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

July 12, 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 **June 19, 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 _____	C 06/19/2019

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 000	INITIAL COMMENTS An unannounced on-site investigation of a facility reported incident was conducted by the Division of Licensing and Protection on 6/19/2019. The following regulatory violations were identified: F 600 Free from Abuse and Neglect SS=D CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility failed to ensure that one (1) of three (3) residents, (Resident #1) was free from abuse. Findings include: Per record review, Resident #1 was admitted to the facility on 12/14/2016 with the diagnoses of Dementia with Behavioral Disturbance, Type 2 Diabetes, Chronic Pain Syndrome, Anxiety Disorder, Restlessness and Agitation, and Depressive Disorder. S/he is often resistive to care and is care planned to re-approach if refusing blood sugars or care.	F 000 F 600	How will the corrective action be accomplished for those residents found to have been affected by the alleged deficient practice? The R.N. no longer works at the facility. The resident #1 remains at the facility with no negative impact. How will the facility identify other residents having the potential to be affected by the same alleged deficient practice? All residents have the potential to be affected. What measures will be put in place to ensure that the alleged deficient practice will not occur? All staff have been in serviced and educated on the facility policy and procedure for recognizing, preventing, and reporting abuse, neglect, or exploitation. POC amend 7.11.19 Sf 18	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Shawn T. Hallisey	Administrator	7/11/19

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 600	Continued From page 1 Per review of the facility's internal investigation, and confirmed by interview, a Licensed Nursing Assistant (LNA) reported to the supervisor that on 4/6/2019 at approximately 7:30 AM, a Registered Nurse (RN) was attempting to obtain a blood sample from a resident's finger. The resident became resistive and combative grabbing the RN's arm. The RN yelled at the resident to stop and called out for help. The LNA responded and attempted to remove the resident's hand from the RN's arm. The RN then slapped the resident's hand and stated "what's wrong with you people?" Per interview with the LNA on 6/19/2019 at 2:10 PM s/he confirmed that the RN appeared frustrated and slapped Resident #1's hand. The LNA then left the unit to report the incident to the supervisor.	F 600	How will the facility monitor its corrective action to ensure that the alleged deficient practice will not reoccur? Random Audits by the Administrator, DNS, or their designee will be completed to ensure residents are free from abuse, neglect, or exploitation. They will be done weekly X4 weeks and monthly X2 months or until substantial compliance is achieved. The results of the audits will be reported to the monthly QAPI Committee for review until substantial compliance is achieved.	7.10.19
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 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	F 609	How will the corrective action be accomplished for those residents found to have been affected by the alleged deficient practice? The R.N. no longer works at the facility. The resident #1 remains at the facility with no negative impact. POC accept 7.11.19 SF 18	

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F 609 Continued From page 2

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 staff interview and record review, the facility failed to ensure that all alleged violations involving abuse and mistreatment are reported immediately, but not later than 2 hours if the allegation involves abuse, to the administrator of the facility and to other officials (including State Survey Agency, and Adult Protective Services). Findings include:

Per review of the facility's internal investigation, a Licensed Nursing Assistant (LNA) reported to the supervisor that on 4/6/2019 at approximately 7:30 AM, a Registered Nurse (RN) was attempting to obtain a blood sample from a resident's finger. The resident became resistive and combative grabbing the RN's arm. The RN yelled at the resident to stop and called out for help. The LNA responded and attempted to remove the resident's hand from the RN's arm. The RN then slapped the resident's hand and stated "what's wrong with you people?"

F 609

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

All residents have the potential to be affected.

What measures will be put in place to ensure that the alleged deficient practice will no occur?

All staff have been in serviced and educated on the facility policy and procedure for recognizing, preventing, and reporting abuse, neglect, or exploitation.

How will the facility monitor its corrective action to ensure that the alleged deficient practice will not reoccur?

Random Audits by the Administrator, DNS, or their designee will be completed to ensure residents are free from abuse, neglect, or exploitation. They will be done weekly X4 weeks and monthly X2 months or until substantial compliance is achieved.

The results of the audits will be reported to the monthly QAPI Committee for review until substantial compliance is achieved.

7.10.19

Poc accent 7.11.19 SF/SL

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F 609	Continued From page 3	F 609		

After the alleged incident, staff members who have worked with the RN were interviewed by the Director of Nursing (DON). Nine (9) out of ten (10) staff that were interviewed reported previous incidents with the RN regarding violations of resident's rights to be free from abuse and to be treated with dignity and respect for five (5) residents. Per interview with the DON on 6/19/2019 at 1:45 PM, s/he confirmed that staff did not report these incidents, or their concerns about the RN's practice to administration timely.

Per interview with the LNA on 6/19/2019 at 2:10 PM s/he confirmed that this incident was not the first time that s/he had witnessed the RN mistreat residents and had not reported it to administration.