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

May 26, 2020

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 federal and state survey conducted on **February 5, 2020**. 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

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 _____	02/05/2020

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	E 000		

The Division of Licensing and Protection conducted an emergency preparedness review during the annual recertification survey on 2/5/20. The following regulatory violation was cited as a result.

E 039 SS=C EP Testing Requirements
CFR(s): 483.73(d)(2)

"[For RNCHI at §403.748, ASCs at §416.54, HHAs at §484.102, CORFs at §485.68, OPO, "Organizations" under §485.727, CMHC at §485.920, RHC/FQHC at §491.12, ESRD Facilities at §494.62]:

(2) Testing. The [facility] must conduct exercises to test the emergency plan annually. The [facility] must do all of the following:

(i) Participate in a full-scale exercise that is community-based every 2 years; or

(A) When a community-based exercise is not accessible, conduct a facility-based functional exercise every 2 years; or

(B) If the [facility] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required community-based or individual, facility-based functional exercise following the onset of the actual event.

(ii) Conduct an additional exercise at least every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following:

(A) A second full-scale exercise that is community-based or individual, facility-based functional exercise; or

E309
The facility has conducted a second community based or tabletop exercise as required. The Emergency Preparedness Drill will be conducted with City of Barre Fire Department Deputy Chief Joe Aldsworth.
All residents have the potential l to be affected by the alleged deficient practice.
The Maintenance Director has been inserviced on the requirements on regulation E039 and ensuring appropriate number and content of exercises are conducted to test the emergency plan annually.
Random audits will be conducted to ensure the facility is meeting the requirement of appropriate number and content of exercises to test the emergency plan annually.
These audits will be conducted every other month x 3 or until substantial compliance has been achieved.
The results of the drill will be and to determine the need for further action. 3.17.20

LABORATORY DIRECTOR OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Shawn T. Halliseg	Administrator	3.3.20

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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E 039	Continued From page 1	E 039	E039 POC accepted 3/24/20 SFreemanRN/PMC	

(B) A mock disaster drill; or

(C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated,

clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.

(iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [facility's] emergency plan, as needed.

*[For Hospices at 418.113(d):]

(2) Testing for hospices that provide care in the patient's home. The hospice must conduct exercises to test the emergency plan at least annually. The hospice must do the following:

(i) Participate in a full-scale exercise that is community based every 2 years; or

(A) When a community based exercise is not accessible, conduct an individual facility based functional exercise every 2 years; or

(B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospital is exempt from engaging in its next required full scale community-based exercise or individual facility- based functional exercise following the onset of the emergency event.

(ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d) (2)(i) of this section is conducted, that may include, but is not limited to the following:

(A) A second full-scale exercise that is community-based or a facility based functional exercise; or

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E 039	Continued From page 2	E 039		

(B) A mock disaster drill, or

(C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.

(3) Testing for hospices that provide inpatient care directly. The hospice must conduct exercises to test the emergency plan twice per year. The hospice must do the following:

(i) Participate in an annual full-scale exercise that is community-based; or

(A) When a community-based exercise is not accessible, conduct an annual individual facility-based functional exercise; or

(B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospice is exempt from engaging in its next required full-scale community based or facility-based functional exercise following the onset of the emergency event.

(ii) Conduct an additional annual exercise that may include, but is not limited to the following:

(A) A second full-scale exercise that is community-based or a facility based functional exercise; or

(B) A mock disaster drill; or

(C) A tabletop exercise or workshop led by a facilitator that includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an

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E 039	Continued From page 3	E 039		

emergency plan.

(iii) Analyze the hospice's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the hospice's emergency plan, as needed.

*[For PRFTs at §441.184(d), Hospitals at §482.15(d), CAHs at §485.625(d):]
(2) Testing. The [PRTF, Hospital, CAH] must conduct exercises to test the emergency plan twice per year. The [PRTF, Hospital, CAH] must do the following:

(i) Participate in an annual full-scale exercise that is community-based; or

(A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or

(B) If the [PRTF, Hospital, CAH] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event.

(ii) Conduct an [additional] annual exercise or and that may include, but is not limited to the following:

(A) A second full-scale exercise that is community-based or individual, a facility-based functional exercise; or

(B) A mock disaster drill; or

(C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated,

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E 039	Continued From page 4	E 039		

emergency plan.

(iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the [facility's] emergency plan, as needed.

"[For LTC Facilities at §483.73(d):]
(2) The [LTC facility] must conduct exercises to test the emergency plan at least twice per year, including unannounced staff drills using the emergency procedures. The [LTC facility, ICF/IID] must do the following:

(i) Participate in an annual full-scale exercise that is community-based; or

(A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise.

(B) If the [LTC facility] facility experiences an actual natural or man-made emergency that requires activation of the emergency plan, the LTC facility is exempt from engaging its next required a full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event.

(ii) Conduct an additional annual exercise that may include, but is not limited to the following:

(A) A second full-scale exercise that is community-based or an individual, facility based functional exercise; or

(B) A mock disaster drill; or

(C) A tabletop exercise or workshop that is led by a facilitator includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.

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	475037	A. BUILDING _____ B. WING _____	02/05/2020

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E 039	Continued From page 5	E 039		

(iii) Analyze the [LTC facility] facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [LTC facility] facility's emergency plan, as needed.

*[For ICF/IIDs at §483.475(d)]:
(2) Testing. The ICF/IID must conduct exercises to test the emergency plan at least twice per year. The ICF/IID must do the following:

(i) Participate in an annual full-scale exercise that is community-based; or

(A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or.

(B) If the ICF/IID experiences an actual natural or man-made emergency that requires activation of the emergency plan, the ICF/IID is exempt from engaging in its next required full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event.

(ii) Conduct an additional annual exercise that may include, but is not limited to the following:

(A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or

(B) A mock disaster drill; or

(C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.

(iii) Analyze the ICF/IID's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise

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E 039 Continued From page 6 E 039

the ICF/IID's emergency plan, as needed.

*[For OPOs at §486.360]
(d)(2) Testing. The OPO must conduct exercises to test the emergency plan. The OPO must do the following:

(i) Conduct a paper-based, tabletop exercise or workshop at least annually. A tabletop exercise is led by a facilitator and includes a group discussion, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. If the OPO experiences an actual natural or man-made emergency that requires activation of the emergency plan, the OPO is exempt from engaging in its next required testing exercise following the onset of the emergency event.

(ii) Analyze the OPO's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the [RNHCI's and OPO's] emergency plan, as needed.

This REQUIREMENT is not met as evidenced by:

Based on staff interview and record review, the facility failed to conduct exercises to test the emergency plan annually. Findings include:

Per record review, the facility experienced an actual emergency requiring activation of the emergency plan in November 2019. There is no evidence that the facility conducted a second community based or tabletop exercise as required. This was confirmed by the facility Administrator on 2/5/20 at 12:30 PM.

F 000 INITIAL COMMENTS F 000

An unannounced, on-site re-certification survey

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F 000	Continued From page 7 was conducted by the Division of Licensing and Protection between 2/2 - 2/5/2020. The following regulatory violations were identified during the survey.	F 000		
F 656 SS=E	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for	F656	Resident #74 has a personalized activity care plan to address his activities preferences. Resident #58 has a comprehensive care plan to address his personal individualized care of an indwelling catheter use.Resident #10 has a personalized activity care plan to r eflect the resident's preference to participate in religious service or practice. Residents with religious preferences and indwelling catheters have the potential to be affected by this alleged deficient practice. Residents will have activity care plans personalized to address activity preferences including religious preferences. Residents with indwelling urinary catheters plan to address care. in house-wide audit of care plans was conducted to ensure that identified residents have an activities care plan, catheter care, and religious needs as appropriate.The Activities Director has been in serviced regarding	

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F 656	Continued From page 8	F 656		

future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.
(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.
This REQUIREMENT is not met as evidenced by:
Based on observation, staff interview and record review, the facility failed to develop a comprehensive care plan for 3 of 23 applicable residents (Residents #74, 58, 10). Findings include:

1. Per record review, Resident # 74 does not have a care plan to address activity needs. The Resident was admitted on 11/4/19. The Resident was observed in bed over 2 of the 3 survey days with no individual or group activities involvement. The Unit Manager stated that Resident # 74 should have a plan of care for activities and confirmed that there is no care plan to address activity needs.

2. Per record review, Resident #58 was re-admitted to the facility on 10/1/19 with an indwelling urinary catheter related to retention of urine. Per review of the care plan there is no evidence that the facility developed a compressive care plan to address the presence and/or care of the indwelling urinary catheter. The Registered Nurse (RN) confirmed on 02/05/20 11:41 AM that a care plan had not been developed to include a indwelling urinary catheter which reflects the current status of the resident.
3. Per record review, Section F (Preferences for

completion of comprehensive activity care plans and to include religious preferences.
Licensed nurses have been in serviced regarding the implementation of care plans to address resident's need for indwelling urinary catheter care.
Random audits will be conducted weekly X 4, then monthly X 2 to evaluate the completion of care plans related to Activities, urinary catheters and significant religious needs. The results of these audits will be presented to the monthly QAPI committee to review and determine if any further actions are needed.

3.17.20

F656 POC accepted 3/24/20 SFreemanRN/PMC

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F 656	Continued From page 9 Customary Routine and Activities) of Resident #10's Minimum Data Set (a comprehensive assessment tool used for all residents of long term care nursing facilities certified to participate in Medicare or Medicaid) indicates that it is very important for Resident #10 to participate in religious service or practice. Resident #10's plan of care does not reflect the importance for the resident to participate in religious service or practice. During an interview with the Director of Activities on 2/5/2020 at 2:52 PM s/he stated that s/he was not aware that religious service or practice was very important to Resident #10. The Activities Director also confirmed that it was not incorporated into the residents plan of care.	F 656		
F 679 SS=E	Activities Meet Interest/Needs Each Resident CFR(s): 483.24(c)(1) §483.24(c) Activities. §483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and record review the facility failed to provide activities that support the physical, mental, and psychosocial well-being of each resident for 3 of the 38 residents in the sample (Residents #10, #27, and	F679	Resident #10, 27 and 37's are being provided with activities to support their physical, mental, and psychosocial wellbeing. All dementia residents have the potential to be affected by this alleged deficient practice. Residents will have activities provided to address physical, mental and psychosocial wellbeing per their preference and careplan to include religious preferences. The activity calendar has been	

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F 679 Continued From page 10

#37). Findings include:

1. On 2/3/2020 Resident #10, #27, and #37 were observed in the Sun room with one other resident. The television was on with a show called "My Haunted House" (interviews and re-enactments of people who say they have experienced paranormal activities in their own home). At 10:55 AM, a staff member entered the sun room, offered resident #27 a puzzle and another resident a maraca. S/he then exited the room at 10:57 AM.

On 2/3/2020 at 11:10 AM during an interview with a Licensed Nursing Assistant, s/he stated that animal planet was usually on television and then confirmed that the television show that was on was not appropriate for residents with Dementia (due to the frightening and sometimes violent imagery).

2. Per record review, Resident #10's Minimum Data Set (a comprehensive assessment tool used for all residents of long term care nursing facilities certified to participate in Medicare or Medicaid) Section F (Preferences for Customary Routine and Activities) indicates that it is very important for Resident #10 to participate in religious service or practice.

During an interview with the Director of Activities on 2/5/2020 at 2:52 PM s/he stated that s/he was not aware that religious service or practice was very important to Resident #10. The Director of Activities also confirmed that it was not incorporated into the residents plan of care.

3. Per review of the February 2020 Activity Calendar there are 14 days that a program called

F 679 updated to include additional dementia specific activities. The Activity Director and staff was in serviced regarding provision of dementia activities to address the residents physical, mental and psychosocial wellbeing per their preference and careplan to include religious preferences. The Administrator will randomly audit the activities and calendar to ensure provision of activities to support the physical, mental, and psychosocial wellbeing, including religious preferences weekly X 4, then monthly X 2. The results of these audits will be presented to the monthly QAPI committee to review and determine if any further actions are needed. 3.17.20

F679 POC accepted 3/24/20 SFramanR#1PMC

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F 679	Continued From page 11 "Busy Hands" is offered there is no other evidence of any dementia care specific activities. On 2/5/20 at 2:52 PM the Director of Activities confirmed that there was a need for more dementia specific activities and that s/he was planning on implementing a dementia specific program.	F 679		
F 680 SS=E	Qualifications of Activity Professional CFR(s): 483.24(c)(2)(i)(ii)(A)-(D) §483.24(c)(2) The activities program must be directed by a qualified professional who is a qualified therapeutic recreation specialist or an activities professional who- (i) Is licensed or registered, if applicable, by the State in which practicing; and (ii) Is: (A) Eligible for certification as a therapeutic recreation specialist or as an activities professional by a recognized accrediting body on or after October 1, 1990; or (B) Has 2 years of experience in a social or recreational program within the last 5 years, one of which was full-time in a therapeutic activities program; or (C) Is a qualified occupational therapist or occupational therapy assistant; or (D) Has completed a training course approved by the State. This REQUIREMENT is not met as evidenced by: Based on staff interview the facility failed to ensure that the Activity Director had the required qualifications per regulation. Findings include: On 12/5/2020 at 2:52 PM during an interview with the Director of Activities, s/he stated that s/he has	F680	The facility hired an Activities Director who has the required qualification per regulation. All residents have the potential to be affected by the alleged deficient practice by the alleged deficient practice.An Activities Director with the required qualifications has been hired per regulation. The Administrator will be in serviced on the new CMS rule, regulations, and requirements for Activity Directors in LTC.The hiring process will be monitored by Payroll/Human Resources. All results will be reported to QAPI until substantial compliance is achieved. F680 POC accepted 3/24/20 SFreemanRN/PMC	3.17.20

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 _____	02/05/2020

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 680	Continued From page 12 been an Activity Assistant for a year and is in the process of becoming certified. Per interview with the Administrator on 2/5/20 at approximately 3:30 PM confirmation was made that the Director of Activities does not have the required certification for the position of Director of Activities.	F 680		
F 725 SS=E	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty.	F725 The facility has filled open positions to ensure sufficient LNA staff. All residents are at risk to be affected by this alleged deficient practice. These residents will have the LNA minimum staffing levels met to maintain the highest practicable physical, mental and psychosocial well-being. An audit has been conducted of the current schedule to ensure sufficient daily LNA staffing The DNS, Administrator, and the scheduler were inserviced on requirements regarding sufficient LNA staffing to maintain the highest practicable physical, mental and psychosocial well-being. The DNS or designee will conduct random schedule audits to ensure sufficient LNA	

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	475037	A. BUILDING _____ B. WING _____	02/05/2020

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F 725	Continued From page 13	F 725		

This REQUIREMENT is not met as evidenced by:
Based on observations, record review, facility assessment review, and staff interviews, the facility failed to ensure that there was sufficient nursing staff with appropriate competencies and skills to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. Findings include:

1. Per review of Licensed Nursing Assistant (LNA) Assignment Sheets, there are 48 residents on wing 2. There are assignment sheets written for 5, 4, or 3 LNAs. Of the residents on wing 2, 11 require a mechanical lift for transfers (2 staff members must assist with the use of a mechanical lift). 8 other residents require 2 staff assist for transfers without mechanical lift. 19 residents require the assistance of 1 staff member. 13 residents require assistance of 2 staff for Activities of Daily Living (ADLs). 35 require assistance or supervision of 1 staff member. 34 of the 48 residents are incontinent of bowel and/or bladder and require assistance with toileting and/or incontinence care.

During an interview with an LNA on 2/4/2020 at 12:17 PM s/he stated that s/he would not be "finished with resident care until around 1:40 (PM)". S/he stated that it was "impossible" to get everything done, and the residents "don't get quality care" because of the care needs and lack of staffing.

2. During observation on 02/05/20 at 8:15 AM, 4 residents were in the sun room. 1 resident was sleeping. Residents # 37 and another resident were seated at a table drinking coffee. Resident # 79 asked this Surveyor if s/he could have a cup of

staffing requirements are in place. These audits will be conducted weekly x4 and then monthly x2 or until substantial compliance has been achieved. The results of these audits will be presented to the monthly QAPI committee to review and determine if any further actions are needed. 3-17-20

F725 POC accepted 3/24/20 SFremmer RN/DNE

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 _____	02/05/2020

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 725	Continued From page 14	F 725		

coffee. When asked if Resident # 79 could have a cup of coffee, the Geri-aide (facility staff) stated "oh, s/he is thickened so she has to wait for her breakfast tray" . When asked when that would be here, s/he stated "around 8:30. S/he is a feeder and needs to be feed, even her/his drinks. There wont be anyone to help her until breakfast comes". The Geri-aide confirmed that 15 minutes is a long time to wait when two other residents are enjoying a cup of coffee in front of her/him. The Geri-aide stated "I know it's hard for me to not be able to help, s/he has asked me three times already."
Per interview with the Unit Manager on 2/5/20 at 8:25 AM confirmation was made that the resident requires assistance with beverages and that her/his breakfast would be coming.

3. Per the Facility Assessment, the ratios of direct care staff (LNAs) to residents was listed as 1:8 for day shift, 1:8.8 for evening shift, and 1:22 for night shift. On a unit of 48 residents, many who have dementia, there were day and evening shifts documented when there were only 3-4 LNAs caring for a group of 48 residents with high needs such as two person transfers and 2 person mechanical lifts.
Per review of the daily staffing sheets from 1/19/2020 to 1/31/2020, the facility's assessed ratios of 1:8 and 1:8.8 staffing were below that ratio for most of the shifts on Unit 2.

On 1/19/2020, there were 48 residents on the unit, and two LNAs from 6AM to 2:30 PM, one LNA who worked 5 AM to 3:30 PM, and one who worked for 4 hours on that shift. On the evening shift of that day, There was one LNA who worked 8 hours, one who worked from 7PM to 11 PM, and one LNA who worked from 3 PM to 9 PM.

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	475037	A. BUILDING _____ B. WING _____	02/05/2020

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F 725	Continued From page 15	F 725		

On 1/20/2020, cencus was 48 residents on Unit 2. There were five LNAs who worked the day shift, however one of them was a first day orientee. On the evening shift, there were 3 LNAs that worked the entire shift, and one who worked 3 PM to 9 PM, and one from 7PM to 11 PM.
On 1/21/2020, cencus was 48 for Unit 2. Day shift had 5 LNAs and one orientee. The evening shift had 4 LNAs on for the full shift.
On 1/22/2020, cencus was 48 residents on Unit 2. There were 4 LNAs on the day shift. The evening shift had 4 LNAs, with a fifth LNA working from 6-11PM.
On 1/23/2020, cencus was 48 residents on Unit 2. The day shift had 6 LNAs scheduled which would have met the 1:8 ratio, however the evening shift only had 4 LNAs on the floor scheduled and one was listed as an orientee.
1/24/2020, the cencus was 48 residents on Unit 2. The day shift schedule had two LNAs working a partial shift, and three 8 hour shift LNAs with one orientee. The evening shift only has 3 LNAs scheduled on the floor.
1/25/2020, the cencus was 48 residents on Unit 2. The day shift had 4 LNAs on for the full shift, and one who worked 12PM -3PM, and one from 7AM to 9:30 AM. The evening shift only has two LNAs listed for the full shift, and then two who split the shift making three LNAs on at one time.
On 1/26/2020, the resident cencus was 48 on Unit 2. During the day shift, there were 5 LNAs scheduled, one who was an orientee. On the evening shift, there were for LNAs working the full shift, and then two who each worked 1/2 the shift.
On 1/27/2020, the cencus was 48 on Unit 2. There were 4 LNAs scheduled for the day shift. The evening shift had 5 LNAs on from 3PM to 7 PM, and then 3 LNAs to cover the rest of the evening shift.

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 _____	02/05/2020

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F 725	Continued From page 16	F 725		

On 1/28/2020, the cencus was 48 residents on Unit 2. There were 6 LNAs scheduled that day with one orientee, which would meet the 1:8 ratio. The evening shift however only had three LNAs on the schedule, with the Director of Nursing working 3.5 hours to supplement the staffing.
On 1/29/2020, cencus was 48 on Unit 2. There were 4 LNAs working the shift, with one orientee as well. A fifth LNA was on the schedule, however was providing transport out of the facility for part of that shift. The evening shift had 3 LNAs on from 3- 11 PM, 2 LNAs who worked 3-7 PM, and one who worked 6PM to 11PM.
On 1/30/2020, the cencus was 48 on Unit 2. The day shift had 5 LNAs working, but one of them was orienting. One LNA worked from 1PM to 3 PM on that shift as well. The evening shift was patched together with partial shift hours. There were 4 LNAs on from 3 PM to 11PM taking into account the split shifts. There was also an orientee on with them.
On 1/31/2020, the cencus was again 48 residents on Unit 2. The day shift had 5-6 LNAs on, with one orientee. There were LNAs splitting the shift, or working shorter hours. The evening shift only had 3 LNAs scheduled, plus one orientee.
When calculating ratios of LNAs to residents, 3 LNAs for 48 residents comes to 1:16, 4 LNAs comes to 1:12 ratio, and 5 LNAs equals a 1:9.6 ratio. In order to meet the ratio of LNAs to residents as assessed by the facility, there needs to be 6 LNAs on that unit per shift.
4. A Resident Council group meeting was held on 2/4/20. There were 4 residents present representing both units within the facility. During the meeting the residents reported that wait times for staff to assist them is especially long on the weekends, during change of shift and at meal times.

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 _____	02/05/2020

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 730 Nurse Aide Peform Review-12 hr/yr In-Service
SS=C CFR(s): 483.35(d)(7)

§483.35(d)(7) Regular in-service education.
The facility must complete a performance review of every nurse aide at least once every 12 months, and must provide regular in-service education based on the outcome of these reviews. In-service training must comply with the requirements of §483.95(g).
This REQUIREMENT is not met as evidenced by:
Based on record review and staff interview, the facility failed to ensure that Licensed Nursing Assistants (LNAs) received 12 hours of inservice education per year for 4 of 6 LNAs reviewed. Findings include:

LNA #1's inservice record for 2019 showed documentation of 8.25 hrs of education.

LNA #2's record for 2019 has documentation of 11 hours of inservice education.

LNA #3's record has documentation of 9.5 hours of inservice education.

LNA #4's record has documentation of 3.25 hours of inservice education.

The Director of Nursing Services confirmed the above information during interview on 2/5/2020 at 11:45 AM.

F730
LNA # 1 no longer works here. LNAs #2, #3, #4 have completed 12 hours of regular in service education
An audit of LNA employee records was completed to evaluate completion of 12 hrs in service education.
The Staff Development nurse has implemented a plan to ensure all LNA's receive the required 12 hours annually.
The Staff Development nurse has been in serviced regarding the 12-hour inservice requirement for LNAs.The DNS or designee will conduct random audits weekly X 4 and monthly X 2 to ensure LNAs have completed 12 hours of in service education annually. The results of these audits will be presented to the monthly QAPI committee to review and etermine if any further actions are needed. 3-17-20
F730 POC accepted 3/24/20 SFreeman RN/PMC

F 744 Treatment/Service for Dementia
SS=E CFR(s): 483.40(b)(3)

§483.40(b)(3) A resident who displays or is diagnosed with dementia, receives the appropriate treatment and services to attain or maintain his or her highest practicable physical,

F 744
Residents are now receiving dementia specific activities and the LNAs have received Dementia management training. Residents with dementia have

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	475037	A. BUILDING _____ B. WING _____	02/05/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 744	Continued From page 18 mental, and psychosocial well-being. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interview, the facility failed to ensure that residents with dementia received appropriate treatment and services to attain or maintain their highest practicable physical , mental and psychosocial well- being related to activities and staff training. Findings include: 1. Per observations on 2/3/2020 between 10:40 and 11:10 AM four residents were sitting in the sun room unattended. During this 30 minute time period, the television was on a program about being haunted by ghosts, and it contained violent and frightening images with a spooky music soundtrack. At 10:55 a Licensed Nursing Assistant (LNA) entered the room, offered a puzzle to Resident # 27 and a maraca to another resident then left the room. There was no interaction between the LNA and Resident # 10 or Resident # 37, and the LNA did not address the inappropriate program on the television. Per interview with the LNA on 2/3/20 at 11:10 PM, s/he stated that the television is usually set on Animal Planet and that the program on was not appropriate for residents who have dementia. S/he also stated that staff do come in and give the residents activities to do, but they are left alone in the room. Per observations over the three days of survey, there were a few activities in the sunroom that involved residents with dementia. There was a "Books on Tape" session that included three or four residents, and staff handing specific residents a puzzle or percussion instrument, or offering a magazine to one. The residents were	F 744	the potential to be affected by this alleged deficient practice they will have dementia specific activities and LNA's caring for them that have had dementia management training. An audit was conducted of Dementia activities and LNA dementia training to ensure requirements have been met.The Activity Director and staff was in serviced on ensuring provision of dementia activities.The Staff Development nurse has been in serviced regarding the mandatory 12 hours of in servicing and dementia in servicing requirement for LNAs. The DNS or designee will conduct random audits weekly X 4 and monthly X 2 to ensure LNAs have completed the mandatory annual dementia in servicing. The Administrator will randomly audit the activities and calendar to ensure provision of dementia specific activities weekly X 4, then monthly X 2. The results of these audits will be presented to the monthly QAPI committee to nd determine if any further actions are needed. 3/17/20	

F744 POC accepted 3/24/20 SFreemanRN/RMC

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 _____	02/05/2020

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BARRE GARDENS NURSING AND REHAB LLC	378 PROSPECT STREET BARRE, VT 05641

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F 744	Continued From page 19 often just sleeping in the sunroom, and there was very minimal staff interaction that engaged them in any way. Some of the residents with dementia on that unit were attending the main activity in the dining room, but many residents were seen in bed most of the day, or sitting around with minimal stimulation from staff to engage them in any way. The former Activity Director, who is now the Social Services director, stated that they had a plan to start a Namaste room, and expand the activity program to include more activities for the residents with dementia, but that it was a work in progress. 2. Per review of staff training records, four out of six Licensed Nursing Assistants (LNAs) had not received any dementia management training in 2019. The facility list of education topics lists this as a mandatory annual inservice topic for all LNAs. This was confirmed by the Director of Nursing on 2/5/2020 at 11:45 AM. Per interview with LNA #2 on 2/4/20 at 12:17 PM s/he stated that dementia care training offered consists of "here are the forms, sign here".	F 744		
F 947 SS=C	Required In-Service Training for Nurse Aides CFR(s): 483.95(g)(1)-(4) §483.95(g) Required in-service training for nurse aides. In-service training must- §483.95(g)(1) Be sufficient to ensure the continuing competence of nurse aides, but must be no less than 12 hours per year. §483.95(g)(2) Include dementia management training and resident abuse prevention training.	F 947	F947 LNA's #2, #3, #4 and #5 have completed their 12 hours of in servicing and the dementia specific in servicing. An audit was completed of LNA records to evaluate completion of the mandatory annual 12 hours of in servicing and dementia specific in servicing. The Staff Development nurse has implemented a plan to ensure all LNA's receive the mandatory annual 12 hours of in servicing and dementia in servicing.	

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 _____	02/05/2020

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 947	Continued From page 20 §483.95(g)(3) Address areas of weakness as determined in nurse aides' performance reviews and facility assessment at § 483.70(e) and may address the special needs of residents as determined by the facility staff. §483.95(g)(4) For nurse aides providing services to individuals with cognitive impairments, also address the care of the cognitively impaired. This REQUIREMENT is not met as evidenced by: Per record review and staff interview, the facility failed to ensure that Licensed Nursing Assistants (LNAs) received inservice education of at least 12 hours per year, included dementia care training, and resident abuse prevention training for 5 of 6 staff reviewed. Findings include: LNA #1's inservice record for 2019 showed documentation of 8.25 hrs of education. There was no evidence that this LNA received education on the topics of dementia management training and resident abuse prevention training. LNA #2's inservice record for 2019 has documentation of 11 hours of inservice education. There is no documentation of dementia management training. LNA #3's inservice record for 2019 has documentation of 9.5 hours of inservice training. LNA #4's record has documentation of 3.25 hours of inservice education. No documentation of dementia management training or resident abuse prevention training listed. LNA#5's record has documentation of over 12 hrs for the year, however does not list dementia	F 947	The Staff Development nurse has been in serviced regarding the mandatory 12 hours of in servicing and dementia in servicing requirement for LNAs. The DNS or designee will conduct random audits weekly X 4 and monthly X 2 to ensure LNAs have completed t he mandatory annual 12 hours of in servicing and dementia in servicing. The results of these audits will be presented to the monthly QAPI committee to review and determine if any further actions are needed. 3.17.20 F947 POC accepted 3/24/20 SFreemanRN/PMC	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 947	Continued From page 21	F 947		

management training as part of their education inservices.

Per interview with an LNA on 2/4/20 at 1:33 PM s/he atended part one of a four part dementia training, but didn't get to go to the other three parts because s/he was working on the floor.

Per interview on 2/5/2020 at 11:45 AM, the Director of Nursing confirmed that the inservice education records showed that some of the LNAs had not met the 12 hour per year of inservice education, and that some of the required areas of education were also not met.

Division of Licensing and Protection

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 _____	02/05/2020

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S 000	Initial comments During the course of a recertification survey, completed on 2/3/20 - 2/5/20 by the Division of Licensing and Protection, the following violation of the Vermont Licensing and Operating Rules for Nursing Homes was identified.	S 000		
S321 SS=E	7.13 (d)(2) QUALITY OF CARE - STAFFING LEVELS 7.13 (d)(2) The facility shall provide staffing information to the licensing agency in a manner and on a schedule prescribed by the licensing agency. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to meet the minimum staffing levels for Licensed Nursing Assistants (LNA) of 2 hours per day per resident. Findings include: During the month of January 2020, there were 3 weeks reviewed that did not meet the 2 hour per day per resident staffing ratios for LNAs. The week reviewed of December 31, 2019 to January 6, 2020, the average daily hours of LNA to resident only averaged 1.91 hrs per resident per day. January 14th -20th, 2020, the average LNA hours were 1.93 hours of LNA per resident per day. January 21rst- Jan. 27th, 2020, the average daily LNA hours were 1.94 hours per day per resident. Per interview on 2/5/2020 at 11:29 AM, the	S321	S321 The facility has filled open positions to ensure sufficient LNA staff. All residents are at risk to be affected by this alleged deficient practice. These residents will have the LNA minimum staffing levels met. An audit has been conducted the current schedule to ensure sufficient daily LNA staffing. The DNS, Administrator, and the scheduler were inserviced on requirements regarding sufficient LNA staffing. The DNS or designee will conduct random schedule audits to ensure sufficient LNA staffing requirements are in place. These audits will be conducted weekly x4 and then monthly x2 or until substantial compliance has been achieved. The results of these audits will be presented to the monthly QAPI committee to review and determine if any further actions are needed. 3/17/20	

Division of Licensing and Protection
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

S321 POC accepted 3/24/20 SFreeman RN/PM

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 _____	02/05/2020

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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S321	Continued From page 1 Director of Nursing confirmed that the averaged hours of these weeks did not meet the state minimum requirement for LNAs.	S321		