

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

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 01/25/2019 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	<u>O</u>	MB NO. 0938-039* (xs) DATE SURVEY COMPLETED
		475037	D. WING	بحجبحت			01/09/2019
. NAME OF	PROVIDER OR SUPPLIER		1	STF	REET ADDRESS, CITY, STATE, ZIP	CODE	1 01/00/2010
DACOF	GÁRDENO MUROMA	ALID OPILINGS		378	PROSPECT STREET		
BAKKE	GARDENS NURSING	ANU REHABILLG	- 1	BA	RRE, VT 05641		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	iD		PROVIDER'S PLAN OF CO	épcémou	
PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING IMPORMATION)	PREFI TAG	K,	(BACH CORRECTIVE ACTION OROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD	BE COMPLETION
E 000	Initial Comments		E 0	00			
±	survey, which was on Licensing and Prote facility was found to	inced, on-site recertification conducted by the Division of action between 1/7-9/2018, the be in substantial compliance preparedness planning					
F 000		S	F0	00		. "	
F 584	was conducted by the Protection between regulatory findings was safe/Clean/Comfort CFR(s): 483.10(i)(1). \$483.10(i) Safe Environmentable and how the protection of the facility must prospect for daily live. The facility must prospect for the protection of the or theft.	able/Homelike Environment H(7) ironment ight to a safe, clean, melike environment, including veiving treatment and ing safely. vide- , clean, comfortable, and nt, allowing the resident to nat belongings to the extent uring that the resident can vices safely and that the e facility maximizes resident oes not pose a safely risk, exercise reasonable care for resident's property from loss	F 51	34	#1 All bathroom exhaucleaned #2 Contaminated liner laundry aide educated #3 Wash machine filte cleaned. Clean laundry area cle laundry aide educated #4 Resident #80 oxyge concentrator filter clea #5 Resident #80 nebuli tubing changed and ba #6 Electrical outlet for #7 Resident #16 mattre	ns laund er empt aned/d n tubin aned izer mon igged resider	dered and ied and isinfected and g changed and outhpiece/ nt #16 repaired
الاسلام	§483.10(i)(2) House services necessary l and comfortable inte	keeping and maintenance o maintain a sanitary, orderly, rlor _{y A. A.}					4
ABORATOR	DIRECTOR'S OR PROVIDE	HISUPPLIER PEPRESENTATIVES SIGNA	TURE		TITLE,		(X5) DATÉ

Any deficiency statement ending with an exterisk (*) 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.

DEPARTMENT OF HEALTH AND HUMAN SERVICES.

PRINTED: 01/25/2019

CENTER	RS FOR MEDICARE	& MEDICAID SERVICES			ſ	FORM APPROVED 1938-0391 DMB NO.
STATEMENT	OF DEFICIENCIES IF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		475037	B. WING		STREET, ST.	01/09/2019
NAME OF	PROVIDER OR SUPPLIER		1	STE	REET ADDRESS, CITY, STATE, ZIP CODE	
BARRE	SARDENS NURSING	AND REHAB LLC			PROSPECT STREET RRE, VT 05641	
(XA) ID PREFIX TAG	- (EACH DEFICIENCY	JEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTH (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETION
F 584	in good condition; §483.10(i)(4) Privat resident room, as s §483.10(i)(5) Adequevels in all areas; §483.10(i)(6) Comfilevels. Facilities init 1990 must maintain 81°F; and §483.10(i)(7) For the sound fevels. This REQUIREMENT by: Based on observatifacility failed to ensult facility failed to ensult homelike environment. Per observation of 1/7/19, the exhaust bathrooms were contained to the Maintenance Direction of the Ma	ge 1 bed and bath linens that are e closet space in each pecified in §483.90 (e)(2)(iv); uate and comfortable lighting ortable and safe temperature ially certified after October 1, in a temperature range of 71 to e maintenance of comfortable NT is not met as evidenced lions and staff interview, the ure a clean, comfortable, and ent. Findings include; on initial tour of the facility on vents in many resident vered with a layer of dust/dirt, as made by multiple surveyors erview on 1/9/19 at 2:45 PM, rector confirmed that the part and cleaned in July 2018,	F	584	Residents have the potential by the alleged deficient pract residents will have their bath washing machines filters cleahandled appropriately, resp. changed and cleaned per pole #1 Housewide audit of bathrousekeeping staff will be in bathroom exhaust vent rout schedule #2 Laundry staff in-serviced soiled linen appropriately ar areas #3 All washing machines auditlers are clean. Laundry staff in-serviced audit Equipment completed to encleaned and maintenance prestaff in-serviced on respirate "Cleaning of Equipment" and Maintenance"	cice. These aroom vents and aned, soiled linen equipment icy. From exhaust re clean. In-serviced on ine cleaning on handling and in the correct dited to ensure aff in-serviced on lters of all Respiratory sure changed, ovided. Licensed ory policies
	however the outer by very dusty in many	plades of the vent were now of the rooms and overlooked dusting them as			#6 Housewide audit of all electronic completed to ensure no outlestaff in-serviced on notifying when electrical outlets are expenses.	ets exposed. All g maintenance

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

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	TOF DEFICIENCIES DEF CORRECTION IDENTIFICATION NUMBER: (X2) MULTIPLÉ CONSTRUCTION A BUILDING			(X3) DATE SURVEY COMPLETED		
		475037 8. WING				
NAME OF PROVIDER OR SUPPLIER BARRE GARDENS NURSING AND REHAB LLC					1109/2019	
(X4) ID PREFIX YAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHO) CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE C	(X5) COMPLETION DATE

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

#7 Housewide audit completed of all resident mattresses to ensure they are not bottoming out needing replacement. Nursing Staff inserviced 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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(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			E SURVEY APLETED
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(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC (DENTIFYING INFORMATION)		(EACH CORRECTIVE ACTION SH	HOULD BE	(X5) COMPLETION DATE
	A75037 R G AND REHAB LLC STATEMENT OF DEFICIENCIES STORY MUST BE PRECEDED BY FULL	IDENTIFICATION NUMBER: 475037 B. WING R G AND REHAB LLC TATEMENT OF DEFICIENCIES BOTH CONTROL OF THE PREFIX PREFIX	A BUILDING 475037 B. WING STREET ADDRESS, CITY, STATE, ZIP COD 378 PROSPECT STREET BARRE, VT 05641 STATEMENT OF DEFICIENCIES BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PROSPECTED TO THE AP	A BUILDING COM 475037 B. WING R STREET ADDRESS, CITY, STATE, ZIP CODE 378 PROSPECT STREET BARRE, VT 05641 STATEMENT OF DEFICIENCIES BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE

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

#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 2/119 G. Colemaner Silely RD

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

PRINTED: 01/25/2019

		& MEDICAID SERVICES			FORM APPROVED OMB NO. 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	TIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED
		475037	B. WING	and the same of th	01/09/2019
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODI	g .
BARRE	SARDENS NURSING	AND REHAB LLC		BARRE, VT 05641	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	QUILD BE COMPLETION
F 585	Continued From pa residents, and othe facility stay.	ge 4 r concerns regarding their LTC	F 58	The Grievance policy and poupdated	ostings have been
	§483.10(j)(2) The resident has the right to and to facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph.			Residents needing to file a graph potential to be affected by the practice. These residents wi	is alleged deficient
		acility must make information vance or complaint available		Grievance information avail	able to them.
	grievance policy to of all grievances reg contained in this pa provider must give a to the resident. The include: (i) Notifying residen postings in promine	acility must establish a ensure the prompt resolution garding the residents' rights ragraph. Upon request, the a copy of the grievance policy grievance policy must tindividually or through nt locations throughout the		The Grievance policy has be grievance official is identifie information has been update postings and they have been the facility. All staff to be educated on the	d and their contact ed and added to the placed throughout
	(meaning spoken) of grievances anonym of the grievance offican be filed, that is,	offile grievances orally or in writing; the right to file ously; the contact information cial with whom a grievance his or her name, business		Random audits will be cond administrator or designee to ensure the grievance policy identifies the grievance office	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 21719 G. Colemaneu

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

responsible for overseeing the grievance process.

program or protection and advocacy system;

(ii) Identifying a Grievance Official who is

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A, BUILDII		CONSTRUCTION	(X3) DA	(X3) DATE SURVEY COMPLETED	
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NAME OF	PROVIDER OR SUPPLIER		<u> </u>	STDE	ET ADDRESS, CITY, STATE, ZIP CO	1 01	/09/2019	
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BARRE	GARDENS NURSING .	AND REHAB LLC	1		PROSPECT STREET	4		
	DALLA MARTINE STATE OF THE STAT			BAR	RRE, VT 05641			
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E 585	Continued From pa	an #		_				
1 000			F 58	35				
	receiving and tracki	ng grievances through to their						
	conclusions; leading	any necessary investigations						
	by the facility; maint	aining the confidentiality of all					140	
	information associa	ted with grievances, for						
	example, the identit	y of the resident for those						
	grievances submitte	ed anonymously, issuing						
	written grievance de	cisions to the resident; and						
	coordinating with sta	ate and federal agencies as						
	necessary in light of	specific allegations;						
		aking immediate action to						
	provent further note	ntial violations of accounting						
	right while the allege	ntial violations of any resident						
	right while the allege	ed violation is being						
1.60	investigated;			51.				
161	(IV) Consistent with	§483.12(c)(1), immediately						
	reporting all alleged	violations involving neglect,		3 00				
	abuse, including inju	ries of unknown source,		348				
	and/or misappropria	tion of resident property, by	2	;				
	anyone furnishing se	ervices on behalf of the		3.				
	provider, to the adm	inistrator of the provider; and						
	as required by State	law;						
	(v) Ensuring that all	written grievance decisions						
	include the date the	grievance was received, a	3.00					
	summary statement	of the resident's grievance,						
	the steps taken to in	vestigate the grievance, a						
	summary of the pert	inent findings or conclusions						
	regarding the resider	nt's concerns(s), a statement						
	as to whether the ori	avance was sentiment						
	confirmed any corre	evance was confirmed or not						
	taken by the feeling	ctive action taken or to be						
	and the date the weit	is a result of the grievance,					Į.	
	fuil Taking annua si	ten decision was issued;					j	
	(vi) taking appropria	te corrective action in						
	accordance with Sta	te law if the alleged violation					1	
	or the residents' right	ts is confirmed by the facility					1	
	or it an outside entity	having jurisdiction, such as					ļ	
	the State Survey Age	ency, Quality Improvement					ŀ	
	Organization, or loca	I law enforcement agency					ļ	
	confirms a violation f	or any of these residents'					Į.	
	rights within its area	of responsibility; and					1	

CENTE	RS FOR MEDICARE	& MEDICAID SERVICES						MB NO	. 0938-0391
	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	With the state of		ONSTRUCTION				E SURVEY MPLETED
		475037	B. WING		CO-THEORY CARDON			0.1	09/2019
NAME OF	PROVIDER OR SUPPLIER		T	STRE	ET ADDRESS, C	HTY, STATE	ZIP CODE	1 011	03/2015
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BARRE	GARDENS NURSING	AND REHABILE	=		RE, VT 0564				£.
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	;	(EACH COR	RECTIVE AC	F CORRECTION SHOULD THE APPROP CY)	BE	(X5) COMPLETION DATE
F 595	Continued From pa	m = C	9						
1 200			F 58	35	*				
	result of all grievand	dence demonstrating the ces for a period of no less than tuance of the grievance							
	This REQUIREMEN by:	IT is not met as evidenced							
		ion, interview, and record							
	review the facility fa	iled to establish a grievance							
	policy that identified	the grievance official and		:					
	provided the grievar	nce official's contact		3.53					i
	information for all re	sidents. Findings include:		į					
	"The facility will make	cility grievance policy, it read, se information on how to file a		ļ					
	by notifying the resid	aint available to the resident dent individually or with		į					
	include: The require	throughout the facility to ed contact information of the ame, Business Phone and		¥ 10					
	address (mailings a	nd email)."							
	the residents' rights who the grievance o contact him/her. Pe	1/8/19, throughout the facility, postings did not delineate fficial was and/or how to r interview on 1/8/19 at 3:49							
	PM with the Vice Pres/he confirmed that	esident of Clinical Services, the grievance policy did not							
	identify who the grie	vance official was and did not							
F 600	provide their contact	information.							
SS=D	Reporting of Alleged CFR(s): 483.12(c)(1)(4)	F 60	9					
	§483.12(c) In response neglect, exploitation, must:	nse to allegations of abuse, or mistreatment, the facility							= *
	§483.12(c)(1) Ensure involving abuse neg	e that all alleged violations lect, exploitation or							

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CENTER	RS FOR MEDICARE	& MEDICAID SERVICES			Ţ,	OMB NO. 0938-0391	
	ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA ID PLAN OF CORRECTION IDENTIFICATION NUMBER:		31 //22		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
*		475037	B. WING		***	01/09/2019	
NAME OF	PROVIDER OR SUPPUER			STR	REET ADDRESS, CITY, STATE, ZIP CODE		
BARRE	GARDENS NURSING	AND REHAB LLC			PROSPECT STREET ARRE, VT 05641		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	ζ.	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETION	
F 609	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		F6	09	The altercation between resi has been reported to the app agencies		
	hours after the alleg that cause the alleg serious bodily injury the events that cau	gation is made, if the events gation involve abuse or result in r, or not later than 24 hours if se the allegation do not involve esult in serious bodily injury, to	e sa		Residents involved in resideral altercations have the potention by this alleged deficient practice.	al to be affected	

§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

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

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 #26 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

residents will have these altercations reported.

DNS and Administrator in-serviced on

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 POCallepted 217119 G. Coteman ev S. lewyer

procedures.

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 01/25/2019 FORM APPROVED OMB NO. 0938-0391

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER;		an see Be on		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	475037	B. WING_	193		01/09/2019	
OVIDER OR SUPPLIER	**************************************	T	STR	EET ADDRESS, CITY, STATE, ZIP CODE		
BARRE GARDENS NURSING AND REHAB LLC						
(EACH ÖEFICIÉNC)	MUST BE PRECEDED BY FULL	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	DISE COMPLETION	
no evidence that th appropriate State A 1/9/19 at 3:45 PM v confirmed that the i the appropriate Sta Investigate/Prevent	is incident was reported to the gencies. Per interview on with the Administrator, s/he incident was not reported to te Agencies. ///////////////////////////////////		10	The resident to resident alter residents #75 and #25 has been investigated a summary sent	en thoroughly	
				survey agency, and corrective implemented.		
violations are thoro §483.12(c)(3) Prev- neglect, exploitation investigation is in p §483.12(c)(4) Repressed investigations to the designated repressed accordance with St Survey Agency, with incident, and if the appropriate correct This REQUIREME! by: Based on interview failed to thoroughly resident altercation investigation to the take appropriate corresidents (Residen Findings include:	ent further potential abuse, n, or mistreatment while the rogress. The results of all end administrator or his or her entative and to other officials in ate law, including to the State hin 5 working days of the alleged violation is verified five action must be taken. The is not met as evidenced and record review the facility investigate a resident to a summary of the State Survey Agency, and prective action for 2 applicable t #25 and Resident #75).	To the property of the control of th		Residents involved in resident altercations have potential to this alleged deficient practice residents will have a thoroug completed, a summary submicorrective actions implement DNS and Administrator inscregulatory guidelines for ensicompletion of a thorough invisending a summary to the statement agency, and taking appropriation.	be affected by These h investigation itted and ted. erviced on uring vestigation, ate survey	
	CONTINUED ROVIDER OR SUPPLIER ARDENS NURSING SUMMARY STA (EACH OEFICIENCY REGULATORY OR L Continued From pa no evidence that th appropriate State A 1/9/19 at 3:45 PM v confirmed that the if the appropriate State Investigate/Prevent CFR(s): 483.12(c)() §483.12(c) In responses neglect, exploitation must: §483.12(c)(3) Prevent violations are thoro §483.12(c)(3) Prevent propriate State violations are thoro supplied to the designated represe accordance with St Survey Agency, with incident, and if the appropriate correct This REQUIREMEN by: Based on interview failed to thoroughly resident altercation investigation to the take appropriate corresidents (Resident Findings include:	CONTINUED ROSSING AND REHAB LLC SUMMARY STATEMENT OF DEFICIENCIES (EACH OEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 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. 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).	CORRECTION (X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER: 475037 ROWIDER OR SUPPLIER ARDENS NURSING AND REHAB LLC SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 8 To 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. 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 investigation is in progress. S483.12(c)(4) Report the results of all investigation 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:	CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 475037 ROVIDER OR SUPPLIER ARDENS NURSING AND REHAB LLC SUMMARY STATEMENT OF DEFICIENCIES (EACH OEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 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. 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 investigation 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:	The resident to resident alter residents will have evidence that all alleged violations, or mistreatment while the investigation is in progress. S483.12(c)(2) Have evidence that all alleged violation, or mistreatment while the investigation 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 investigation to the State Survey Agency, and takking 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 summary of the investigation to the State Survey Agency, and takking 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 alking appropriate corrective action for 2 applicable residents (Resident #25 and Resident #75). Findings include:	

4:00 PM, Resident #25 was in the dining room

DEPARTMENT OF HEALTH AND HUMAN SERVICES

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CENTE	RS FOR MEDICARE	& MEDICAID SERVICES			OMB NO. 0938-0391
STATEMENT	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CL/A IDENTIFICATION NUMBER:	•	LTIPLE CONSTRUCTION DING	(X3) DATE SURVEY COMPLETED
	B- 4	475037	B. WING		01/09/2019
	PROVIDER OR SUPPLIER	AND REHAB LLC		STREET ADDRESS, CITY, STATE, ZIP CO 378 PROSPECT STREET BARRE, VT 05641	A 2000 Con 1900
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F 657	by Resident #75. Tand Resident #25 vassessment, Resident moted adverse effect Unit Manager, Direct Physician, and family Resident #75, there medical record that altercation and/or wourther record reviet the altercation was summary of the investigated the potential abuse. Per interview on 1/9 Administrator, s/he was not reported to Agencies and as an investigated thorough investigated thorough investigated that the the residents, that in the incident, or that other. Care Plan Timing and CFR(s): 483.21(b)(2)	ed on the left side of the face he residents were separated was assessed by staff. Upon ent #25 did not to have any ets from the interaction. The ctor of Nursing, Social Worker, by were all notified. For was no notation in the s/he was involved in the as the aggressor. Upon w, there was no evidence that thoroughly investigated, a estigation was sent to the y, or that appropriate is taken to prevent further with at 3:45 PM with the confirmed that the incident the appropriate State result, the incident was not phy, that a summary of the ot sent to the State Survey ective action plan was not put the further potential abuse. The was no harm to either of either resident remembered they were afraid of each and Revision (i)(i)-(iii)		DNS or Administrator will resident to resident altercarensure a thorough investig summary sent to the state scorrective actions were imply 4 weeks then monthly x2 m substantial compliance has Results to be reported to the for further recommendation. The Administrator will over Date of Compliance: 2/20/25 F-UO POC accepted Conference with S. Coleman will sent support the state of the state	tion incidents to ration is completed, a survey agency, and plemented weekly for nonths or until s been achieved. The QAPI committee ons as necessary. The errors of the poor of the poo
	be- (i) Developed within the comprehensive	prehensive care plan must 7 days after completion of assessment. hterdisciplinary team, that			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (X2) MULT (CENTIFICATION NUMBER: A. BUILDIF A. BUILDIF B. WING _				(X3) DATE SURVEY COMPLETED 01/09/2019	
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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, "8ed 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 inserviced 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

G. Coleman Ru / S. Ruy, Rs

CENTER	RS FOR MEDICARE	& MEDICAID SERVICES			OMB NO. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A BUILDING		(X3) OATE SURVEY COMPLETED
		475037	B. WING_	77786	01/09/2019
100 CO	PROVIDER OR SUPPLIER GARDENS NURSING	AND REHAB LLC		STREET ADDRESS, CITY, STATE, ZIP 378 PROSPECT STREET BARRE, VT 05641	The state of the s
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC (DENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE COMPLÉTION RE APPROPRIATE DATE
F 657	dated, 8/30/18, readimpairment r/t (relationstageable pressureview of the multidenotes from 12/4/18, intact". Per interviet the Director of Nursinesident did not have	v. Resident #50's care plan d. "Actual skin integrity ted to): immobility resulting in tre ulcer to left heel." Per isciplinary care conference the resident's "skin" is" w on 1/9/19 at 2:53 PM with ting, s/he confirmed that the re a pressure ulcer on his/her and that the resident's-care	F 65	57	
	Free of Accident Hat CFR(s): 483.25(d)(§483.25(d) Accident The facility must en §483.25(d)(1) The ras free of accident \$483.25(d)(2)Each supervision and assaccidents. This REQUIREMENT by:	nzards/Supervision/Devices 1)(2) ts.	F 68	report completed. The reeducated. Residents involved in have the potential to be	e OT and GA have been a verbal altercation be affected by this ice. These residents will eported and an
	facility failed to prove 2 of 20 sampled restrictions include: Per observation on #32 was pacing around their roommate, Reyelled "I don't want Resident #63 was a did not want her/him repeated "I don't watime, an Occupation."	ide adequate supervision for idents, (Residents #32 & #63) 1/7/19 at 12:18 PM, Resident und their room while yelling at sident #63. Resident #32 you here! I hate you, get out!" sking Resident #32 why s/he in there and Resident #32 int you here! Get out!" At this lal Therapist (OT) was red the room. S/he asked		an investigation condu	ved in resident e incidents reported and acted. Facility staff will buse policy specific to

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILC	LTIPLE CONSTRUCTION DING	(X3) DATE SURVEY COMPLETED
		475037	B. WING	12	01/09/2019
NAME OF F	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COL	
	GARDENS NURSING	AND REHAB LLC		378 PROSPECT STREET BARRE, VT 05641	
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F 689	stated "I don't want OT asked Residen closed the curtain to yes. The OT then ke the OT s/he confirm Resident #32 yellin	ige 12 was wrong and Resident #32 her in here, it's my room!" The it #32 if it would help if she between the two and s/he said eft the room. Per interview with ned that s/he had heard g at their room mate and that inform the nurse of the incident,		The DNS/designee will co audits of residents involv altercations to ensure the been reported and an inv weekly for 4 weeks then r or until substantial comp achieved.	ed in verbal se incidents have estigation conducted nonthly x2 months
	Resident #63 yellin here!" A Geri-Aide I room and asked wh stated I don't want I stated "s/he is your here", Resident #32 want her there and	Resident #32 was standing by g "Shut up! I don't want you (GA) entered the Resident's nat was wrong. Resident #32 this woman here! The GA room mate, s/he belongs 2 repeated that she did not that s/he was not her is stated " okay, I'll go tell your		Results to be reported to for further recommendate. The Administrator will on Date of Compliance: 2/20 F-689 Pocaccepte G. Weman Polis	ions as necessary. versee this POC. 0/2019
	1/7/2018 at approxiconfirmed that s/he incident involving the OT or GA.	he Unit Charge Nurse on imately 12:40 PM, s/he had not been notified of the he two residents by either the liew, Report Irregular, Act On 1)(2)(4)(5)	F	756	
		drug regimen of each resident at least once a month by a			
	§483.45(c)(2) This of the resident's me	review must include a review edical chart			*
		pharmacist must report any attending physician and the		* ,	, ,

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STATEMENT OF AND PLAN OF	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	TIPLE CONSTRUCTION		OATE SURVEY COMPLETED
×.		475037	B. WING	*	_	01/09/2019
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F 756	Continued From pa	age 13	F 7	756 Resident #61's Ha	aldol has been di	scontinued

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

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-754 POC accepted 2/7/19 G. Coteman eu S. Lewy, RV

DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 01/25/2019 FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** A. BUILDING COMPLETED 475037 8. WING 01/09/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 378 PROSPECT STREET BARRE GARDENS NURSING AND REHAB LLC BARRE, VT 05641 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION DATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX LEACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) F 756 Continued From page 14 F 756 (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

\$\$=D CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug in a con-

§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

and report that the Lorazepam order was not written for the appropriate time frame.

F 758 Free from Unnec Psychotropic Meds/PRN Use

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	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER-	1-01 1-101-1-0-0 101-1-0-0	The article of the second seco	(X3) DATE SURVEY COMPLETED
	475037	6 WING_	\$7.7.7.7 %	01/09/2019
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	ARDENS NURSING SUMMARY S (EACH DEFICIEN	CORRECTION IDENTIFICATION NUMBER	CORRECTION IDENTIFICATION NUMBER: A BUILDIN 475037 6 WING _ OVIDER OR SUPPLIER ARDENS NURSING AND REHAB LLC SUMMARY STATEMENT OF DEFICIENCIES ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX	A BUILDING 475037 6 WING GVIDER OR SUPPLIER ARDENS NURSING AND REHAB LLC SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ABUILDING STREET ADDRESS, CITY, STATE, ZIP CODE 378 PROSPECT STREET BARRE, VT 05641 PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD) REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPR

F 758 Continued From page 15

categories:

- (i) Anti-psycholic:
- (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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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	The second second		CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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E 40 14 15 15 15 15 15 15 15 15 15 15 15 15 15	PROVIDER OR SUPPLIER GARDENS NURSING			37	REET ADDRESS, CITY, STATE, ZIP CODE 8 PROSPECT STREET ARRE, VT 05641	
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F 758	prescribing practition the appropriateness. This REQUIREME by: Based on interview failed to to ensure twere free from unnuse for 2 of 7 resid (Resident #16, and include: 1. Per record review Resident #61 dated (antipsychotic med (mg)/milliliter (ml) of 0.5 ml (1mg) by mo for agitation or hallowidence that the 'a Haloperidol was lim regulation. Per intewith the Director of	age 16 e attending physician or oner evaluates the resident for s of that medication. NT is not met as evidenced or and record review the facility that residents' drug regimens recessary psychotropic drug ents in the applicable sample is Resident #61). Findings w, a physician's order for d, 4/6/18, read, "Haloperidol ication) 2 milligram concentrate-15 ml bottle-take buth every 6 hours as needed ucinations". There was no as needed' order for the nited to 14 days as per erview on 1/9/19 at 6:12 PM Nursing, s/he confirmed that needed Haloperidol was out	P7	2 C SERVICES	DNS or designee will rand for PRN psychotropic med they reflect a 14 day limit documented additional ralexceeding that timeframe then monthly x2 months compliance has been achieved. Results to be reported to the committee for further reconcessary. The Administrator will over Date of Compliance: 2/20, and a complex of the compliance of the compliance of the complex of the comple	dications to ensure or the MD has tionale to support weekly for 4 weeks or until substantial eved. The QAPI commendations as versee this POC.

#61's physician.

of date and had not been renewed by Resident

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

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CENTE	RS FOR MEDICARE	& MEDICAID SERVICES			OMB NO. 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBÉR:	(X2) MULTIP A. BUILDING	PLE CONSTRUCTION 3	(X3) DATE SURVEY COMPLETED
		475037	8. WING		01/09/2019
NAME OF	PROVIDER OR SUPPLIER	1.		STREET ADDRESS, CITY, STATE, ZIP COL	
BARRE	GARDENS NURSING	AND REHABILC	1	378 PROSPECT STREET BARRE, VT 05641	,
(X4) ID PREFIX TAG	(EACH DEFICIENC)	STEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	IO PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEPICIENCY)	HOULD BE COMPLETION
F 758	Continued From pa	ige 17	F 758	3	-
		I to exceed the 14 day		-	
	prescribing requires	ments.		*	a Salati ka kolada
	Infection Prevention		F 880		
SS=E	CFR(s): 483.80(a)(1)(2)(4)(e)(f)		had their nebulizers disco	ntinued.
	§483.80 Infection C	Control		#3 Resident #39 no longer	resides in the
		itablish and maintain an		facility	
	 infection prevention 	and control program		#4 Resident #59 oxygen tu	ıbing and humidifier
	designed to provide	e a safe, sanitary and		bottle replaced and conce	ntrator filter cleaned
	development and tr	nment and to help prevent the ransmission of communicable		per policy	
ā	diseases and infect	tions.		#5 Resident #30 and resid	ent #27 have had
				their concentrator filters	
		n prevention and control		#6 Contaminated linens la	
	program. The facility must as	tablish an infection prevention		laundry aide was reeducat	
	and control program	n (IPCP) that must include, at		#	
	a minimum, the follo	owing elements:		#7 Wash machine filter er	📦
		-		clean laundry area cleaned	
	§483.80(a)(1) A sys	tern for preventing, identifying,		#8 and #9- Resident #80 h	
	and communicable	ting, and controlling infections diseases for all residents,		and nebulizer tubing and	and the same of th
	staff, volunteers, vis	sitors, and other individuals		replaced and/or bagged p	
	providing services u	inder a contractual		concentrator filter replace	ed
	arrangement based	upon the facility assessment		#10 Resident #284 no lon	ger resides at the
	accepted national s	g to §483.70(e) and following tandards;		facility	
	§483.80(a)(2) Writte	en standards, policies, and		Residents utilizing respira	ntory equipment
	procedures for the p	program, which must include,		and/or linen and/or requi	5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5
	but are not limited to			changes have the potentia	
	(i) A system of survi possible communication	eillance designed to identify		this alleged deficient prac	7
	infections before the	ey can spread to other			
	persons in the facilit	ty:		will have the proper infec	tion control
	(ii) When and to wh	om possible incidents of		practices followed.	

reported;

communicable disease or infections should be

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)F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULT A. BUILDIN		CONSTRUCTION (XX	DATE SURVEY COMPLETED
		475037	B. WING_			01/09/2019
	ARDENS NURSIN	R G AND REHAB LLC		378	EET AODRESS, CITY, STATE, ZIP CODE PROSPECT STREET RRE, VT 05641	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	JD PREFIX TAG	1 3	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	

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 incidentsidentified 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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STATEMENT OF I	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER-	(X2) MULTIPLE A. BUILDING	E CONSTRUCTION (X3) DATE SURVEY COMPLETED
		475037	8 WING		01/09/2019
	OVIDER OR SUPPLIE RDENS NURSIN	R G AND REHAB LLC	37	REETADDRESS, CITY, STATE, ZIP CODE 18 PROSPECT STREET ARRE, VT 05641	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD & CROSS-REFERENCED TO THE APPROPRIN DEFICIENCY)	

F 880 Continued From page 19

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 tast. Per interview, the resident stated that they had not used the nebulizer in "quite awhile, back when I was it!".
- 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

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 en /5. Rungier

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	FOF DEFICIENCIES DE CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MUL'I A. BUILDII		CONSTRUCTION	(X3) D	ATE SURVEY OMPLETED
		475037	B. WING		THE RESERVE THE THE PROPERTY OF THE PROPERTY O	1	1/09/2019
	PROVIDER OR SUPPLIER GARDENS NURSING	AND REHAB LLC		378	REET ADDRESS, CITY, STATE, ZIP CODE 8 PROSPECT STREET ARRE, VT 05641		103/2013
(X4) ID PREFIX TAG	(ÉACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION))D PREFIX TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	(X5) COMPLETION DATE
	uncovered masks a confirmed that they and in the case of the also confirmed that used the nebulizer of and that they should be and that they should be a confirmed that they should be a confirmed time, s/he confirmed that they are the confirmed that they are	ge 20 rector of Nursing observed the nd concentrator filter and were unlabeled, uncovered, ne filter, very dirty. The DNS the three residents had not equipment in the recent past, I have been discarded. on 1/8/19 at 9:37 AM, the concentrators for Resident 27 contained caked black w with a staff nurse at that I that the filters were dirty and responsibility it was to clean	F 88	30			8
a a	laundry service aide away, dropped a cle With a hand full of o up, contaminating them in the clean lin confirmed that the shave been placed in interview with the La 1/9/2019 at 10:10 Al the dropped sheet s	in 1/9/19 at 9:35 AM, a , while putting clean linen an bed sheet on the floor. ther sheets s/he scooped it is other sheets and placed en cart. At that time, s/he heet was dirty and should not the cart with clean linen. Per undry Service Director on M, s/he also confirmed that hould not have been placed rt, and that the entire cart was					
	1/9/2019 at 9:45 AM filters were filled with was a sign under the daily. Per interview vat that time, s/he cor	f the laundry area on the two washing machine in lint and other debris. There is filter reading clean filter with the laundry service aide infirmed they should be no only cleans them once or					

twice a week. The laundry service aide also explained that after the dirty laundry is collected,

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STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER.	1		CONSTRUCTION		(X3) DATE	SURVEY PLETED
		475037	B. WING			X	0470	00/2040
	PROVIDER OR SUPPLIER GARDENS NURSING	AND REHAB LLC		37	REET ADDRESS, CITY, STATE, ZIP C 8 PROSPECT STREET ARRE, VT 05641	ODE	0170	9/2019
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD	BE	(X5) COMPLETION DATE
F 880	it is brought down, a area. Per interview Director on 1/9/2019 confirmed that dirty	ge 21 and sorted in the clean laundry with the Laundry Service 3 at 10:10 AM, s/he laundry should be sorted in m, not in the clean laundry	F 8	80		2		
	Resident #80 was a through an oxygen of room. The oxygen indicate the last time filter on the concent resident reported the lady" to rinse it out y	on 1/7/19 at 10:42 AM, ctively using oxygen therapy concentrator present in the tubing was not labeled to e it had been changed. The rator was dusty and the at he had asked the "cleaning esterday, s/he reported it was is to that. The Unit Nurse this observation.		·				
. 8	Resident #80 had a connected to a nebubedside table. The lab a bag and was simp the floor and near a contained urine. The indicate the last time	on 1/7/19 at 10:42 AM, mouthpiece and tubing lizer machine sitting on the mouthpiece was not placed in ly hanging several inches off male portable urinal that e tubing was not labeled to it had been changed. The confirmed this observation.		i,			-	140
ar (room to perform a bit to the resident's feet was lying on the end under the resident's dressing from the resqueezed a bottle of	on 1/7/19 at 3:47 PM, the N) entered Resident #284's lateral clean dressing change. The RN took a blanket that of the bed and placed it feet. The RN removed a sident's left foot and normal saline into the wound hall saline dripped from the			3			

left foot onto the blanket. Per further observation, the RN then proceeded to remove the dressing

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	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MUI · A. BUILD		ONSTRUCTION	···			TÉ SURVEY MPLETEO
		475037	B. WING				1	01	/09/2019
NAME OF F	ROVIDER OR SUPPLIER			STRE	et address, cit	Y. STATE, ZI	PCODE		
BARRE (SARDENS NURSING	AND REHAB LLC		10018 54 900	ROSPECT STR RE, VT 05641				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER (EACH CORR CROSS-REFER		ON SHOULD HE APPROP	98	(X5) COMPLETION DATE
F 880	with a vial of normal dripped from the for removed his/her gld supplies, and left the or sanitize his/her higloves. The RN wo through the entire planket on the end retrieved it after que. During interview, the infection control.	this foot and cleansed the area of saline. The normal saline of onto the blanket. The RN oves, gathered his/her are room. The RN did not wash ands after the removal of the ore only 1 pair of gloves process. S/he also left the wet of the resident's bed and only estioning. RN confirmed a breach of I process. S/he further		880					
	followed, glove cha properly, and remo-	per hand hygiene had not been nges had not taken place val of the soiled items from the done until prompted to do so.		to the second	×				
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AH "A" FORM

DEPARTMENT OF THEALTH AND HUMAN SERVICES CENTERS FOR MEDICARL & MEDICAID SERVICES

	OF ISOLATED DEFICIENCIES WIJICH CAUSE	PROVIDER 9	MOLTIPLE CONSTRUCTION	DATE SURVEY
HARM WI	TH ONLY A POTENTIAL FOR MINIMAL HARM		A BUILDING	COMPLETE.
L SNFs ANI	D NES	475037	B WING	1/9/2019
	OVIDER OR SUPPLIER ARDENS NÜRSING AND REHAB LLC	STREET ADDRESS. 378 PROSPECT BARRE, VT	CITY, STATE, ZIP CODE STREET	* 0
FIX	SUMMARY STATEMENT OF DEFICIE	NCIES		8
41	Accuracy of Assessments CFR(s): 483.20(g)			
œ	§483.20(g) Accuracy of Assessments. The assessment must accurately reflect This REQUIREMENT is not met as e Based on interview and record review applicable residents in the sample (Res	videnced by: the facility failed to	accurately assess and reflect	the status for 1 of 20
	Per review the Minimum Data Sheet (Note to being used and that these restraints we bed rails noted on Resident #5's bed. Per interview on 1/9/19 at 12:38 PM wincorrectly; Resident #5 did not have brestraints.	re bed rails. Per obs	servation during the days of s inator, s/he stated that the MI	urvey, there were no
	F641			
	No POC Required	*		60 500
	- 4		86 KI	
	ь.			
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	8.4	2		

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 oursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are end, an approved plan of

The above isolated deficiencies pose no actual harm to the residents