician's order was not written for the appropriate time frame. 2. Per record review, a physician's order for Resident #16 dated, 11/10/18, read, Lorazepam 0.5 mg by mouth every 4 hours as needed for anxiety/agitation for 6 months. As needed orders for Lorazepam should be limited to 14 days. The pharmacist reviewed resident #16's medication regime on 1/7/2019. This irregularity was not documented as part of the pharmacist medication regimen review. Per interview on 1/9/2018, at approximately 4:00 PM, the Unit Manager confirmed that the pharmacist failed to document and report that the Lorazepam order was not written for the appropriate time frame.	F 756		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following	F 758		

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F 758 Continued From page 15

categories:
(i) Anti-psychotic;
(ii) Anti-depressant;
(iii) Anti-anxiety; and
(iv) Hypnotic

Based on a comprehensive assessment of a resident, the facility must ensure that---

§483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record;

§483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs;

§483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and

§483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order.

§483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be

F 758

Resident #61's Haldol has been discontinued
Resident #16's Ativan has been discontinued

Residents with PRN psychotropic medication orders have the potential to be affected by this alleged deficient practice. These residents will have their medication orders limited to 14 days or the MD will document additional rationale to support exceeding that timeframe.

A housewide audit of residents with md orders for prn psychotropic medications has been completed to ensure they reflect a 14 day limit or the MD has documented additional rationale to support exceeding that timeframe. Medical Director, MD, NP, Licensed staff will be educated on the guidelines for PRN psychotropic medication orders and the documentation requirements to reflect a 14 day limit or the MD will document additional rationale to support exceeding that timeframe.

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F 758	Continued From page 16 renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to to ensure that residents' drug regimens were free from unnecessary psychotropic drug use for 2 of 7 residents in the applicable sample (Resident #16, and Resident #61). Findings include: 1. Per record review, a physician's order for Resident #61 dated, 4/6/18, read, "Haloperidol (antipsychotic medication) 2 milligram (mg)/milliliter (ml) concentrate-15 ml bottle-take 0.5 ml (1mg) by mouth every 6 hours as needed for agitation or hallucinations". There was no evidence that the 'as needed' order for the Haloperidol was limited to 14 days as per regulation. Per interview on 1/9/19 at 6:12 PM with the Director of Nursing, s/he confirmed that the order for the as needed Haloperidol was out of date and had not been renewed by Resident #61's physician. 2. Per record review, a physician's order for Resident #16 dated, 11/10/18, read, Lorazepam (a psychoactive medication) 0.5 mg by mouth every 4 hours as needed for anxiety/agitation for 6 months. 'As needed' orders for psychotropic drugs are limited to 14 days unless the physician documents the rational in the medical record. Per interview on 1/9/2018, the Director of Nursing confirmed that the order for the 'as needed' Lorazepam was not written for the appropriate time frame, and that the physician did not	F 758	DNS or designee will randomly audit orders for PRN psychotropic medications to ensure they reflect a 14 day limit or the MD has documented additional rationale to support exceeding that timeframe weekly for 4 weeks then monthly x2 months or until substantial compliance has been achieved. Results to be reported to the QAPI committee for further recommendations as necessary. The Administrator will oversee this POC. Date of Compliance: 2/20/2019 F758 POC accepted 2/7/19 G. Coleman RN / S. Lucy RN	

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F 758	Continued From page 17 document a rational to exceed the 14 day prescribing requirements.	F 758		
F 880 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, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) 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;	F 880	#1 and #2- Resident's #22 & Resident #46 have had their nebulizers discontinued. #3 Resident #39 no longer resides in the facility #4 Resident #59 oxygen tubing and humidifier bottle replaced and concentrator filter cleaned per policy #5 Resident #30 and resident #27 have had their concentrator filters replaced per policy #6 Contaminated linens laundered and the laundry aide was reeducated #7 Wash machine filter emptied and cleaned, clean laundry area cleaned and disinfected #8 and #9- Resident #80 has had their oxygen and nebulizer tubing and mouthpiece replaced and/or bagged per policy, and the concentrator filter replaced #10 Resident #284 no longer resides at the facility Residents utilizing respiratory equipment and/or linen and/or require clean dressing changes have the potential to be affected by this alleged deficient practice. These residents will have the proper infection control practices followed.	

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F 880	Continued From page 18 (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. 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 observations, record review, and staff interview, the facility failed to ensure that they had an infection control program to maintain a safe, sanitary, and comfortable environment regarding handling of linens and respiratory equipment for 7 of 20 residents (Residents #22, #27, #30, #39, #46, #59, and #80). Further the facility failed to	F 880	Housewide audit of all Respiratory Equipment completed to ensure changed, cleaned and maintenance provided. Licensed staff in-serviced on respiratory policies "Cleaning of Equipment" and Concentrator Maintenance". Laundry staff in-service on handling soiled linen appropriately. All washing machines audited to ensure filters are clean. Laundry staff in-serviced on cleaning washing machine filters Licensed staff will be educated on the "Clean dressing change" policy Facility staff will be educated on Hand hygiene Random audits will be conducted by the DON/designee of residents utilizing Oxygen, Nebulizers, CPAP, and/or concentrators to ensure the equipment has been maintained, changed and cleaned per policy for 4 weeks then monthly x2 months or until substantial compliance has been achieved.	

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ensure proper infection control processes were followed for 1 applicable resident (Resident #284) during a dressing change. Findings include:

1. Per observation on 1/7/19, Resident #22 had a mask and tubing for a nebulizer sitting uncovered on the bedside table, which was also unlabeled as to the date it was replaced last. Per interview, the resident stated that they had not used the nebulizer in "quite awhile, back when I was ill".

2. Per observation on 1/7/19, Resident #46 had a nebulizer mask and tubing on the bedside table that was unlabeled with the date put in use and uncovered. Per interview with the resident and the significant other in the room, Resident #46 had not used the nebulizer since the last time they had a respiratory illness at least a month ago.

3 Per observation on 1/7/19, Resident #39 had a CPAP (Continuous Positive Air Pressure) machine and mask uncovered on the bedside table. Per documentation, the resident had refused to wear the CPAP mask, and it was not currently in use due to the refusals. The resident's plan of care stated that the mask should be cleaned and put away after use.

4. Per observation on 1/7/19, Resident #59 was actively using oxygen therapy through a portable tank during the day, and sometimes through an oxygen concentrator present in the room.. The oxygen tubing on the portable tank did not have a label to indicate the last time it was changed. The humidifier bottle on the oxygen concentrator was also not labeled as to when it was last changed. Per inspection of the filter on the concentrator, it was very dirty and dusty. Per interview on 1/7/19

F 880 Random audits will be conducted by the administrator or designee to ensure the staff handle soiled linen appropriately weekly for 4 weeks then monthly x2 months or until substantial compliance has been achieved.

Random audits will be conducted by the administrator or designee to ensure washing machine filters are clean weekly for 4 weeks then monthly x2 months or until substantial compliance has been achieved.

Random audits will be conducted by the DON or designee to ensure residents with clean dressing change treatments have infection control practices followed related to hand hygiene, glove changes, and removal of soiled linen weekly for 4 weeks then monthly x2 months or until substantial compliance has been achieved.

Results to be reported to the QAPI committee for further recommendations as necessary. The Administrator will oversee this POC.
Date of Compliance: 2/20/2019

F_880 POC accepted 2/7/19
G. Coleman RN / S. Rumpler

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F 880	Continued From page 20	F 880		

at 12:05 PM, the Director of Nursing observed the uncovered masks and concentrator filter and confirmed that they were unlabeled, uncovered, and in the case of the filter, very dirty. The DNS also confirmed that the three residents had not used the nebulizer equipment in the recent past, and that they should have been discarded.

5. Per observation on 1/8/19 at 9:37 AM, the filters on the oxygen concentrators for Resident #30 and Resident #27 contained caked black matter. Per interview with a staff nurse at that time, s/he confirmed that the filters were dirty and did not know whose responsibility it was to clean them.

6. Per observation on 1/9/19 at 9:35 AM, a laundry service aide, while putting clean linen away, dropped a clean bed sheet on the floor. With a hand full of other sheets s/he scooped it up, contaminating the other sheets and placed them in the clean linen cart. At that time, s/he confirmed that the sheet was dirty and should not have been placed in the cart with clean linen. Per interview with the Laundry Service Director on 1/9/2019 at 10:10 AM, s/he also confirmed that the dropped sheet should not have been placed in the clean linen cart, and that the entire cart was now contaminated.

7. Per observation of the laundry area on 1/9/2019 at 9:45 AM, the two washing machine filters were filled with lint and other debris. There was a sign under the filter reading clean filter daily. Per interview with the laundry service aide at that time, s/he confirmed they should be cleaned daily, but s/he only cleans them once or twice a week. The laundry service aide also explained that after the dirty laundry is collected,

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 _____	01/09/2019

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 DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 21	F 880		

it is brought down, and sorted in the clean laundry area. Per interview with the Laundry Service Director on 1/9/2019 at 10:10 AM, s/he confirmed that dirty laundry should be sorted in the dirty laundry room, not in the clean laundry area.

8. Per observation on 1/7/19 at 10:42 AM, Resident #80 was actively using oxygen therapy through an oxygen concentrator present in the room. The oxygen tubing was not labeled to indicate the last time it had been changed. The filter on the concentrator was dusty and the resident reported that he had asked the "cleaning lady" to rinse it out yesterday, s/he reported it was much worse previous to that. The Unit Nurse Manager confirmed this observation.

9. Per observation on 1/7/19 at 10:42 AM, Resident #80 had a mouthpiece and tubing connected to a nebulizer machine sitting on the bedside table. The mouthpiece was not placed in a bag and was simply hanging several inches off the floor and near a male portable urinal that contained urine. The tubing was not labeled to indicate the last time it had been changed. The Unit Nurse Manager confirmed this observation.

10. Per observation on 1/7/19 at 3:47 PM, the Registered Nurse (RN) entered Resident #284's room to perform a bilateral clean dressing change to the resident's feet. The RN took a blanket that was lying on the end of the bed and placed it under the resident's feet. The RN removed a dressing from the resident's left foot and squeezed a bottle of normal saline into the wound to clean it. The normal saline dripped from the left foot onto the blanket. Per further observation, the RN then proceeded to remove the dressing

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 _____	01/09/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BARRE GARDENS NURSING AND REHAB LLC	378 PROSPECT STREET BARRE, VT 05641

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F 880	Continued From page 22	F 880		

on the resident's right foot and cleansed the area with a vial of normal saline. The normal saline dripped from the foot onto the blanket. The RN removed his/her gloves, gathered his/her supplies, and left the room. The RN did not wash or sanitize his/her hands after the removal of the gloves. The RN wore only 1 pair of gloves through the entire process. S/he also left the wet blanket on the end of the resident's bed and only retrieved it after questioning.

During interview, the RN confirmed a breach of the infection control process. S/he further confirmed that proper hand hygiene had not been followed, glove changes had not taken place properly, and removal of the soiled items from the room had not been done until prompted to do so.

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 1/9/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BARRE GARDENS NURSING AND REHAB LLC	378 PROSPECT STREET BARRE, VT

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 641	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to accurately assess and reflect the status for 1 of 20 applicable residents in the sample (Resident #5). Findings include: Per review the Minimum Data Sheet (MDS) from 10/15/18, for Resident #5, it indicated that restraints were being used and that these restraints were bed rails. Per observation during the days of survey, there were no bed rails noted on Resident #5's bed. Per interview on 1/9/19 at 12:38 PM with the MDS Coordinator, s/he stated that the MDS was coded incorrectly; Resident #5 did not have bed rails on his/her bed and that bed rails should not be coded as restraints. F641 No POC 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 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

The above isolated deficiencies pose no actual harm to the residents