VERMONT

Department of Disabilities, Aging and Independent Living
Division of Licensing and Protection
280 State Drive/HC 2 South
Waterbury, VT 05671-2060
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AGENCY OF HUMAN SERVICES

January 12, 2026

Ms. Amanda Moxley, Administrator
Barre Gardens Nursing and Rehab, LLC
378 Prospect Street
Barre, VT 05641

Provider ID #: 475037

Dear Ms. Moxley:

Enclosed is a copy of your acceptable plans of correction for the complaint investigation conducted on **November 13, 2025.** 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, BS
Assistant Division Director
State Survey Agency Director

Enclosure

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 475037	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 11/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Barre Gardens Nursing and Rehab, LLC	378 Prospect Street , Barre, Vermont, 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
F0000	INITIAL COMMENTS The Division of Licensing and Protection conducted an unannounced, onsite investigation of 2 complaints #2657562 and #2657472 on 11/4/25 to determine compliance with 42 CFR Part 483 requirements for Long Term Care Facilities. During the complaint survey, the survey team identified substandard quality of care as a result of a violation at F584; safe, clean, comfortable, homelike environment. An onsite extended survey was conducted on 11/13/25. The following regulatory deficiencies were identified.	F0000	The filing of this plan of correction does not constitute an admission of allegations set forth in the statement of deficiencies. Barre Gardens has prepared and executed a plan of correction as evidence of the facility's continued compliance with applicable law.	
F0550 SS = D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States.	F0550	Resident #4 continues to reside at the facility and had no ill effects from this alleged deficient practice. All residents who reside in the facility are at risk for the alleged deficient practice. A house wide audit will be conducted on all residents care planned to receive feeding assistance to ensure staff are sitting at eye level with them while assisting with eating. All licensed nurses and LNAs will be educated on residents' rights, specifically surrounding sitting at eye level with the resident while assisting them with eating. The administrator or designee will conduct random weekly audits X 4 and monthly X 2 to ensure staff are sitting at eye level with residents while they assist them with eating. The audit results will be reviewed at QAPI for further interventions. Date of compliance: December 28, 2025	

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 reverse for further 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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Amanda Cuplay	LNHA	12/19/2025

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F0550 SS = D	Continued from page 1 §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is NOT MET as evidenced by: Based on record review and interview it was determined that the facility failed to treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of her/his quality of life, recognizing each resident's individuality for 1 resident in a sample of 9 residents. (Resident #4). Findings include: Per record review, Resident #4 has diagnoses that include Alzheimer's disease, dementia, bipolar disease, schizophrenia, and need for assistance with personal care. Per Resident #4's care plan, revised 11/4/25, "EATING: [She/he] requires extensive assist from staff participation to eat. Staff please encourage resident to open hand to engage in self-feeding and holding cup during meals." On 11/4/25 at 12:55 PM, an observation was conducted of Resident #4 during lunch. An LNA (licensed nursing assistant) was observed assisting the resident with eating. She/he was standing next to resident and leaning over to place the food in the resident's mouth. The LNA repeated the process of standing next to the resident and assisting with feeding. On 11/4/25 at 12:57 PM, an interview was conducted with the LNA. She/he was asked if they should be sitting at eye level with the resident. She/he stated, "I choose not to do that." Upon further inquiry about facility practice with regard to sitting next to residents while assisting in eating, She/he responded, 'I don't do that." Facility policy titled "Resident Rights," revised June 2023, states that "Federal and state laws guarantee basic rights to all residents of this facility." Those	F0550	**Tag F 550 POC accepted on 1/12/26 by J. Kendall/S. Stem**	

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F0550 SS = D	Continued from page 2 rights include the right to a dignified existence and to be treated with respect, kindness and dignity. On 11/4/25 at 2:45 PM, an interview was conducted with the Administrator. They confirmed that facility practice is to sit at eye level with a resident while assisting them with eating, and that this was communicated to staff when they go through orientation.	F0550		
F0584 SS = SQC-F	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas;	F0584	All residents who reside in the facility are at risk for this alleged deficient practice. A house wide audit will be conducted to ensure compliance with the following alleged deficiencies: 1) Shower rooms are kept clean and orderly. The walls and floors located in the shower rooms are free from jagged metal and broken tiles. 2) All communal dining areas are cleaned prior to every meal. 3) All light cords are long enough for residents to safely reach. 4) All fans located on the units and in resident rooms are free of dust and debris. 5) All doors are free of splinters and have all hinges securely attached. 6) All overbed tables are free from foreign substances. 7) All privacy curtains are free from stains and tears. 8) All pillows are free from tears. 9) All stained/frayed fabric furniture is cleaned and/or replaced. 10) All existing chair rails strips are fully attached to the wall.	

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F0584 SS = SQC-F	Continued from page 3 §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is NOT MET as evidenced by: Based upon observation, interview, and record review, the facility failed to ensure that areas used for bathing/showering, resident rooms, and a resident gathering area were clean, safe, and homelike. This deficient practice has the potential to affect all residents residing in the facility. This is a repeat deficiency for this facility, with the violation cited during the previous two recertification surveys, dated 6/25/25 and 5/9/24, and partial survey dated 4/17/25. Findings include: During the initial tour of the facility on 11/4/25 at approximately 10:40 AM the following observations were made: Wing 1 short hall, room #156 and room #157 appeared dirty with loose debris on the floor. At the end of Wing 1 short hall there was a room that contained a tub room, a bathroom, and a shower room. The tub room revealed a tub chair that had a loose white powdery substance on the seat and the foot pedals had a thick white and gray substance within the pattern of both foot pedals. The shower room area contained a rolling cart with the top shelf containing 3 bottles of hair conditioner, 2 bottles of shampoo, a bottle of body wash, a bottle of quaternary ammonium chloride disinfectant cleaner (a concentrated cleaning formula use to cut cleaning time and quickly wipe out a broad spectrum of bacteria, like viruses and fungi) and a handful of unboxed gloves. The second shelf on this rolling cart contained 2 boxes of gloves and 4 razors. The shower room revealed a lift bar/rail with a disposable rubber glove tied to the rail. The corner bead (a protective strip, typically made of vinyl or metal, that is installed on outside corners where two pieces of drywall meet to reinforce and protect the corner) going into the shower room revealed broken, rusted, and jagged metal. Many broken floor and wall tiles were noted throughout this area between the shower room, the tub room, and the bathroom.	F0584	11) All resident rooms and communal areas are clean and free from crumbs, clumps of hair, spills, etc. All staff will be educated on residents' rights to a safe, clean, comfortable, and homelike environment, as well as the importance of reporting and fixing environmental issues as they occur. The following corrective actions will occur to ensure compliance: 1) Housekeeping will clean both shower rooms on a daily basis and nursing staff will be responsible for cleaning/picking up after each shower given. Maintenance will remove all jagged metal pieces, and all broken tiles will be filled or replaced. 2) Housekeeping will implement a cleaning schedule to ensure all communal dining areas are cleaned prior to each meal. 3) All light cords will be long enough for residents to reach safely. 4) All fans located on the units and in resident rooms will be cleaned of dust and debris. 5) All doors with splinters will be smoothed out and all loose hinges will be tightened or replaced. 6) All overbed tables will be cleaned on a daily basis by housekeeping. Nursing staff will clean on an as needed basis. 7) All privacy curtains that have stains or tears will be thrown away and replaced. 8) All pillows that are torn will be thrown away and replaced.	

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F0584 SS = SQC-F	Continued from page 4 Per interview on 11/4/25 at approximately 10:55 AM with the travel LPN #1, they confirmed the noted concerns listed above. Observation on 11/4/25 at approximately 11:05 AM of the Sun Room on Wing 1 revealed trash cans without trash bags inside; a coffee carafe that was dirty with a brown substance on all sides; a drawor within a cabinet that contained packets of condiments noted to have what appeared to be food debris throughout the drawer and a puddle of a brown sticky substance; a chair with fabric back, armrests and seat that had a dried reddish brown substance in droplet form on the seat that was still accessible for use; a yellow substance that appeared to be scrambled eggs under a table and on the windowsill next to the table; a pillow without a pillow case on the steam table; the floors appeared dirty with spills and debris; and a cooler of ice with a gray coffee cup sitting on a cart next to the and the inside of the cooler cover was dirty. Outside the sunroom was a small area with a counter and a fridge. Upon the counter was a blue tray with partially eaten breakfast foods, coffee cups, and miscellaneous silverware. Per interview on 11/4/25 at approximately 11:30 PM with the travel LPN #1, they confirmed the above noted concerns. S/he stated that this sunroom is used as a dining area and housekeeping does not have enough staff. S/he stated, "if I knew where they kept the brooms and mops, I could help when I had some time to do so." S/he confirmed that the tray with various partially eaten breakfast foods was there from breakfast and had to be taken down to the kitchen or they may wait until the next meal and send it back to the kitchen on one of the carts. Observation on Wing 1 of the nurse's station revealed a thick pile of crumbs/debris in front of the nurse's station that went the length of the nurses' station. Interview on 11/4/25 at approximately 11:50 AM with the travel LPN #1, they confirmed that these were cookie crumbs and that staff will give the residents cookies when they are sitting out in this area. S/he was asked about housekeeping staff, and s/he responded that s/he is aware that there are not enough housekeeping staff to keep the area clean and neat. Observation on 11/4/25 at approximately 12:10 PM	F0584	9) All stained/frayed fabric furniture will be cleaned and/or replaced. 10) All existing chair rails strips that are not fully attached to the wall will be reattached and/or removed. 11) Housekeeping will implement a deep clean schedule of all resident rooms and communal areas. The administrator or designee will conduct random weekly audits X 4 and monthly X 2 to ensure all alleged deficiencies listed above have been addressed and corrected. The audit results will be reviewed at QAPI for further interventions. Date of compliance: December 28, 2025 Since the November 13th survey, the facility has successfully hired enough housekeepers to fully staff the department. The facility is keeping all housekeeping and laundry reqs open in the event of staff turnover. **Tag F 584 POC accepted on 1/12/26 by J. Kendall/S. Stem**	

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F0584 SS = SQC-F	Continued from page 5 residents were being brought to the sunroom for their lunch meal. The room had not been cleaned prior to the residents arriving to the sunroom for this meal. On 11/4/25 at approximately 12:20 PM the physician was asked about the poor conditions and how dirty the facility currently is, and s/he explained that s/he will be addressing that in her/his 6-month plan. S/he was asked for a copy of the 6-month plan and s/he stated, "it's in draft form at this point." The physician confirmed that the facility was dirty and stated, "yes, the residents here do have a right to live in a clean facility." S/he was asked if s/he considered the facility "clean enough" for the residents that lived there and s/he stated, "no, it needs to be better". Observation on 11/4/25 at approximately 12:45 PM of Wing 1 Long Hall revealed room #162 with dirty floors, the overbed lights had 2 inch pull chords (used to turn the light on), a fan with a thick coat of dust on the back and front fan piece, the bathroom exhaust fan covered in a thick coat of dust, and cobwebs in all 4 corners of the bathroom. Observation on 11/4/25 at approximately 12:50 PM of room #163, the door to the room was broken at the hinge and revealed splintered wood fragments, there was a used blood glucose test strip on the floor, the overbed table by the door bed was covered on the wheels and metal support with a thick dried white milky type substance, the privacy curtains had a dried brown substance on the outer edge and about 2 feet in from the outer edge, the overbed lights for both beds only had a 2 inch pull chord, and there was an uncovered pillow on the bed next to the window with its plastic cover torn in many areas revealing the pillows contents. Observation on 11/4/25 between 1 PM and 1:20 PM of rooms 165 through 176 revealed various housekeeping issues specific to the cleanliness of each room. Floors were dirty, a lot of various types of debris were noted, bathroom fans were noted to be covered with thick dust, toilets were dirty and not clean inside or out or the floor around the toilets. Review of the housekeeping schedule from 11/9/25 to 11/15/25 revealed the following: 11/9/25 - 8 hours of housekeeping (1 staff); 11/10/25 - 13 hours between 2 staff; 11/1/25 - 8 hours (1 staff); 11/12/25 - 7 hours	F0584		

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F0584 SS = SQC-F	Continued from page 6 (staff orientee and no other staff listed to orient this new staff); 11/13/25 - 10 hours (1 staff); 11/14/25 - 7 hours (staff orientee and no other staff listed to orient this new staff); 11/15/25 - 7 hours (staff orientee and no other staff listed to orient this new staff). Per interview on 11/4/25 at approximately 3 PM with the Administrator, s/he confirmed that they did not have many housekeeping staff, 2 had recently walked out, and both the maintenance director and assistant maintenance director had left employment at this facility. S/he confirmed that the facility was not clean and that there was not enough housekeeping staff to clean the facility or maintain the facility at this time. 2. During the initial tour of the facility on 11/13/25 at approximately 10:00 AM the following observations were made: · Wing 2 Long Hall, there was a trail of liquid down the hallway, and debris on the floor by the medication cart. Wing 2 Showers in the bathroom, the toilet safety bar was noted to have paper tape covering two holes. Light-colored caulk between tiles on both floors and walls was noted to have a buildup of black debris, which appears to be mold and mildew. A shower chair had a pinkish-orange buildup of debris at the connections. There was debris behind the doors, including spider webs and rust on the doorframes, with holes where the frames met the floors. The room with the bathtub had a Hoyer lift and cardboard boxes being stored in it. · Wing 2 Short Hall, Resident room #116 revealed a strip of plastic-like material approximately 4-6 inches wide at chair rail level, which runs the full length of the right-hand side of the Residents' room. The strip was falling off the wall. In one of the alcoves, a dirty spoon was on the seat of a wheelchair · In the Crossover area, a chair was noted to have worn off vinyl on both arms. · Wing 1 Showers, the shower floors and walls had dark debris, which appeared to be mold and mildew, and there was a breach in the tile wall on the corner. The ceiling vent had a buildup of dust. The doorframe metal had a hole at the base, and debris is visible behind the door. There was yellow colored debris on the shower chair. In the bathroom, the call bell pull is a shoelace covered with paper tape, and the end has the shoelace material exposed. · In the whirlpool room, there was a sticker, and a	F0584		

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F0584 SS = SQC-F	Continued from page 7 medication cup with white powder was located on the frame of the bathtub. Hair is in the wheels of a bath chair, and two black bundles of unknown substance were on the floor under the chair. There is a box of gloves on the floor, and a Broda chair (a type of wheelchair) with a resident gown. The bathtub chair foot supports have a white residue, and there is a walker with a used bedsheet. A chair located in the corner had used resident socks. Debris and a brown, dried liquid were noted in the whirlpool. Per interview on 11/13/25 at 3:00 PM, the Infection Prevention staff member confirmed housekeeping concerns. She stated two staff members had left abruptly and the Administrator has implemented leadership members assisting the remaining housekeeping staff with their duties by selecting five resident rooms weekly to clean. Per interview on 11/13/25 at 3:50 PM, the Administrator confirmed housekeeping staffing to be inadequate, and the leadership team is assisting the department with cleaning. When asked if there were education or audits for cleaning, she stated, "all had to do it before." 3. During the initial tour of the facility on 11/13/25 at approximately 10:00 AM the following observations were made: In room 105 a trail of crumbs were on the floor, with a small partially crushed plastic cup. There was a trail of visible black residue on the floor from the doorway and extended approximately two feet out of the room In between room 109 and room 111 an alcohol wipe package was observed on the floor with a red piece of plastic and a white piece of plastic lying beside it In room 112 there were orange crumbs observed by the bottom of the bed Outside of room 114 there was a rubber band on the floor and a small piece of paper In room 116, the brown bumper guard against the wall was falling off the wall and was observed partially on the empty bed There was a clump of hair observed at the nurse's station by room 116 A dead brown, multilegged insect was observed on the floor and a partial footprint was noted adjacent to the	F0584		

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F0584 SS = SQC-F	Continued from page 8 Insect The entrance to room 118 at the base on the doorframe was black and grey with residue on the floor, visible footprints and black and grey marks that appeared to be from shoes observed in the room and immediately outside of the room Outside room 118, immediately to the left, were brown stains extending down from the wall below the handrail. Additionally, there was a cluster of hair against the exterior frame of the door Between room 117-119 two clumps of hair observed on the floor Room 119 had black residue coming off the floor to the left and right of the doorframe Room 122 had crumbs below the two dressers with one piece of paper balled up in front of the trash can near the door Room 124 had visible brown and black matter on the floor that appears to be dirt The sunroom (near room 125) had a clump of hair on the floor by the door. Next to the windows facing a small green yard, there was multiple brown clumps and crumbs on the floor. Additionally, the resident bedside table by the windows had brown matter on it. Opposing the windows facing the green yard, on the other side of the room, there was a rubber band on the floor. Outside room 176, to the left of the exterior door frame, below the handrail, there was a circular blob of a white and grey substance. There was one primary circular blob of this substance with two smaller circles of white and grey matter immediately next to it. Three circular like blobs of an unknown substance in total. In the shower room there was hair observed on the floor, brown residue smeared onto the wall, and brown residue on the shower chair. Additionally, hair was observed in the shower drain and there was a large amount of a brown smelly substance in the toilet that had not been flushed, on the seat of this toilet, there was also a brown residue. The shower wall had specks of black and grey on the tile and wall and the shower vent was covered in a thick white and grey substance.	F0584		
F0687 SS = D	Foot Care	F0687		

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F0687 SS = D	Continued from page 9 CFR(s): 483.25(b)(2)(i)(ii) §483.25(b)(2) Foot care. To ensure that residents receive proper treatment and care to maintain mobility and good foot health, the facility must: (i) Provide foot care and treatment, in accordance with professional standards of practice, including to prevent complications from the resident's medical condition(s) and (ii) If necessary, assist the resident in making appointments with a qualified person, and arranging for transportation to and from such appointments. This REQUIREMENT is NOT MET as evidenced by: Based on observation, staff interview, and record review the facility failed to ensure that 1 resident in the applicable sample (Resident #6) received proper foot care. Findings include: Per observation on 11/13/25 at 10:21 AM, Resident #6 was sitting barefoot at the edge of the bed with his/her feet on the floor. Resident #6's feet appeared to be dry and had long discolored toenails that were thick. Per interview with Resident #6 on 11/13/25 at 10:21 AM, they reported that their toenails are very long and that it is an issue, they haven't had their nails trimmed in a long time or seen a podiatrist. Per record review of Resident #6's care plan dated 9/19/25, s/he is care planned for skin breakdown due to impaired mobility, DM (Diabetes Mellitus), and peripheral vascular disease. Interventions include Podiatry consult as needed with a date of 3/8/23. The care plan also identifies that the resident has an ADL (activities of daily living) self-care performance deficient and requires assistance with personal hygiene, dated 3/8/23. Per review of the facilities policy titled "Fingernails/Toenails, Care of" with a revision date of 2/18, it states that the "purpose of this procedure is to clean the nail bed, to keep nails trimmed, and to prevent infections... Nail care includes daily cleaning and regular trimming."	F0687	Resident #6 continues to reside at the facility and had no ill effects from this alleged deficient practice. All residents who reside in the facility are at risk for the alleged deficient practice. A house wide audit will be conducted on all residents to ensure their toenails are trimmed. All licensed nurses and LNAs will be educated on ensuring resident toenails receive regular trimming. The DON or designee will conduct random weekly audits X 4 and monthly X 2 to ensure resident toenails are receiving regular trimming. The audit results will be reviewed at QAPI for further interventions. Date of completion: December 28, 2025 **Tag F 687 POC accepted on 1/12/26 by J. Kendall/S. Stem**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 475037	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 11/13/2025

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F0687 SS = D	Continued from page 10 Per interview with the Physician on 11/13/25 at 3:30 PM, he reported that he is having to triage work and is prioritizing the most urgent visits as there is only one provider for the residents. He reported that he hasn't time to do anything except for "crisis management." Per interview with the Administer and Director of Nursing (DON) on 11/13/25 at 6:17 PM, they reported they don't have a podiatrist here and that the provider trims nails in house. Per interview with a Register Nurse (RN) on 11/13/25 at 6:29 PM, she confirmed that Resident #6's toenails were long and should be trimmed.	F0687		
F0712 SS = E	Physician Visits-Frequency/Timeliness/Alt NPP CFR(s): 483.30(c)(1)-(4) §483.30(c) Frequency of physician visits §483.30(c)(1) The residents must be seen by a physician at least once every 30 days for the first 90 days after admission, and at least once every 60 thereafter. §483.30(c)(2) A physician visit is considered timely if it occurs not later than 10 days after the date the visit was required. §483.30(c)(3) Except as provided in paragraphs (c)(4) and (f) of this section, all required physician visits must be made by the physician personally. §483.30(c)(4) At the option of the physician, required visits in SNFs, after the initial visit, may alternate between personal visits by the physician and visits by a physician assistant, nurse practitioner or clinical nurse specialist in accordance with paragraph (e) of this section. This REQUIREMENT is NOT MET as evidenced by: Based on record review and interview, it was determined that the facility failed to ensure physician visits occurred every 30 days for the first 90 days after admission, and at least once every 60 thereafter for 12 of 25 residents (Resident # 1, 2, 3, 6, 7, 8, 11, 12, 13, 15, 16, and 17). Findings include: Per review of the facility policy titled "Physician	F0712	Residents #1, #2, #3, #6, #7, #8, #11, #12, #13, #16, and #17 all continue to reside at the facility and had no ill effects from this alleged deficient practice. All residents who reside in the facility are at risk for the alleged deficient practice. A house wide audit will be conducted to ensure all new admissions receive a regulatory visit every 30-days for the first 90-days after admission. The physician will complete their first regulatory visit within 30-days of admission. A second house wide audit will be conducted to ensure all residents have a regulatory visit every 60-days after their initial 90-days. These visits may alternate between physician and midlevel. Any resident affected will have an updated regulatory visit to review plan of care. Medical director, physician and NP will be educated on policy surrounding regulatory visits. The DON or designee will conduct random weekly audits X 4 and monthly X 2 to ensure regulatory visits are tracked, completed, and that substantial compliance is maintained.	

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F0712 SS = E	Continued from page 11 Services" dated 2/21, it states that "the medical care of each resident is supervised by a licensed physician and that ""supervising the medical care of residents includes... conducting routine required visits...Physician visits, frequency of visits, emergency care of residents, etc., are provided in accordance with current OBRA regulations and facility policy..." 1.Review of Resident #6's medical record shows that Resident #6 has not had a regulatory visit since 8/7/25, which was with a Nurse Practitioner (NP), and as of 11/13/25 did not have a regulatory visit within sixty days with a Physician. 2.Review of Resident #7's Physician visits revealed that Resident #7 was admitted on 12/17/24 and had their initial visit with a NP on 1/24/25 and then only had visits with a NP up until 10/23/25 with the current Physician, which was not a regulatory visit. 3. Review of Resident #8's Physician visits revealed that their last regulatory visit was on 5/30/25, with a Physician's Assistant (PA), and there was no in-person visit with a Physician until 10/16/25, which was not a regulatory visit. Resident #8 has not had a regulatory visit since 5/30/25. Per interview with the Medical Director on 11/13/25 at approximately 2:15 PM, he reported that he's aware that the regulatory visits are well behind and that the onsite Physician is trying to catch up stating there is "no excuse it has to be done." Per interview with the facilities Physician on 11/13/25 at 3:30 PM, he reported that he is behind on regulatory visits. The Physician stated that he "inherited an absolute just medical disaster here" and that he hasn't had time to do anything except for "crisis management". He reported that he has a choice of seeing a sick patient like someone with covid, an urgent medical need, or a regulatory visit, he is going to take care of the sick patients. The Physician also stated he has a list of residents that he knows need to be seen for their regulatory visits. The Physician also stated that they had a Nurse Practitioner (NP) but that they only lasted a week, but they have a new NP starting on Monday, 11/17/25. He reported his plan is to start doing regulatory visits once the NP starts, and that he has a list of residents who need to be seen. He also reported that he does not count acute care visits as regulatory visits, as regulatory visits are much more comprehensive than acute care visits, so that if it doesn't say regulatory visit, then he has not completed a regulatory visit for that resident. The Physician	F0712	The audit results will be reviewed at QAPI for further interventions. Date of completion: December 28, 2025 **Tag F 712 POC accepted on 1/12/26 by J. Kendall/S. Stem**	

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F0712 SS = E	Continued from page 12 would not speak to if regulatory visits were performed prior to him being there, but he did confirm that Resident #7 needs a regulatory visit and has not had one yet, that Resident #8 needs a regulatory visit and he has not done one yet, and that for Resident #6 he has not done a regulatory visit and needs one, and he also confirmed the facilities policy states one of his responsibilities as a physician is "supervising the medical care of residents includes... conducting routine required visits". 4. Review of Resident #2's Physician visits revealed that they were admitted on 4/9/25 and they did not receive an in-person regulatory visit with a Physician by 5/19/25. 5. Review of Resident #3's Physician visits revealed that their last regulatory visit was on 6/13/25 with a Physicians Assistant (PA) and there was no in-person regulatory visit with a Physician by 9/23/25. 6. Review of Resident #1's medical record shows that Resident #1 was admitted on 7/18/25 and her/his first regulatory visit was on 10/28/25 which does not meet the regulatory requirement of this regulation. 7. Review of Resident #11's Physician visits revealed that Resident #11 was admitted on 7/23/25 and had their initial physician visit on 11/13/25, which does not meet the regulatory requirement of this regulation. 8. Review of Resident #12's Physician visits revealed that Resident #12 was admitted on 5/16/25 and had their initial physician visit on 11/13/25, which does not meet the regulatory requirement of this regulation. 9. Review of Resident #13's Physician visits revealed that Resident #13 was admitted on 7/15/25 and had their initial physician visit on 11/10/25, which does not meet the regulatory requirement of this regulation. 10. Review of Resident #15's Physician visits revealed that Resident #15 was admitted on 5/5/25 and had their initial physician visit on 11/4/25, which does not meet the regulatory requirement of this regulation. 11. Review of Resident #16's Physician visits revealed that Resident #16 was admitted on 5/27/25 and had their initial physician visit on 9/23/25, which does not meet the regulatory requirement of this regulation. 12. Review of Resident #17's Physician visits revealed that Resident #17 was admitted on 6/6/25 and had their initial physician visit on 8/25/25, which does not meet	F0712		

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F0712 SS = E	Continued from page 13 the regulatory requirement of this regulation. Per interview on 11/13/25 at approximately 11:45 AM, the facility Physician confirmed that regulatory visits had not been completed timely and that s/he was working on getting them caught up. S/he stated that a new PA would be starting "next week on Monday" and this would help her/him stay caught up on visits. Per interview on 11/13/25 at approximately 2:00 PM, the Medical Director confirmed that s/he was aware that regulatory visits were behind and that the facility physician was working to get them all caught up. S/he stated they were working on the process and considering getting a tracking tool/system for regulatory visits but at this time had not secured any type of system for doing this. S/he stated, "There is no excuse for these visits to not have been completed on time."	F0712		
F0744 SS = D	Treatment/Service for Dementia 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, mental, and psychosocial well-being. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and record review, the facility failed to implement interventions to address the residents' dementia care needs for 1 of 1 residents (Resident #10). Findings include: Per an observation on 11/13/25 at 6:43 PM at a nurse's station, Resident #10 was asking to call his/her family member. A Licensed Practical Nurse (LPN) was observed telling Resident #10 that she couldn't call his/her family member because they had died. Upon hearing this, Resident #10 got visibly upset and again asked for the LPN to call Resident #10 's family member and called the LPN a liar. The phone started ringing and Resident #10 was asking for them to pick it up saying it might be their family member, and the nurse was dismissive towards the Resident saying that it couldn't be. At 6:45 PM, the Resident #10 again asked to call the family member to which the LPN again stated that they had passed and that "we told you this months ago, but you keep on forgetting". Resident #10 then stated that they were going to try and walk home and hoped they	F0744	Resident #10 continues to reside at the facility and had no ill effects from this alleged deficient practice. All residents who reside in the facility are at risk for the alleged deficient practice. All licensed nurses and LNAs will be educated to follow the interventions listed in a resident's care plan when a resident is expressing anxiety and/or grief. The DON or designee will monitor weekly X 4 and monthly X 2 for residents who express anxiety and/or grief to ensure their care plan interventions are being followed. The audit results will be reviewed at QAPI for further interventions. Date of completion: December 28, 2025 **Tag F 744 POC accepted on 1/12/26 by J. Kendall/S. Stem**	

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F0744 SS = D	Continued from page 14 would be killed. Per interview with the LPN on 11/13/25 at 6:48 PM, when asked how she redirects Resident #10 when s/he forgets that their family member has died, the LPN reported that sometimes we say maybe later, sometimes we tell her the truth, and that the Resident #10 calls us liars when we tell him/her that their family member is dead. The LPN also reported Resident #10 has dementia and s/he "just gets like this sometimes". The LPN confirmed that each time she reminded Resident #10 that the family member had died, that Resident #10 became visibly upset. Per record review of Resident #10 medical diagnosis on 11/13/25, s/he has a diagnosis of Alzheimer's disease, adjustment disorder with anxiety, and depression. Per review of a progress note dated 10/22/25, the resident was informed by their family of a family member's death. The Resident's progress notes from 10/23/25 to 11/13/25 document that the Resident was reminded by staff of his/her family member's death on seven different documented occasions since 10/23/25, with resulting behaviors of yelling, crying, wandering, and exist seeking. Per Review of the Resident #10 care plan, it revealed they are care planned for a family member's death on 10/22/25 with interventions of assisting the resident with their grief to help the resident identify care needs, encourage the resident to express feelings of anger and concern, encourage the resident to recognize grief situation, observe for contributing factors that may delay the grief process, assist the resident to identify, access and use support systems, for consults to be placed to pastoral care, social services, home health, psychiatry as needed, describe to the resident the stages and how to identify grief, and to assist the resident with problem solving. The Resident #10 is also care planned for dementia, for which interventions include allowing the resident time to talk and express feelings. An intervention related to the Resident #10's anxiety and trauma is to engage the resident in "conversations that will help them to remain calm". The observation on 11/13/25 did not demonstrate that care plan interventions were being utilized for this resident regarding assisting with grief, allowing time to talk and express feelings, or engaging the resident in conversation to help them remain calm.	F0744		
F0761 SS = D	Label/Store Drugs and Biologicals	F0761		

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F0761 SS = D	Continued from page 15 CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is NOT MET as evidenced by: Based on observation and interview, the facility failed to ensure only authorized personnel had access to the medication storage rooms. This is a repeat deficiency for this facility, with the violation cited during the previous recertification surveys, dated 6/25/25. Findings include: Per observation on 11/4/25 at 12:45 PM, a pharmacy delivery was accepted by an LPN (Licensed Practical Nurse). The delivery person and LPN went into the medication room together. The LPN emerged without the delivery person who remained alone in the medication room for approximately 5 minutes before exiting. Per interview on 11/4/25 at 1:00 PM, the LPN confirmed that the delivery person should not go into the medication room alone. The LPN confirmed that he/she was left alone in the medication room. Per interview with the Administrator on 11/4/25 at 2:45 PM, they confirmed the delivery person should not have	F0761	All licensed nurses will be educated on ensuring only authorized personnel have access to the medication storage rooms. The DON or designee will monitor weekly X 4 and monthly X 2 to ensure only authorized personnel have access to the medication storage rooms The audit results will be reviewed at QAPI for further interventions. Date of completion: December 28, 2025 **Tag F 761 POC accepted on 1/12/26 by J. Kendall/S. Stem**	

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F0761 SS = D	Continued from page 16 been in the medication room alone.	F0761		
F0812 SS = F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is NOT MET as evidenced by: Based on observation and interview, the facility failed to ensure that all food was stored safely and to ensure that sanitary conditions for safe food handling were maintained. This has the potential to impact all residents. This is a repeat deficiency for this facility, with violations cited during the previous three recertification surveys, dated 4/26/23, 5/9/24, and 6/25/25. Findings include: A kitchen tour was conducted with a Dietary Staff Member on 11/13/25 at 11:40 AM. Per observation of the dry food storage area, the following items were found improperly stored: Gluten free pasta, (1) expired June 11, 2024, (3) expired July 20, 2024; Baking mix, expired 4/24/24;	F0812	All residents who reside in the facility are at risk for the alleged deficient practice. 1) An audit will be conducted to ensure there are no expired food items located in the dry food storage area. Dietary staff will be educated on ensuring all expired food is removed from the dry food storage area. Administrator or designee will conduct random weekly audits X 4 and monthly X 2 to ensure no expired food items are located in the dry food storage area. 2) An audit will be conducted to ensure all food located in the walk-in refrigerator and walk-in freezer are being properly stored in accordance with professional standards for food service safety. Dietary staff will be educated on how to properly store food in accordance with professional standards for food service safety. Administrator or designee will conduct random weekly audits X 4 and monthly X 2 to ensure all food in the walk-in refrigerator and walk-in freezer are properly stored in accordance with professional standards for food service safety. 3) An audit will be conducted on the preparation of trays, cups and dishes to ensure wet nesting does not occur. All fans located in the kitchen will be cleaned of dust and debris.	

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F0812 SS = F	Continued from page 17 Pasta, expired May 3, 2025; Hormel Thick & Easy Clear Thickened Cranberry Juice Cocktail, dated 10/24, instructions on back of label "discard if not used within 10 days of opening;" and Hormel Thick & Easy Clear Thickened Orange Juice Cocktail, dated 10/24, instructions on back of label "discard if not used within 10 days of opening." Per interview on 11/13/25 at 11:55 AM, the Dietary Staff Member stated the above items should have been discarded and confirmed they were expired. Per observation of the walk-in refrigerator, the following item was found improperly stored: Two packages of deli ham stored on a tray with raw hamburger, sitting in raw meat juices. Per observation of the walk-in freezer, the following item was found improperly stored: A box of hamburger patties left open to air and not sealed. The Dietary Staff Member confirmed the observations in the walk-in refrigerator and freezer and stated that ready-to-eat foods should not be stored with/on/in raw meat and stated that prepared and open food containers and packages should be sealed. She/he confirmed that the above items were improperly stored. Per observation of the kitchen area the following were noted: Preparation trays, cups, and dishes were noted to be wet nesting (stored wet and not air dried). The floor fan facing the food preparation area noted to be covered with dust and debris. The Dietary Staff Member confirmed these observations.	F0812	Dietary staff will be educated on ensuring all trays, cups and dishes are dried prior to being stored, and to keep all fans located in the kitchen area free from dust and debris. Administrator or designee will conduct random weekly audits X 4 and monthly X 2 to ensure all trays, cups and dishes are dried prior to being stored, and all fans located in the kitchen area free from dust and debris. The audit results will be reviewed at QAPI for further interventions. Date of completion: December 28, 2025 The medical director will be educated on the implementation of resident care policies and the coordination of medical care within the facility. The Medical director will be responsible for overseeing all physicians who provide care to residents in the facility and ensuring they remain compliant within regulatory requirements. **Tag F 812 POC accepted on 1/12/26 by J. Kendall/S. Stem**	
F0841 SS = F	Responsibilities of Medical Director CFR(s): 483.70(g)(1)(2) §483.70(g) Medical director. §483.70(g)(1) The facility must designate a physician to serve as medical director. §483.70(g)(2) The medical director is responsible for-	F0841		

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F0841 SS = F	Continued from page 18 (i) Implementation of resident care policies; and (ii) The coordination of medical care in the facility. This REQUIREMENT is NOT MET as evidenced by: Based on interview and record review, the facility failed to ensure that the Medical Director fulfilled his/her responsibility to coordinate medical care with facility providers and assist the facility with the development and implementation of resident care policies. This deficient practice has the potential to affect all residents residing in the facility. Findings include: Per review of the facility's "Medical Director Services" policy [policy undated] on 11/13/25, "the scope of services for the Medical Director will include: -Ensuring that each resident's responsible physician attends to the resident's medical needs- -Periodic review and development of medical care policies and procedures as required to ensure compliance with Federal, State, and local laws, rules, and regulations." An interview was conducted with the facility's Medical Director on 11/13/25 at 2:02 PM. The Medical Director [MD] stated there was no system in place to monitor regulatory visits by physicians, and that they were "working on a process" regarding required regulatory visits. The MD stated, "There is no excuse, they [regulatory visits] have to be done." Further review of the "Medical Director Services" policy includes: "-Participation in policy decision-making and direct supervision regarding quality of care and delivery of medical services to residents -Performance of all necessary general administrative tasks including assigning medical duties and scheduling, and communication of this information to appropriate staff." Per interview on 11/13/25, the Medical Director [MD] stated there is no consistent or scheduled communication between medical providers regarding	F0841	The medical director will be sent a weekly correspondence from the facility as a way to communicate information regarding resident updates, staffing concerns, infection prevention issues, and any changes surrounding policies and procedures. Administrator or designee will conduct random weekly audits X 4 and monthly X 2 to ensure weekly correspondences are being sent and physicians providing care to residents remain compliant with regulatory requirements. The audit results will be reviewed at QAPI for further interventions. Date of completion: December 28, 2025 **Tag F 841 POC accepted on 1/12/26 by J. Kendall/S. Stem**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 475037	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 11/13/2025

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F0841 SS = F	Continued from page 19 facility issues or resident status. The MD stated s/he had reviewed the Facility Assessment, dated 6/5/25. Per the facility assessment, "Medical/Physician Services" list Dr. [A] and Dr. [B] as "Attending Physicians". The Medical Director stated s/he was "not familiar with those physicians." The MD stated the facility's Acting Physician [APhys] was "the eyes and ears of the facility." The MD stated "we are working on a process" regarding "reporting on a weekly basis" with [APhys] and other providers, but there was no process currently in place. Review of the "Medical Director Services" policy also includes: "-Supervision of high-level quality of care delivered to residents, with supervision exercised over medical, nursing, and pharmaceutical services." Per interview with the Medical Director [MD] the MD stated the facility's Attending Physician [APhys] notified h/her this morning [11/13/25] of a COVID outbreak in the facility. The MD stated [APhys] reported the first case was identified as "7- 10 days ago." The MD said h/her expectation was to be notified when the first case appeared. Per facility Infection Control records, the first COVID cases were identified 11 days prior on 11/2/25; one resident and one staff member. As of the day of the extended survey [11/13/25], 8 staff members and 16 residents had tested positive for COVID infection.	F0841		
F0880 SS = F	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections	F0880	All residents who reside in the facility are at risk for the alleged deficient practice. A house wide audit will be conducted to ensure all residents have been offered the up-to-date COVID-19 vaccine, and those who signed a consent to receive the vaccine have received it. Education will be provided to all licensed nurses to offer the COVID-19 vaccination to all new admissions and to re-offer the vaccine to residents who refused on a quarterly basis. The DON or designee will conduct random weekly audits X 4 and monthly X 2 to ensure all residents are offered the COVID-19 vaccine, and those who signed the consent to receive the vaccine have received it.	

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F0880 SS = F	Continued from page 20 and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (I) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.	F0880	The medical director will be sent a weekly correspondence from the facility as a way to communicate information regarding resident updates, staffing concerns, infection prevention issues, and any changes surrounding policies and procedures. A house wide audit will be conducted to ensure compliance with the following alleged deficiencies: 1) Shower rooms are kept clean and orderly. The walls and floors located in the shower rooms are free from jagged metal and broken tiles. 2) All communal dining areas are cleaned prior to every meal. 3) All coolers and areas where condiments are located are kept clean. 4) All overbed tables are free from foreign substances. 5) All privacy curtains are free from stains and tears. 6) All pillows are free from tears and when not in use, placed in clean storage. 7) Shower chairs remain clean. 8) All doorframes are intact with no holes or rust and remain free of cobwebs. 9) All resident rooms and communal areas are orderly, clean and free from crumbs, clumps of hair, spills, etc. All staff will be educated on residents' rights to a safe, clean, comfortable, and homelike environment, as well as the importance of reporting and fixing environmental issues as they occur.	

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F0880 SS = F	Continued from page 21 §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is NOT MET as evidenced by: Based on observations, record reviews, and interviews, the facility failed to provide a system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards. This has the potential to impact all residents. Findings include: A review of the facility's "Coronavirus Disease—Infection Prevention and Control Measures Policy Statement" [Version 2.0 Revised 2023] includes: "This facility follows infection prevention and control (IPC) practices recommended by the Centers for Disease Control and Prevention to prevent the transmission of COVID-19 within the facility. Policy Interpretation and Implementation: 1.The infection prevention and control measures that are implemented to address the SARS-CoV-2 pandemic are incorporated into the facility infection prevention and control plan. These measures include: a. encouraging staff, residents and visitors to remain up-to-date with all COVID-19 vaccine doses;" and "following current environmental infection prevention and control recommendations." A review of the facility's documented COVID-19 outbreak line listing revealed that 16 residents tested positive for COVID-19 between 11/2/25 and 11/13/25. 1. An interview was conducted with the facility's Medical Director on 11/13/25 at 2:02 PM. The Medical Director [MD] stated the facility's Acting Physician [APhys] notified him this morning [11/13/25] of a COVID outbreak in the facility. The MD defined an "outbreak" as a single case. The MD stated [APhys] reported the first case was identified as "7- 10 days ago." The MD said his expectation was to be notified when the first case appeared. Per facility Infection Control records, the first COVID cases were identified 11 days prior, on 11/2/25: one resident, one staff member. As of the day of the extended survey [11/13/25], 8 staff members and 16 residents had tested	F0880	The following corrective actions will occur to ensure compliance: 1) Housekeeping will clean both shower rooms on a daily basis and nursing staff will be responsible for cleaning/picking up after each shower given. Maintenance will remove all jagged metal pieces, and all broken tiles will be filled or replaced. 2) Housekeeping will implement a cleaning schedule to ensure all communal dining areas are cleaned prior to each meal. 3) Dietary will implement a cleaning schedule to ensure all coolers and condiment containers remain clean. 4) All overbed tables will be cleaned on a daily basis by housekeeping. Nursing staff will clean on an as needed basis. 5) All privacy curtains that have stains or tears will be thrown away and replaced. 6) All pillows that are torn will be thrown away and replaced. 7) Shower chairs will be wiped down by nursing staff after every use. 8) Maintenance will fill holes and remove rust from all doorframes. Housekeeping will ensure all cobwebs are removed during their daily cleaning. 9) Housekeeping will implement a deep clean schedule of all resident rooms and communal areas. The administrator or designee will conduct random weekly audits X 4 and monthly X 2 to ensure all alleged deficiencies listed above have been addressed and corrected.	

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F0880 SS = F	Continued from page 22 positive for COVID infection. Per record review, 10 of 16 residents who tested positive for COVID as of 11/13/25 were sampled regarding having signed consent forms in October to receive the COVID vaccine and then having received the vaccine. Per record review, 2 of the 10 residents sampled refused consent to be vaccinated. Further review revealed the remaining 8 sampled residents had all consented to be administered the COVID vaccine, but none had received it prior to being infected by the virus Per interview with the Director of Nursing on 11/13/25, the facility had only begun vaccinating residents for COVID on 11/12/25, 10 days after the initial infection was identified, and 55 days after the Quality Assurance Performance Improvement meeting noting the facility would be receiving the COVID vaccine. See F887 for more information. 2. Multiple observations of environmental conditions on 11/4/25 and 11/13/25 demonstrated a lack of overall sanitation and cleanliness affecting infection prevention in the facility. On 11/4/25, the corridors and residents' rooms' floors were dirty; various types of debris were noted; bathroom fans were covered with thick dust; and toilets were dirty, not clean inside or out, or the floor around the toilets. In one of the shower rooms, a lift bar/rail with a disposable rubber glove tied to the rail, a corner bead (a protective strip, typically made of vinyl or metal, that is installed on outside corners where two pieces of drywall meet to reinforce and protect the corner) going into the shower room revealed broken, rusted, and jagged metal. Many broken floor and wall tiles were noted throughout this area between the shower room, the tub room, and the bathroom. Sun Room on Wing 1 revealed trash cans without trash bags inside, a coffee carafe that was dirty with a brown substance on all sides; a drawer within a cabinet that contained packets of condiments noted to have what appeared to be food debris throughout the drawer and a puddle of a brown sticky substance; a chair with fabric back, armrests and seat that had a dried reddish brown substance in droplet form on the seat that was still accessible for use; a yellow substance that appeared to be scrambled eggs under a table and on the windowsill next to the table; a pillow without a pillow case on the steam table; the floors appeared dirty with spills and debris; and cooler cover was dirty.	F0880	Education will be provided to all staff regarding the importance of cleaning high touch surfaces on a daily basis. Administrator or designee to monitor weekly X 4 and monthly X 2 to ensure high touch surface areas are being disinfected multiple times throughout the day. The audit results will be reviewed at QAPI for further interventions. Date of compliance: December 28, 2025 As of November 27, 2025, the facility has a full-time certified infection preventionist. **Tag F 880 POC accepted on 1/12/26 by J. Kendall/S. Stem**	

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F0880 SS = F	Continued from page 23 Wing 1 of the nurse's station revealed a thick pile of crumbs/debris in front of the nurse's station that went the length of the nurses' station. There was a used blood glucose test strip on the floor. The overbed table by the door bed was covered on the wheels and the metal support with a thick, dried, white, milky substance. The privacy curtains had a dried, brown substance on the outer edge and about 2 feet in from it. There was an uncovered pillow on the bed next to the window, with its plastic cover torn in several places, revealing its contents. On 11/13, Floors were dirty; various types of debris were noted; bathroom fans were covered with thick dust; toilets were dirty, not clean inside or out, or the floor around the toilets. In the bathrooms, observations included light-colored caulk between tiles on both floors and walls, with a buildup of black debris that appears to be mold and mildew. A shower chair had a pinkish-orange buildup of debris at the connections. There was debris behind the doors, including spider webs and rust on the doorframes, with holes where the frames met the floors. The bathtub chair foot supports have white residue, and a walker has a used bedsheet. A chair located in the corner had used resident socks. Debris and a brown, dried liquid were noted in the whirlpool. See citation F584 for additional information regarding clean, sanitary environment observations. 3. Per interview with the (IP) on 11/13/25 at 3:00 PM, she confirmed that the facility's cleanliness is an issue. She explained that short staffing (two members left without notice) in the Housekeeping department has impacted regular scheduled cleaning. The IP also stated that the Administrator has implemented a plan for the leadership team to assist the Housekeeping department by cleaning five resident rooms per week. 4. Per interview with the Administrator on 11/13/25 at 3:50 PM, she confirmed that the Housekeeping department isn't adequately staffed and that leadership team members (ten members) are assisting the department with resident room cleaning by cleaning five rooms weekly. When asked about education, training, or audits for cleaning, she stated that those areas had not been addressed and said, "all had to do it before." The Administrator also confirmed high-touch surfaces (i.e., bedrails, doorknobs, light switches, call buttons, bedside tables, remote controls, or surfaces in bathrooms) are not regularly disinfected. 5. Per the Centers for Disease Control and Prevention (CDC) Nursing Home Infection Preventionist Training Course - WB4973, Module 11-B, titled "Environmental	F0880		

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F0880 SS = F	Continued from page 24 Cleaning and Disinfection 2025," slide 24 states, "Common areas in the facility should also be cleaned and disinfected. High-touch surfaces in the facility's common areas, such as the family room or lounge, should be cleaned and disinfected when soiled and on a regular basis, such as daily." 6. Per the CDC's Core Infection Prevention and Control Practices for Safe Healthcare Delivery in All Settings" (2024), core practice for Environmental Cleaning and Disinfection states "Clean and disinfect surfaces in close proximity to the patient and frequently touched surfaces in the patient care environment on a more frequent schedule compared to other surfaces." Reference: Centers for Disease Control and Prevention. (2025, September 15). Environmental Cleaning and Disinfection 2025." https://www.train.org/cdctrain/course/1131818/details Centers for Disease Control and Prevention. (2024, April 12). CDC's Core Infection Prevention and Control Practices for Safe Healthcare Delivery in All Settings." https://www.cdc.gov/infection-control/hcp/core-practices/index.html#:~:text=Require%20routine%20and%20targeted%20cleaning,contaminate%20the%20patient%2Dcare%20environment Centers for Disease Control and Prevention. 2024, June 24). Infection Control Guidance: SARS-CoV-2, https://www.cdc.gov/covid/hcp/infection-control/#:~:text=test%20or%20NAAT-,Environmental%20Infection%20Control,-Dedicated%20medical%20equipment	F0880		
F0887 SS = F	COVID-19 Immunization CFR(s): 483.80(d)(3)(i)-(vii) §483.80 Infection control §483.80(d)(3) COVID-19 immunizations. The LTC facility must develop and implement policies and procedures to ensure all the following: (i) When COVID-19 vaccine is available to the facility, each resident and staff member is offered the COVID-19 vaccine unless the immunization is medically contraindicated or the resident or staff member has already been immunized;	F0887	All residents who reside in the facility are at risk for the alleged deficient practice. A house wide audit will be conducted to ensure all residents have been offered the up-to-date COVID-19 vaccine, and those who signed a consent to receive the vaccine have received it. Education will be provided to all licensed nurses to offer the COVID-19 vaccination to all new admissions and to re-offer the vaccine to residents who refused on a quarterly basis.	

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F0887 SS = F	Continued from page 25 (ii) Before offering COVID-19 vaccine, all staff members are provided with education regarding the benefits and risks and potential side effects associated with the vaccine; (iii) Before offering COVID-19 vaccine, each resident or the resident representative receives education regarding the benefits and risks and potential side effects associated with the COVID-19 vaccine; (iv) In situations where COVID-19 vaccination requires multiple doses, the resident, resident representative, or staff member is provided with current information regarding those additional doses, including any changes in the benefits or risks and potential side effects, associated with the COVID-19 vaccine, before requesting consent for administration of any additional doses. (v) The resident or resident representative, has the opportunity to accept or refuse a COVID-19 vaccine, and change their decision; and (vi) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident representative was provided education regarding the benefits and potential risks associated with COVID-19 vaccine; and (B) Each dose of COVID-19 vaccine administered to the resident, or (C) If the resident did not receive the COVID-19 vaccine due to medical contraindications or refusal. (vii) The facility maintains documentation related to staff COVID-19 vaccination that includes at a minimum, the following: (A) That staff were provided education regarding the benefits and potential risks associated with COVID-19 vaccine; (B) Staff were offered the COVID-19 vaccine or information on obtaining COVID-19 vaccine; and (C) The COVID-19 vaccine status of staff and related information as indicated by the Centers for Disease Control and Prevention's National Healthcare Safety Network (NHSN). This REQUIREMENT is NOT MET as evidenced by:	F0887	The DON or designee will conduct random weekly audits X 4 and monthly X 2 to ensure all residents are offered the COVID-19 vaccine, and those who signed the consent to receive the vaccine have received it. The medical director will be sent a weekly correspondence from the facility as a way to communicate information regarding resident updates, staffing concerns, infection prevention issues, and any changes surrounding policies and procedures. As of December 12, 2025, all residents who signed consents wanting the up-to-date COVID-19 vaccine have received it. **Tag F 887 POC accepted on 1/12/26 by J. Kendall/S. Stem**	

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F0887 SS = F	Continued from page 26 Based on interview and record review, the facility failed to develop and implement policies and procedures to ensure when COVID-19 vaccine is available to the facility, each resident and staff member is offered the COVID-19 vaccine unless the immunization is medically contraindicated or the resident or staff member has already been immunized. Findings include: A review of the facility's "Coronavirus Disease—Infection Prevention and Control Measures Policy Statement" [Version 2.0 Revised 2023] includes: "This facility follows infection prevention and control (IPC) practices recommended by the Centers for Disease Control and Prevention to prevent the transmission of COVID-19 within the facility. Policy Interpretation and Implementation: 1.The infection prevention and control measures that are implemented to address the SARS-CoV-2 pandemic are incorporated into the facility infection prevention and control plan. These measures include: a. encouraging staff, residents and visitors to remain up-to-date with all COVID-19 vaccine doses." A review of the facility's documented COVID-19 outbreak line listing revealed that 16 residents tested positive for COVID-19 between 11/2/25 and 11/13/25. An interview was conducted with the facility's Medical Director on 11/13/25 at 2:02 PM. The Medical Director [MD] stated the facility's Acting Physician [APhys] notified him this morning [11/13/25] of a COVID outbreak in the facility. The MD stated [APhys] reported the first case was identified as "7- 10 days ago." The MD said his expectation was to be notified when the first case appeared. Per facility Infection Control records, the first COVID cases were identified 11 days prior, on 11/2/25: one resident, one staff member. As of the day of the extended survey [11/13/25], 8 staff members and 16 residents had tested positive for COVID infection. Per record review, 10 of 16 residents who tested positive for COVID as of 11/13/25 were sampled regarding having signed consent forms in October to receive the COVID vaccine and then having received the vaccine. Per record review, 2 of the 10 residents sampled refused consent to be vaccinated. Further review revealed the remaining 8 sampled residents [Resident #4, #11, #12, #13, #14, #15, #16, & #17] had all consented to be administered the COVID vaccine, but none had received it prior to being infected by the	F0887		

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F0887 SS = F	Continued from page 27 virus. Per interview with the Director of Nursing on 11/13/25, the facility had only begun vaccinating residents for COVID on 11/12/25, 10 days after the initial infection was identified, and 56 days after the Quality Assurance Performance Improvement meeting noting the facility would be receiving the COVID vaccine.	F0887		
F0947 SS = D	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. §483.95(g)(3) Address areas of weakness as determined in nurse aides' performance reviews and facility assessment at § 483.71 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: Based on review of employee training records and interview, the facility failed to provide evidence of the minimum 12 hours of nurse aide training per year required to ensure the continuing competence of the LNAs (Licensed Nursing Assistants) for 1 (LNA #1) of 3 LNAs sampled. Findings include: Per review of the training records, three LNAs sampled were noted to have start dates before the 2025 calendar year. LNA #1's education file lacked documentation of evidence of the 12 hours of training per year required to meet identified staff or resident needs. Per interview on 11/13/25 at 5:18 PM, the Director of	F0947	A house wide audit will be conducted to ensure all LNAs have the minimum 12-hours of nurse aide training that is required annually. Education will be provided to the nurse educator that all LNAs must have the minimum 12-hours of nurse aide training that is required annually. The DON or designee will conduct random weekly audits X 4 and monthly X 2 to ensure all LNAs have the minimum 12-hours of nurse aide training that is required annually. The audit results will be reviewed at QAPI for further interventions. Date of completion: December 28, 2025 **Tag F 947 POC accepted on 1/12/26 by J. Kendall/S. Stem**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 475037	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 11/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Barre Gardens Nursing and Rehab, LLC	378 Prospect Street , Barre, Vermont, 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
F0947 SS = D	Continued from page 28 Nursing (DON) was unable to provide evidence that the LNA #1 had completed their required 12-hour annual training. POC reviewed and approved 1/12/2026 Jane Kendall	F0947		