Division of Licensing and Protection HC 2 South, 280 State Drive Waterbury, VT 05671-2060 <u>http://www.dail.vermont.gov</u> 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,

Jamela McotaRN

Pamela M. Cota, RN Licensing Chief

STATEMENT	RS FOR MEDICARE	(Xt) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER			DINSTRUCTION	(X3) DATE SURVEY COMPLETED	
		475037	B WING			07	/05/2020
NAME OF	PROVIDER OR SUPPLIER		1	STRE	ET ADDRESS, CITY STATE, 21P CODE	1 02	30312020
	GARDENS NURSING	AND REHAB LLC		378 P	ROSPECT STREET RE, VT 05641	•	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFD TAG	¢	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) Completion Date
E 00 0	Initial Comments		E 0	00			
а ж	The Objective states	environment Dente altra					
		ensing and Protection gency preparedness review					
		ecertification survey on 2/5/20.					
		atory violation was cited as a	2				
E 039	EP Testing Require	ments	E34	09			
	CFR(s): 483,73(d)(2		Th	e facil	ity has conducted a second		14 19 19
					ity based or tabletop exercis	se	
		3.748, ASCs at §416.54,			ed. The Emergency Prepare		
i		CORFs at §485.68, OPO,			l be conducted with City	ulless.	3
		ler §485.727, CMHC at HC at §491.12, ESRD					3
	Facilities at §494.62				Fire Department Deputy		
	i oolingoo at 3404.95	*]·			Aldsworth.		
1	(2) Testing, The [fac	cility) must conduct exercises			ents have the potential		:
		cy plan annually. The [facility]	l to	be af	fected by the alleged		3
	must do all of the fo		def	icient	practice.		:
		a full-scale exercise that is	The	Mair	itenance Director has		
	community-based e		ber	en inse	erviced on the requirements		
		community-based exercise is duct a facility-based functional			ation E039 and ensuring		
	exercise every 2	years; or		to an exercity	ate number and content		
		cility] experiences an actual			ses are conducted to test		
		e emergency that requires			gency plan annually.		
	activation of the em				audits will be conducted		
		aging in its next required r individual, facility-based					
		xercise following the onset of			the facility is meeting		
	the actual event,				rement of appropriate		
	(ii) Conduct an a	additional exercise at least			nd content of exercises		
		site the year the full-scale or			emergency plan annually.		
	functional exercise u				dits will be conducted every	t	
	not limited to the foll	icted, that may include, but is	oth	er mo	nth x 3 or until substantial		
		d full-scale exercise that is	con	plian	ce has been achieved.		
		r individual, facility-based	The	result	ts of the drill will be		
	functional exercise;		and	to def	ermine the need for further	action.	317-20
		ERUSUPPTIER REPRESENTATIVES SIGN	AJURE		1 YITLE /		(X6) DATE

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 provide. 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.

in

ATEMEN	RS FOR MEDICARE	(X:) PROVIDER	SUPPLIERICLIA	(X2) MUL		ISTRUCTION		(X3) D	0. 0938-0391 ATE SURVEY
ND PLAN OF CORRECTION		ILLEN HEICAT	non Number.	A BUILDING			COMPLETED		
		47	5037	B. WING				0	2/05/2020
IAME OF	PROVIDER OR SUPPLIER				STREET	ADDRESS, CI	ITY, STATE, ZIP C	ODE	
BARRE	GARDENS NURSING	AND REHAB L	LC			OSPECT STF E, VT 0564'			
(X4) ID PREFIX TAG	SUMMARY STA (EACH DEFICIENC) REGULATORY OR L		DED BY FULL	ID PREFU TAG		(EACH CORI	R'S PLAN OF COI RECTIVE ACTION RENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
E 039	Continued From pa	age 1		ΕÓ	39	FO39 Pr	C accepted	3/24/20 550	ma Dei 1 Drus
	ACTIVITIES AND	disaster drill;	or	LU	55		i unafia	5101120 5114	mucken / 11/mc
			workshop that						
	is led by a facilitato	r and includes							
	discussion using a		5-281 521						
			scenario, and a						1
	set of problem state prepared questions		ed messages, or to challenge an		14				55 2
	emergency plan.	uesigned	เด้ การแต่เกลือ ๆไ						
		the [facility's]	response to and		1				
	maintain document	ation of all drill	s, tabletop		12				-
	exercises, and eme		vents, and						
	revise the [facility's]	emergency pl	àn, às needed.						•
	*[For Hospices at 4	18 113/41-1							ţ.
	(2) Testing for hos		ide care in the						
1	patient's home. Th								
	exercises to test the	e emergency p	lan at least						ŧ
	annually. The hosp								1
	(i) Participate i								
	community based e		ased exercise is						** 21
	not accessible, con								
	based functional ex	ercise e	very 2 years; or						
		ospice experier							
	or man-made emer								
	of the emergency p exempt from engag		ospital is required full						
	scale community-ba								
		functional exer							
	the onset of the em								
	(ii) Conduct an								
	years, opposite the functional exercise								
	this section is condu								
	not limited to the fol		r inviouse, paria						
		nd full-scale ex	ercise that is					8	
	community-based o	r a facility base	ed functional					61	
	exercise; or								
M CMS-25	67(02-99) Previous Versions	Obsolete	Event ID: M8YT1:		Facility D. 4	475037	lf -	continuation she	et Page 2 of 22

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		(X1) PROMDER/SUPPLIER/CLIA IOENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION A. BUILDING				ATE SURVEY
		475037	S WING			- 0	2/05/2020
NAME OF F	ROVIDER OR SUPPLIER	net av		STREET	ADDRESS, CITY, ST.		
BARRE (ARDENS NURSING	AND REHAB LLC			OSPECT STREET E, VT 05841		
(X4) ID PRÉFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		(EACH CORRECTIV	NOF CORRECTION E ACTION SHOULD BE D TO THE APPROPRIATE CIENCY)	(X5) COMPLETION DATE
E 039 Continued From page 2 (B) A mock disaster dnll; 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.)39	-			
	care directly. The exercises to test th year. The hospice (i) Participate that is community- (A) When not accessible, cor facility-based funct (B) If the h or man-made eme of the emergency p exempt from engat full-scale communi functional of the emergency of (ii) Conduct ar that may include, b following: (A) A seco community-based of exercise; or (B) A moc (C) A table by a facilitator that using a narrated, emergency scenario	a community-based exercise is induct an annual individual ional exercise; or ospice experiences a natural rgency that requires activation blan, the hospice is ging in its next required ty based or facility-based exercise following the onset					•

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		& MÉDICAID SERVICES	State of these		PLE CONSTRUCTION (X3) DATE S		0938-039 SURVEY PLETED
		475037	B WING			02/	5/2020
	PROVIDER OR SUPPLIER	AND REHAB LLC		378	EET ADDRESS, CITY, STATE, ZIP CODE PROSPECT STREET RRE, VT 05641		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDEN TIFYING INFORMATION)	id Prefit Tag	{	PROVICER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE	(X5) Completion Date
E 039	maintain document exercises, and eme the hospice's emerg *[For PRFTs at §44	e hospice's response to and ation of all drills, tabletop ergency events and revise gency plan, as needed. 1.184(d), Hospitals at	ΕO	39			
	conduct exercises to twice per year. The do the following:	RTF, Hospital, CAH] must o test the emergency plan (PRTF, Hospital, CAH] must n an annual full-scale exercise	20 12 20				
1	(A) When a not accessible, conc facility-based functio (B) If the [P] experiences an actu emergency that requ emergency plan, the engaging in its next based or functional exercise f	community-based exercise is duct an annual individual, onal exercise; or RTF, Hospital, CAH] ual natural or man-made	×	10. J. 10.	ı		
	and that may include following: (A) A second community-based of functional exercise; (B) A mock (C) A tableto is led by a facilitator discussion, using a clinically-relevan	disaster drill; or op exercise or workshop that and includes a group					

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	f of deficiencies of correction	(X1) PROVIDER/SUPPLIER/CLA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	(X3) DATE SURVE COMPLETED	
		475037	B. WING		02/05/2020	
NAME OF	PROVIDER OR SUPPLIER		1	STREET ADDRESS, CITY, STATE, 21P CODE		
BARRE	GARDENS NURSING	AND REHAB LLC		378 PROSPECT STREET BARRE, VT 05641		
(X4) ID PREFIX TAG	EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CORRECTION X (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE COMPLI	ETION
E 039	E 039 Continued From page 4 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 exercises 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		ΕO	39		
	requires activation o the LTC facility is ex required a full-scale individual, facility following the onset o (ii) Conduct an that may include, bu following: (A) A secon community-based or functional exercise; (B) A mock (C) A tablet is led by a facilitator using a narrated, emergency scenario statements, directed	If the emergency plan, empt from engaging its next community-based or y-based functional exercise of the emergency event, additional annual exercise t is not limited to the ad full-scale exercise that is an individual, facility based				

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TATEMENT OF DEFICIENCIES			SUPPLIER/CLIA	and a subscription of	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		: 47	5037	B. WING	;			02/05/2020	
	PROVIDER OR SUPPLIE		.c	3 3	378 P	ET ADDRESS, CITY, STATE ROSPECT STREET RE, VT 05641			
(X4) ID PREFIX TAG	IEACH DEFICIEN	TATEMENT OF DEFIC CY MUST BE PRECE LLSC IDENTIFYING IN	DED BY FULL	ID PREF TAG		PROVIDER'S PLAN (EACH CORRECTIVE / CROSS-REFERENCED T OEFICIE	ACTION SHOULD BE TO THE APPROPRIATE	(XS) Completion Date	
E 039	Continued From	bage 5		F	039		1) 1)		
		he (LTC facility) f naintain docume ercises, and e e the (LTC facility	ntation of all mergency						
	*[For ICF/IIDs at § (2) Testing. The IC	3483.475(d)): CF/IID must cond				8		at R	
	to test the emerge The ICF/IID must (i) Participate that is community	do the following: in an annual full-			12				
	(A) When not accessible, co facility-based fund	a community-ba induct an annual itional exerc	individual, ise; or,	5 : 1					
	(B) If the l natural or man-ma activation of the e is exempt from en	mergency pl	hat requires an, the ICF/IID	2 4 24 29				к	
	full-scale commun	ity-based or indi- nal exercise follo	vidual, facility-						
	may include, but is (A) A seco	ond full-scale exe	e following: Incise that is	t					
		e; or k disaster drill; o	r						
	is led by a facilitate discussion, using a		group						
	set of problem sta prepared question emergency plan.	tements, directed							
			tabletop						

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER		IPLE CONSTRUCTION	(×>) DATE SURVEY COMPLETED
		475037	B. WANG			02/05/2020
	PROVIDER OR SUPPLIER	AND REHAB LLC		STREET ADORESS, CITY 378 PROSPECT STREE 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 (EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD BE REED TO THE APPROPRIAT REFICIENCY)	
E 039	Continued From pa	ge 6	E 0	39		
	the ICF/IID's emerg	ency plan, as needed.				
		2001				
	*[For OPOs at §486 (d)(2) Testing The	OPO must conduct exercises				
		cy plan. The OPO must do the	2			
	following:	and the second sec				
		aper-based, tabletop exercise				
		t annually. A tabletop exercise				
	is led by a facilitator	r and includes a group narrated, clinically relevant				
		o, and a set of problem		a.		
5		ected messages, or prepared				
		to challenge an emergency	24 24 00			1
		periences an actual natural				6 11
		gency that requires activation				- ·
e		lan, the OPO is exempt from				
		required testing exercise of the emergency event.				
		OPO's response to and				
		ation of all tabletop exercises,				
		ents, and revise the [RNHCI's	1			13
		ncy plan, as needed.				
		IT is not met as evidenced				
	by:	rview and record review, the				
		fuct exercises to test the				
		nually. Findings include:				
	Per record review t	he facility experienced an				
	actual emergency re	equiring activation of the				
	emergency plan in I	November 2019. There is no				
		cility conducted a second				
		r tabletop exercise as				
	Administrator on 2/5	confirmed by the facility				
	INITIAL COMMENT		F 0(00		
					2	
120	An unannounced, c	on-site re-certification survey				

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STATEMENT OF AND PLAN OF C		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL	TIPLE CONSTRUCTION		até survey Impleted
		475037	B. WING		0	2/05/2020
	VIDER OR SUPPLIER	AND REHAB LLC		STREET ADDRESS, CITY, STATE, ZI 378 PROSPECT STREET BARRE, VT 05641	> CODĘ	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	id Prefi Tag	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIN CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
wi Pr re	otection between gulatory violations	ge 7 he Division of Licensing and 2/2 - 2/5/2020. The following s were identified during the	FO	00		
F 656 Do SS=E Cl S4 S4 S4 S4 S4 S4 S4 S4 S4 S4 S4 S4 S4	FR(s): 483.21(b)(83.21(b) Compre 83.21(b)(1) The f plement a compre re plan for each r sident rights set fi 83.10(c)(3), that i jectives and time edical, nursing, ar eds that are ident sessment. The co scribe the followin The services that maintain the resik ysical, mental, an puired under §483. Any services that der §483.24, §48 wided due to the der §483.10, inclu atment under §48 habilitative services wide as a result of commendations. I dings of the PASA ionale in the resion in consultation w ident's represent	thensive Care Plans acility must develop and ehensive person-centered esident, consistent with the orth at §483.10(c)(2) and includes measurable frames to meet a resident's nd mental and psychosocial lified in the comprehensive omprehensive care plan must ng - t are to be furnished to attain dent's highest practicable d psychosocial well-being as 3.24, §483.25 or §483.40; and t would otherwise be required 3.25 or §483.40 but are not resident's exercise of rights ading the right to refuse 33.10(c)(6). services or specialized es the nursing facility will of PASARR f a facility disagrees with the ARR, it must indicate its lent's medical record. ith the resident and the	act act Re: car ind cat per efle par Re ath th th th Re par Re ath th th th cat per efle par Re car efle par re car efle par re car efle par re car efle par re car efle par re car efle par re car efle par re car efle par re car efle par re car re car efle par re car re car efle par re car car car car car car car car car car	sident #74 has a personalize ivity care plan to address his ivities preferences. sident #58 has a comprehen- e plan to address his person ividualized care of an indw heter use.Resident #10 has sonalized activity care plan ext the resident's preference ticipate in religious service sidents with religious prefe- nd indwelling catheters hav e potential to be affected by his alleged deficient practic esidents will have activity of ans personalized to address tivity preferences. Reside the indwelling urinary cath an to address care. house-wide audit of care pla- nducted to ensure that ident sidents have an activities care atheter care, and religious ne s appropriate. The Activities D	is asive hal relling a to r to r to r to or practice. rences re v e. care s g nts eters ified e plan, eds	:

FORM CMS-2567(02-99) Previous Versions Obsolute

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Facility ID. 475037

If continuation sheet Page 8 of 22

CENTERS FOR MEDICARE STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION	OMB NO. 0938-039 (X3) DATE SURVEY
AND PLAN OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	COMPLETED
	475037	B WING	02/05/2020
	TEMENT OF DEFICIENCIES	STREET ADDRESS, CITY, STATE, ZIP CODE 378 PROSPECT STREET BARRE, VT 05641 ID PROVIDER'S PLAN OF CORREC	710N (X5)
PREFUX (EACH DEFICIENCY	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX (EACH CORRECTIVE ACTION SHO TAG CROSS-REFERENCED 10 THE APPR DEFICIENCY)	
 whether the resident community was assolical contact agencientities, for this purp (C) Discharge plans plan, as appropriate requirements set for section. This REQUIREMENT by: Based on observation residents (Resident review, the facility factor comprehensive care residents (Resident include: 1. Per record review have a care plan to Resident was admitted was observed in bewith no individual or The Unit Manager's should have a plan confirmed that there activity needs. 2. Per record review of evidence that the fact of the f	acilities must document acilities must document acis desire to return to the bessed and any referrals to bies and/or other appropriate pose. Is in the comprehensive care and any referrals to be and/or other appropriate pose. Is in the comprehensive care and the care plan to address and the care plan there is no	F 656 completion of comprehensive activity care plans and to include religious preferences. Licensed nurses have been in serviced regarding the implement of care plans to address resident need for indwelling urinary cathe Random audits will be conducted X 4, then monthly X 2 to evaluate completion of care plans related to Activities, urinary catheters an significant religious needs. The results of these audits will be presented to the monthly QAPI committee to review and determ if any further actions are needed FUSE AC accepted 3/34/30 SF	tation s eter care. weekty e the d ine

FORM CMS-2587(02-99) Provious Versions Obsolete

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Event ID: M8YT11

Facility ID 475037

If continuation sheet Page 9 of 22

FORM APPROVED OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES. (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMFLETED A BUILDING 475037 6 WING 02/05/2020 STREET ADDRESS, CITY, STATE, ZP CODE NAME OF PROVIDER OF SUPPLIER **378 PROSPECT STREET** BARRE GARDENS NURSING AND REHAB LLC **BARRE, VT 05641** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION DATE iD (\$4) 10 (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG **DEFICIENCY** F 656 Continued From page 9 F 656 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 679 Activities Meet Interest/Needs Each Resident F679 SS=E CFR(s): 483.24(c)(1) Resident #10, 27 and 37's are being provided with activities §483.24(c) Activities. to support their physical, mental, §483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan and psychosocial wellbeing. and the preferences of each resident, an ongoing All dementia residents have the program to support residents in their choice of potential to be affected by this activities, both facility-sponsored group and alleged deficient practice. Residents individual activities and independent activities, will have activities provided to designed to meet the interests of and support the physical, mental, and psychosocial well-being of address physical, mental and each resident, encouraging both independence psychosocial wellbeing per their and interaction in the community. preference and careplan to include This REQUIREMENT is not met as evidenced religious preferences. by: Based on observation, staff interview, and record The activity calendar has been review the facility failed to provide activities that support the physical, mental, and psychosocial well-being of each resident for 3 of the 38

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residents in the sample (Residents #10, #27, and

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Facility ID. 475037

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TATEMEN	T OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(XZ) MULTIP	LE CONSTRUCTION	(X3) DATE SURVEY
NG PLAN I	OF CORRECTION	IDENTIFICATION NUMBER:	A BUILDING		COMPLETED
		475037	B. WING		02/05/2020
NAME OF	PROVIDER OR SUPPLIER	A CONTRACTOR OF A CONTRACTOR O	5	STREET ADDRESS, CITY, STATE, ZIP CODE	
ARRE	GARDENS NURSING	AND REHAB LLC		Big PROSPECT STREET 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 CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION
F 679	Continued From pa	ge 10	F 679	updated to include additional	
	#37). Findings inclu	de:		dementia specific activities.	
	4 CL 215 6666 P			The Activity Director and staff	÷
		ident #10, #27, and #37 were I room with one other	it.	was in serviced regarding provisio	
		sion was on with a show called		of dementia activities to address	4 F
	"My Haunted House			the residents physical, mental	
		ople who say they have		and psychosocial wellbeing per	
		rmal activities in their own		their preference and careplan	:
		I, a staff member entered the esident #27 a puzzle and		to include religious preferences.	
		naraca. Sine then exited the		The Administrator will randomly	*
	room at 10:57 AM			audit the activities and calendar	
		0 AM during an interview with		to ensure provision of activities	
	a Licensed Nursing	Assistant, s/he stated that sually on television and then	12	to support the physical, mental,	12
	confirmed that the te	elevision show that was on		and psychosocial wellbeing,	
		for residents with Dementia		including religious preferences	ħ.
		ng and sometimes violent	1	weekly X 4, then monthly X 2.	а
	imagery).	12-00 Oliver Alter		The results of these audits will	
	9 Des see al	Canada and Address Manada		be presented to the monthly	
		, Resident #10's Minimum rensive assessment tool		QAPI committee to review	
		s of long term care nursing		and determine if any further	3.17.20
	facilities certified to p	participate in Medicare or		actions are needed.	<i>.</i>
		(Preferences for Customary		200	
		s) indicates that it is very		F679 FOL accepted 3124120 SFram	canp#1Pmc
	religious service or p	nt #10 to participate in formatice.		verige general and an an	
		with the Director of Activities			
		PM s/he stated that s/he was			
		ous service or practice was			
	very important to Re- Activities also confirm	sident #10. The Director of			
		residents plan of care.			
	E)	February 2020 Activity			
	A 1 OLIONEW DI LIE	a condert core mountly			2

Calendar there are 14 days that a program called

FORM CMS-2567(02-99) Previous Versions Obsolete

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Event ID: MBYT11

FeoMy ID: 475037

If continuation sheet Page 11 of 22

			WOS here	TIPLE CONSTRUCTION	0MB NO. 0938-039 (X3) DATE SURVEY	
	of déficiencies of correction	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	100 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	NG	COMPLETED	
		475037	6. WING		02/05/2020	
NAME OF P	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	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	id Prefi) Tag	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE AGTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLETION	
F 679	Continued From pa	age 11	F 6	79		
		fered there is no other				
		mentia care specific activities.				
	On 2/5/20 at 2:52 I	PM the Director of Activities		5 4		
		e was a need for more		2		
		activities and that s/he was				
	35 August 10 August 10 - 10 August 10 Augus	nenting a dementia specific		r.		
C sen	program. Ouslifications of Ar	tivity Professional	F6	30		
	80 Qualifications of Activity Professional =E CFR(s): 483.24(c)(2)(i)(ii)(A)-(D)			e facility hired an Activities		
00-c				rector who has the required		
		activities program must be		alification per regulation.	5 2	
•		ied professional who is a	-	residents have the potential to	12	
	activities profession	ic recreation specialist or an		affected by the alleged deficient		
		gistered, if applicable, by the		actice by the alleged deficient	3	
	State in which prac			actice. An Activities Director		
	(ii) Is:			th the required gualifications		
		ification as a therapeulic		s been hired per regulation.		
		t or as an activities acognized accrediting body on		Administrator will be in serviced		
	or after October 1,			the new CMS rule, regulations,		
		experience in a social or		d requirements for Activity		
		m within the last 5 years, one		ectors in LTC. The hiring process		
		ne in a therapeutic activities		be monitored by Payroll/Human		
	program; or (C) is a qualified or	cupational therapist or		sources. All results will be reported		
	occupational therap			QAPI until substantial compliance	3.17.20	
	(D) Has completed	a training course approved by		chieved.	2-11-20	
	the State.					
	by:	NT is not met as evidenced	Fr.	SC POL accepted 3/24/20 SFreemank	a I pmc	
		rview the facility failed to	1 4	0- 10	i.	
	ensure that the Act	ivity Director had the required				
	qualifications per re	gulation. Findings include:				
	On 12/5/2020 at 2:	52 PM during an interview with				
	the Director of Activ					

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Facvity ID. 475037

If continuation sheet Page 12 of 22

PRINTED: 02/21/2020 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED OMB NO. 0938-0391 **CENTERS FOR MEDICARE & MEDICAID SERVICES** (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER. AND PLAN OF CORRECTION A BUILDING B. WANG 02/05/2020 475037 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 378 PROSPECT STREET BARRE GARDENS NURSING AND REHAB LLC BARRE, VT 05641 PROVIDER'S PLAN OF CORRECTION (XS) COMPLETION SUMMARY STATEMENT OF DEFICIENCIES in (X4) (D (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) F 680 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. F725 F 725 Sufficient Nursing Staff SS=E CFR(s): 483.35(a)(1)(2) The facility has filled open positions to ensure sufficient LNA staff. §483.35(a) Sufficient Staff. All residents are at risk to The facility must have sufficient nursing staff with be affected by this alleged the appropriate competencies and skills sets to provide nursing and related services to assure deficient practice. These resident safety and attain or maintain the highest residents will have the LNA practicable physical, mental, and psychosocial minimum staffing levels met well-being of each resident, as determined by resident assessments and individual plans of care to maintain the highest and considering the number, acuity and practicable physical, mental diagnoses of the facility's resident population in and psychosocial well-being. accordance with the facility assessment required An audit has been conducted at §483.70(e). of the current schedule to §483.35(a)(1) The facility must provide services ensure sufficient daily LNA staffing by sufficient numbers of each of the following The DNS, Administrator, types of personnel on a 24-hour basis to provide and the scheduler were nursing care to all residents in accordance with inserviced on requirements resident care plans: (i) Except when waived under paragraph (e) of regarding sufficient LNA staffing this section, licensed nurses; and to maintain the highest practicable (ii) Other nursing personnel, including but not physical, mental and psychosocial limited to nurse aides. well-being. The DNS or designee will conduct random schedule §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must audits to ensure sufficient LNA designate a licensed nurse to serve as a charge nurse on each tour of duty.

FORM CMS-2567(02-99) Previous Versions Obsolete

Facility ID: 475037

If continuation sheet Page 13 of 22

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PRINTED: 02/21/2020 FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	100-01 T.	TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	475037	B WING		02/05/2020
NAME OF PROVIDER OR SUPPLIER BARRE GARDENS NURSING			STREET ADDRESS, CITY, STATE, ZIP CODE 378 PROSPECT STREET BARRE, VT 05641	
PREFIX (EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		O BE COMPLETION
 by: Based on observa assessment review facility failed to ensinursing staff with a skills to attain or m physical, mental, a each resident. Find 1. Per review of Lik (LNA) Assignment on wing 2. There a for 5, 4, or 3 LNAs require a mechanic members must ass mechanical lift). 8 d assist for transfers residents require th member. 13 reside staff for Activities of require assistance member. 34 of the bowel and/or blado toileting and/or inco During an interview 12:17 PM s/he stall "finished with resid (PM)". S/he stated everything done, at quality care" becau of staffing. 2. During observation residents were in the sleeping. Resident were seated at a tagent. 	NT is not met as evidenced tions, record review, facility v, and staff interviews, the sure that there was sufficient ippropriate competencies and aintain the highest practicable nd psychosocial well-being of dings include: censed Nursing Assistant Sheets, there are 48 residents re assignment sheets written . Of the residents on wing 2, 11 cal lift for transfers (2 staff sist with the use of a other residents require 2 staff without mechanical lift. 19 he assistance of 1 staff ents require assistance of 2 if Daily Living (ADLs). 35 or supervision of 1 staff 48 residents are incontinent of ler and require assistance with		25 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. FTAS POC accepted 3/24/be Street	3-17-22

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	MENT OF HEALTH					*	OMB N	MAPPROVE 0. 0938-039
	DE DEFICIENCIES	(X1) PROVIDER/ IDENTIFICA	SUPPLIER/OLIA FION NUMBER:	-				ATE SURVEY MPLETED
<u></u>		47	5037	B. WING)		0	2/05/2020
NAME OF PF	OVIDER OR SUPPLIER	<u></u>		water and a second second	STREE	TADDRESS, CITY, S	STATE, ZIP CODE	
			10		378 PR	ROSPECT STREET		
BARRE G	ARDENS NURSING	AND REMADIL	ĻC		BARR	E, VT 05641		
(X4) ID PREFIX TAG		ATEMENT OF DEFN Y MUST BE PRECO SC IDENTIFYING I	DED BY FULL	ID PREFI TAG		(EACH CORRECT CROSS-REFERENCE	LAN OF CORRECTION IVE ACTION SHOULD BE SED TO THE APPROPRIATE FICIENCY)	(X5) COXIPLETIO DATE
F 725 (Continued From pa	age 14		F	725			
	coffee. When aske	The second secon	79 could have		123			
	cup of coffee, the C							
	oh, s/he is thicken							
	preakfast tray" . W			•	949			
	here, s/he stated "a							
	and needs to be fe wont be anyone to							
	comes", The Geri-a			e e				
	s a long time to wa							
	are enjoying a cup			1	•			
	The Geri-aide state			:	10 10			
	not be able to help,	s/he has aske	ed me three					
	imes already."		0/2/00 -1		1			
	Per interview with t 3:25 AM confirmati				ļ.			
	equires assistance							
	ner/his breakfast w			ł.	-			ii (i
4	3. Per the Facility A	ssessment th	e ratios of direct	ł	ŝ			
	are staff (LNAs) to				-			
	or day shift, 1:8.8 f				12 12			
	hight shift. On a un							
	ave dementia, the			5				
	focumented when aring for a group of			•				
	such as two person					a		
	nechanical lifts.		2 parcon				18	
	Per review of the da	aily staffing she	eets from					
1	1/19/2020 to 1/31/2	020, the facility	y's assessed					
	atios of 1:8 and 1:0							
0	atio for most of the	e stints on Unit	2.					
a	On 1/19/2020, ther	e were 48 resi	dents on the					
	init, and two LNAs							
L	NA who worked 5	AM to 3:30 PN	i, and one who					
v	vorked for 4 hours	on that shift. C	In the evening	14				
\$	hift of that day, Th	ere was one L	NA who worked					
	hours, one who w							
8	ind one LNA who v	vorked from 3	FINI LO 9 FM.					
HICHIC SECT	(02-99) Previous Versions	Decolota	EvenLID: MaYT	15	Facility ID:	475037	If continuation shee	Page 15 o

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STATEMENT	OF DEFICIENCIES	& MEDICAID SERVICES	an reference a		INSTRUCTION	(X3) DAT	0938-0391
		475037	B. WING			TO NOW OWNERS AND IN COMMENSION	/05/2020
NAME OF !	PROVIDER OR SUPPLIER			and the second s	T ADDRESS, CITY, STATE, ZIP CODE		
BARRE	GARDENS NURSING	AND REHAB LLC	-	10111-1000 100	ROSPECT STREET		
				BAR	RE, VT 05641		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION}	ID PREF TAG	IX	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS REFERENCED TO THE APPI DEFICIENCY)	ould be	(XS) COMPLETION DATE
F 725	Continued From pa	ne 15	C ·	725			
1 720		cus was 48 residents on Unit		125			
		NAs who worked the day					
		of them was a first day					
		ening shift, there were 3 LNAs		10			
	that worked the ent	ire shift, and one who worked					
		one from 7PM to 11 PM.					
		cus was 48 for Unit 2. Day shift					
	had 5 LNAs and on had 4 LNAs on for t	e orientee. The evening shift	\$ •				
		cus was 48 residents on Unit	2	-			
		As on the day shift. The					
		LNAs, with a fifth LNA working	÷	10			
	from 6-11PM,		* *	1	25		
		cus was 48 residents on Unit		T.			
		6 LNAs scheduled which	-				2
		1:8 ratio, however the	с. 7				
		ad 4 LNAs on the floor was listed as an orientee.	I.	5			
		cus was 48 residents on Unit	2. 2.		23		
		edule had two LNAs working			57 1		
		nree 8 hour shift LNAs with					*
	one orientee. The e	vening shift only has 3 LNAs	19				
	scheduled on the flo						
		us was 48 residents on Unit					
		4 LNAs on for the full shift, d 12PM -3PM, and one from					
		le evening shift only has two					
		ull shift, and then two who					
		g three LNAs on at one time.					
	On 1/26/2020, the re	esident cencus was 48 on					
		ay shift, there were 5 LNAs					
		was an orientee. On the					
		were for LNAs working the full who each worked 1/2 the shift		6			
	194 W. S. Marson Marson Marson (1953) - 1953 - 1944	encus was 48 on Unit 2.					
		scheduled for the day shift.					3
		d 5 LNAs on from 3PM to 7					
		s to cover the rest of the					

AND PLAN OF	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA ICENTIFICATION NUMBER	(A_2) MOI $(1$	PLE CONSTRUCTION	(X3) DATE SURVEY
			A BUILDIN	G	COMPLETED
		475037	B. WING_		02/05/2020
BARRE G	ROVIDER OR SUPPLIER	а. Т		STREET ADDRESS, CITY, STATE, ZIP CO	DE
	SARDENS NURSING	AND REHAB LLC		378 PROSPECT STREET BARRE, VT 05641	
(X4),iD PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES (Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION & CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE COMPLETION
F 725	Continued From p	ane 16	F 72	5	
	56 DF 56 180	cencus was 48 residents on		-	
		6 LNAs scheduled that day			•
	with one orientee,	which would meet the 1:8 ratio.			
		however only had three LNAs			
		with the Director of Nursing	¥3		
2		to supplement the staffing.			
		icus was 48 on Unit 2. There ing the shift, with one orientee	e:	87 (1	
		was on the schedule, however		8	
	was providing tran	sport out of the facility for part		28 17	
		vening shift had 3 LNAs on			
		LNAs who worked 3-7 PM, and		8	
	one who worked 6		17	1	
		cencus was 48 on Unit 2. The As working, but,one of them			
		LNA worked from 1PM to 3			8
¥2	PM on that shift as	well. The evening shift was			3
	patched logether v	vith partial shift hours. There	6	×	
	were 4 LNAs on fr	om 3 PM to 11PM taking into	Î.		
		hifts. There was also an			
	orientee on with th	em. cencus was again 48 residents			
	on Unit 2 The day	shift had 5-6 LNAs on, with			
	one orientee. Ther	e were LNAs splitting the shift,			18
		hours. The evening shift only			
		uled, plus one orientee.			
		ratios of LNAs to residents, 3			
		ents comes to 1:16, 4 LNAs			
	comes to 1; 12 rate	o, and 5 LNAs equals a 1:9.6 eet the ratio of LNAs to			
		sed by the facility, there needs			
	to be 6 LNAs on th				
	4. A Resident Cou	incil group meeting was held			
		rere 4 residents present			
	representing both	units within the facility. During	•		
	the meeting the re-	sidents reported that wait times			
	IOI SIGIT 10 BSSIST II	nem is especially long on the change of shift and at meal			

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

PRINTED: 02/21/2020 FORMAPPROVED OMB NO. 0938-0391

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MULTIPLÉ CONSTRUCTION A BUILDING	(X3) DATE SURVEY COMPLETED
	<u> </u>	475037	B. WING	02/05/2020
	PROVIDER OR SUPPLIER	AND REHAB LLC	STREET ADDRESS, CITY, STATE, ZI 378 PROSPECT STREET BARRE, VT 05641	PCODE
(X4) 10 PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF PREFIX (EACH CORRECTIVE ACT TAG CROSS-REFERENCED TO T DEFICIENC	ION SHOULD DE COMPLETION HE APPROPRIATE DATE
	CFR(s): 483.35(d)(§483.35(d)(7) Regu The facility must co of every nurse aide months, and must j	Review-12 hr/yr In-Service 7) ular in-service education. Implete a performance review at least once every 12 provide regular in-service in the outcome of these	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 reco was completed to evaluate	ords
	reviews. In-service requirements of §4 This REQUIREME by: Based on record re facility failed to ens	training must comply with the	completion of 12 hrs in service education. The Staff Development nurse has implemented a plan to ensure all LNA's receive the	
•1	education per year Findings include: LNA #1's inservice	for 4 of 6 LNAs reviewed. record for 2019 showed	required 12 hours annually. The Staff Development nurse has been in serviced regarding the 12-hour inservice requirer for LNAs.The DNS or designee	ment
	LNA #2's record fo 11 hours of inservic	r 2019 has documentation of e education.	will conduct random audits weekly X 4 and monthly X 2 to ensure LNAs have completed	
	of inservice educal		12 hours of in service education annually. The results of these a	udits
	of inservice educal		will be presented to the monthing QAPI committee to review and etermine if any further actions a	
	above information (11:45 AM.	sing Services confirmed the during interview on 2/5/2020 at	F730 POC accepted 3/24/20 F744	SFreeman Rr/ PML
	Trealment/Service CFR(s): 483.40(b)(3)	Residents are now receiving dementia specific activities and the LNAs have received	а
	diagnosed with der appropriate treatme	ident who displays or is nentia, receives the ent and services to attain or highest practicable physical,	and the LNAs have received Dementia management trainin Residents with dementia have	g.
WM CMR.75	57(02-99) Previous Versions	and the second	11 Facility ID: 475037	If continuation sheet Page 18 of

FORM CM8-2557(02-99) Previous Versions Obsolete Event ID: MaYT11

PRINTED:	02/21/2020
FORM.	APPROVED
CIA DAAC	1020 9201

STATEMENT OF DEFICIENCIES				IPLE CONSTRUCTION	(X3) DATE SURVEY	
	OF CORRECTION	IDENTIFICATION NUMBER.	and the second second	lG	COMPLETED	
		475037	B, WING	_	02/05/2020	
NAME OF	PROVIDER OR SUPPLIER	t		STREET ADDRESS, CITY, STATE, ZIP CODE		
BARRE	GARDENS NURSING	AND REHAB LLC	2 A	378 PROSPECT STREET BARRE, VT 05641		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	IQ PREFIX TAG	PROVIDER'S PLAN OF CORRECTIV (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D RE COMPLETION	
E 744	Continued From p	aaa 18	F 74	the potential to be affected		
1 /44			F 14	¹⁴ by this alleged deficient practice		
		osocial well-being. NT is not met as evidenced		they will have dementia specific		
	by:			activities and LNA's caring for		
	Based on observa	ations, record review, and staff	l.	them that have had dementia		
		ty failed to ensure that		management training.		
		nentia received appropriate		An audit was conducted		
		vices to attain or maintain their e physical, mental and	s	of Dementia activities and		
		being related to activities and	-	LNA dementia training to		
	staff training. Findi		e.	ensure requirements have		
	-			been met. The Activity Director		
		s on 2/3/2020 between 10:40		and staff was in serviced on		
		residents were silting in the led. During this 30 minute time	-	ensuring provision of dementia		
		on was on a program about		activities. The Staff Development		
		phosts, and it contained violent	1	nurse has been in serviced		
	and frightening ima	ages with a spooky music		regarding the mandatory 12		
د		55 a Licensed Nursing		hours of in servicing and	R	
		itered the room, offered a		dementia in servicing		
		# 27 and a maraca to another ne room. There was no		requirement for LNAs.		
		n the LNA and Resident # 10 or		The DNS or designee will		
	Resident # 37, and	I the LNA did not address the		conduct random audits		
	inappropriate prog	ram on the television.		weekly X 4 and monthly X 2		
	Desinban imu with l	the LNA on 2/3/20 at 11:10 PM.		to ensure LNAs have completed		
		e television is usually set on		the mandatory annual dementia		
		that the program on was not		in servicing. The Administrator w		
	appropriate for res	idents who have dementia.		randomly audit the activities		
		at staff do come in and give		and calendar to ensure provision		
	alone in the room.	ities to do, but they are left		of dementia specific activities	• D	
		over the three days of survey,		weekly X 4, then monthly X 2.		
		ctivities in the sunroom that				
		with dementia. There was a		The results of these audits will	31120	
		ession that included three or		be presented to the monthly		
	rour residents, and	staff handing specific or percussion instrument, or		QAPI committee to	a are pooded	
		e to one. The residents were	÷	nd determine if any further action	s ale neeveu.	

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F744 POL accepted 3124/20 SFreemanRal I'me

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PRINTED: 02/21/2020 FORM APPROVED

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				atë survey Impleted
		475037	8. WING		0	2/05/2020
	PROVIDER OR SUPPLIER	AND REHAB LLC		STREET ADDRESS, CITY, STATE, 378 PROSPECT STREET BARRE, VT 05641	ZIP CODE	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES WUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION	ID PREFI TAG	PROVIDER'S PLAN OF X (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE	(25) Completion Date
F 744	often just sleeping i	ge 19 n the sunroom, and there was nteraction that engaged them	F 7			
	in any way. Some c on that unit were at dining room, but ma	of the residents with dementia tending the main activity in the any residents were seen in y, or sitting around with		1		
	minimal stimulation any way. The forme the Social Services	from staff to engage them in er Activity Director, who is now director, stated that they had maste room, and expand the				
	activity program to i	include more activities for the entia, but that it was a work in				
	six Licensed Nursin received any deme 2019. The facility lis	ff training records, four out of og Assistants (LNAs) had not ntia management training in st of education topics lists this nual inservice topic for all				
	LNAs. This was cor Nursing on 2/5/2020 Per interview with L s/he stated that der	firmed by the Director of		F947 LNA's #2, #3, #4 and #5 completed their 12 ho		ν
	CFŔ(s): 483.95(g)(F 9	47 of in servicing and the dementia specific in se	ervicing.	
	§483.95(g) Require aides. In-service training n	d in-service training for nurse		An audit was complete records to evaluate co of the mandatory ann	mpletion ual 12	2
		ufficient to ensure the nce of nurse aides, but must hours per year.		hours of in servicing al dementia specific in se The Staff Development has implemented a pla	ervicing. t nurse	
		de dementía management I abuse prevention training.		all LNA's receive the m annual 12 hours of in s and dementia in servic	nandatory ervicing	

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CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED:	02/21/2	020
FORM	APPROV	ED
CHAR NO	0000 0	h.A.

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION A. BUILDING	(X3) DATE SURVEY COMPLETED
		475037	B. WING	02/05/2020
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY STATE, ZIP COL 378 PROSPECT STREET BARRE, VT 05641	E
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES IY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORR PREFIX JEACH CORRECTIVE ACTION SI TAG CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE COMPLETION
F 947	determined in nurs and facility assess address the specia determined by the §483.95(g)(4) For to individuals with address the care of This REQUIREME by: Per record review failed to ensure tha (LNAs) received in hours per year, inc and resident abuse staff reviewed. Find LNA #1's inservice documentation of 8 was no evidence th on the topics of de and resident abuse LNA #2's inservice documentation of 1 There is no docum management traini LNA #3's inservice documentation of 9 LNA #4's record ha of inservice educat dementia manager prevention training LNA#5's record ha	ress areas of weakness as se aides' performance reviews ment at § 483.70(e) and may al needs of residents as facility staff. nurse aides providing services cognitive impairments, also if the cognitively impaired. NT is not met as evidenced and staff interview, the facility at Licensed Nursing Assistants service education of at least 12 luded dementia care training, e prevention training for 5 of 6 dings include: record for 2019 showed 3.25 hrs of education. There hat this LNA received education mentia management training e prevention training. record for 2019 has 1 hours of inservice education. entation of dementia ng. record for 2019 has 5 hours of inservice training. s documentation of 3.25 hours ion. No documentation of nent training or resident abuse	F 947 The Staff Development nurse has been in serviced regardin the mandatory 12 hours of in servicing and dementia in servicing requirement for The DNS or designee will conduct random audits weekly X 4 and monthly X 2 to ensure LNAs have complet he mandatory annual 12 hou of in servicing and dementia in servicing. The results of t audits will be presented to monthly QAPI committee to review and determine if am further actions are needed. F 947 Poc accepted 3/24/20	ng LNAs. eted t urs hese the o 7 3. 17.20

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER		CONSTRUCTION	(X3) DATE SURVEY
			A. SUILDING		COMPLETED
		475037	B. WING		02/05/2020
	PROVIDER OR SUPPLIE GARDENS NURSING	R G AND REHAB LLC	378	REET ADDRESS, CITY, STATE, ZIP CODE 9 PROSPECT STREET 9.RRE, VT 05641	
(X4) IO PREFIX TAG	(ÉÁCH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE COMPLETION
F 947	Continued From p	bage 21	F 947		
*	management trair inservices.	ning as part of their education	E C		,
	s/he alended part training, but didn't	an LNA on 2/4/20 at 1:33 PM one of a four part dementia get to go to the other three e was working on the floor.			
÷	Per interview on 2 Director of Nursin education records had not met the 1 education, and the	V5/2020 at 11:45 AM, the g confirmed that the inservice showed that some of the LNAs 2 hour per year of inservice at some of the required areas of			
	education were al	so not met.		а.	
			21 11		
		r.		÷	
				π.	

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TATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION	(X1) PROVIDER/SUPFLIER/CU IDENTIFICATION NUMBER		PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	475037	B. WING		02/05/2020
AME OF PROVIDER OR SUPP		EET ADDRESS, CITY		
ARRE GARDENS NURS	ING AND REHABILIC	RRE, VT 05641		1
PREFIX (EACH DEFIC	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION	id Prefix Tag	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE / DEFICIENCY)	SHOULD BE COMPLET
S 000 Initial commen	'S	\$ 000	2	
completed on 2 Licensing and i the Vermont Li	rse of a recertification survey, 23/20 - 2/5/20 by the Division Protection, the following violat censing and Operating Rules a was identified.	of ion of		
S321 7.13 (d)(2) QUA SS=E LEVELS	ALITY OF CARE - STAFFING	\$321	S321 The facility has filled open positions to ensure sufficie	nt LNA staff.
information to t	facility shall provide staffing he licensing agency in a mani ule prescribed by the licensin		All residents are at risk to b by this alleged deficient pu These residents will have LNA minimum staffing lev An audit has been conduct	e affected ractice. the rels met. ted
by: Based on recor facility failed to for Licensed No	MENT is not met as evidence d review and staff interview, t meet the minimum staffing le irsing Assistants (LNA) of 2 h ident. Findings include:	he (the current schedule to e sufficient daily LNA staffin The DNS, Administrator, a scheduler were inserviced requirements regarding sufficient LNA staffing.	ng. Ind the
weeks reviewed	th of January 2020, there wer I that did not meet the 2 hour t staffing ratios for LNAs.		The DNS or designee will conduct random schedule audits to ensure sufficient	
January 6, 2020	wed of December 31, 2019 to), the average daily hours of L averaged 1.91 hrs per reside	NA	staffing requirements are place. These audits will be conducted weekly x4 and then monthly x2 or until	e
	0th, 2020, the average LNA h s of LNA per resident per day.		substantial compliance h been achieved. The resu of these audits will be pre-	its
LNA hours were	Jan. 27th, 2020, the average (1.94 hours per day per resid		to the monthly QAPI com to review and determine further actions are neede	ifany a in To
Per Interview or on of Licensing and Protecti	1 2/5/2020 at 11:29 AM, the			

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ATEMENT OF DEFICIENCIES ID PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A BUILDING:		(X3) DATE SURVEY COMPLETED	
	475037	6. WING		02/05/2020	
ME OF PROVIDER OR SUPPLIER	AND REHABLIC 378 PRC	DORESS, CITY, S SPECT STREI VT 05641			
REFIX (EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE COMPLETE HE APPROPRIATE DATE	
	confirmed that the averaged ks did not meet the state	\$321			
100 1				· .	
		(а — э		
	6				
		-			
n of Licensing and Protection				· · · · · · · · · · · · · · · · · · ·	

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