VERMONT

Department of Disabilities, Aging and Independent Living
Division of Licensing and Protection
280 State Drive/HC 2 South
Waterbury, VT 05671-2060
www.dlp.vermont.gov

[phone] 802-241-0344
[fax] 802-241-0343

AGENCY OF HUMAN SERVICES

February 24, 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 revisit survey conducted on **February 2, 2026.** 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 02/02/2026

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 revisit survey at the facility on 1/20/26, with additional offsite record review and interviews that ensued through 1/22/26 to determine compliance with 42 CFR Part 483 requirements for Long Term Care Facilities. The revisit was for the survey dated 11/13/25. Offsite review determined that the facility had deficiencies at the Immediate Jeopardy (IJ) level for F841, F865, and F880 related to violations around responsibilities of the Medical Director, the facility's Quality Assurance and Performance Improvement [QAPI] program, and Infection Control and Prevention. The facility was notified of the immediate jeopardy on 1/29/26. On 2/2/26 an onsite visit to assess the removal of the immediate jeopardy was conducted. The facility completed sufficient corrective actions to remove the immediate jeopardy for F841 on 1/30/26 by providing education to the Medical Director on their responsibilities and initiating a communication plan with the providers. The facility completed sufficient corrective actions to remove the immediate jeopardy for F865 on 1/30/26 by meeting holding a QAPI meeting with all required members. The facility completed sufficient corrective actions to remove the immediate jeopardy for F880 on 1/30/26 by implementing health department guidance around infection prevention and control measures, initiating audits, staff education, and competencies for handwashing and appropriate personal protective equipment use, and initiating group A strep testing recommendations. Non-compliance with the requirements at F841, F865, & F880 remain. An onsite partial extended survey was conducted on 2/2/26. There were no additional findings associated with the extended survey. The facility is licensed for 96 beds and had a census of 83 at the time of the survey. The following regulatory violations were identified:	F0000	See attached	
F0584	Safe/Clean/Comfortable/Homelike Environment	F0584		12/28/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Amanda Quakenbush	LNHA	2/20/2026

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 02/02/2026

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
F0584 SS = E	Continued from page 1 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 (a)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §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:	F0584	See attached **Tag F 584 POC accepted on 2/23/26 by T. Dougherty/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 02/02/2026

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
F0584 SS = E	Continued from page 2 Based on 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 two partial surveys dated 4/17/25 and 11/13/25. Findings include: 1. During the initial tour of the facility on 1/20/256 at approximately 10:40 AM the following observations were made: Observation of the Wing #2 shower/tub room revealed a shower curtain in the doorway of the tub room and a shower curtain in the doorway of the shower room that were torn in numerous places. Boxes of supplies were noted on the floor in the shower room storage area. Numerous jagged and broken tiles were noted in the shower room in the area of the shower chair along with many missing tiles along the floor and bottom of the wall in the shower room. Three plastic rolling bins were observed in the shower/tub room entry way that were dirty with dust and a dried grainy type of substance. Interview on 1/20/26 at approximately 11:30 AM with the Unit Manager confirmed the above findings. \ Wing #2, the long hall revealed Room #101 with dirty floors and an over bed table with what appeared to have spills of something white and granular on the metal frame. Room #103 revealed an overbed table that appeared to have spills of a clear substance on the metal frame. Room #105 revealed the dresser by the door had torn and peeling laminate, the bottom laminate was missing and down to the bare wood. The overbed table by the window bed had torn laminate on the top tray portion. At the window, the heater was noted to be encased in a wooden box of bare, unpainted, raw wood. This is an infection control concern as raw wood cannot be effectively cleaned/sanitized. The floor was noted to be dirty and lots of loose debris (dust, hair, paper pieces, etc.) Room #107 revealed a dresser next to the door with torn laminate on the top and the sides. Next to the window, an overbed table was noted to have laminate on the top and the sides and the laminate was torn on the sides. The floor was dirty with various debris (dust, hair,	F0584		

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 02/02/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Barre Gardons 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
F0584 SS = E	Continued from page 3 paper pieces, etc.) The heater was noted to be encased in a wooden box of bare, unpainted, raw wood. Room #116 was noted to have dirty floors with various debris consisting of dust, hair, small pieces of paper, elastic bands, etc. Room #156 was noted to have dirty floors with various debris consisting of dust, hair, small pieces of paper, etc. Room #165 was noted to have a pile of pines needs around the trash can, the floor was dirty, the footboard (door bed) was loose and falling off. Room #166 was noted to have dirty floors with various debris consisting of dust, hair, small pieces of paper, elastic bands, etc. All corridors/halls the floors were dirty and there was various scattered debris consisting of dust, small pieces of paper, paper clips, food debris, band-aid wrappers, pine needles, etc. The Crossover (courtyard side) on the floor by the window revealed a crumpled-up napkin/tissue with a dried red substance all over it. The handrail had many rough spots with splintering on the top and between the 2 boards on the handrail were wrappers that were folded and stuffed in between the boards. The Crossover (overlooking the outside of the building) handrail on the back of the handrail had 4 staples, each staple was pulled out on one side and was sticking out/up. The handrail closest to the dining room was loose and the screw at the bottom of the handrail was out approximately ¼ of an inch and was not in straight. 2. Per observation of Wing #1 on 1/20/26 at 10:55 AM, the shower room had multiple cracked tiles. One tile approximately 4-6 inches from the floor was sharp. There were two shower curtains that had several small holes. There were two pull chords in this shower room to the call bell system; one was attached to a shoestring and wrapped in paper tape and the other pull chord was approximately 3 inches long. Interview with the Administrator at 11:05 AM confirmed the tiles were hazardous, the pull chords were not appropriate, and the shower curtains needed to be replaced.	F0584		
F0812 SS = F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2)	F0812	See attached	12/28/2025

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 02/02/2026

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
F0812 SS = F	Continued from page 4 §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 food is stored safely related to expired food products and dented canned food being made available for use. 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 Per observation on 1/20/2026 at 10:32 AM, the walk-in refrigerator had two 64 oz. tubs of cottage cheese that were labeled with a "best if use–by date" of 12/26/2025. Per interview the Kitchen Manager confirmed the cottage cheese was outdated and could not be used. Per observation on 1/20/2026 at 10:40 AM, 2 dented cans of peaches and 1 dented can of applesauce were available for use. The Kitchen Manager confirmed the cans' seals could be compromised and these could not be used. Per observation on 1/20/2026 at 10:55 AM, there was a tray of bread dated 11/25/2025 and hamburger and hot dog buns dated 12/1/2026. An interview was conducted with a Kitchen Staff Member on 1/20/2026 at 11:00 AM. The Kitchen Staff Member stated that he did not know	F0812	**Tag F 812 POC accepted on 2/23/26 by T. Dougherty/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 02/02/2026

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
F0812 SS = F	Continued from page 5 how long the bread and rolls were to be used and did not know the dating system the kitchen used for tracking food. The Kitchen Staff Member was unable to locate a "use by" date on the bread and rolls. He confirmed these items were intended for use for resident meals. Per interview with the Kitchen Manager on 1/20/2026 at 11:05 AM, he did not know if the dates on the bread and roll packages meant "manufactured on" or "use by." One hot dog roll had a green substance on it. The Kitchen Manager confirmed it was mold, and that the rolls could not be used.	F0812		
F0841 SS = L	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- (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, record review, and facility policy review, the facility failed to ensure that the medical director fulfilled his/her responsibility to assist with the development and implementation of resident care policies and coordinate medical care with facility providers and nursing. As a result, GAS (group A strep) spread through the facility and 12 residents developed symptoms of GAS, 2 of 3 sampled residents with symptoms of GAS were hospitalized with sepsis due to cellulitis (Residents #1 and #2). This citation is at the immediate jeopardy level as these failures put all residents at risk for serious harm and/or death. This is a repeat deficiency for this facility, with the violation cited during a previous complaint survey dated 11/13/25. Findings include: Per review of Vermont Department of Health (VDH) infectious disease situation notes, starting on 10/31/25, the facility had a confirmed case of iGAS (invasive group A strep) in the facility. VDH gave the facility strong guidance over multiple meetings and emails to implement and monitor adherence of strong	F0841	See attached **Tag F 841 POC accepted on 2/23/26 by T. Dougherty/S. Stem**	12/28/2025

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 02/02/2026

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
F0841 SS = L	Continued from page 6 Infection prevention control measures, and guidance for how and when to test residents and staff, which was critical in preventing transmission. Observations on 1/20/26 revealed 10 incidents where staff did not perform infection control measures such as hand washing and wearing appropriate PPE (personal protective equipment). Per Interview, the facility did not conduct regular monitoring and auditing of handwashing and PPE practices to ensure adherence. Per review of the GAS outbreak line list, from 10/26/25 through 1/20/26, 5 residents tested positive for GAS, 2 staff tested positive for GAS, and there were 9 suspected resident cases based on GAS symptoms. 8 of the 9 resident cases were not tested before the start of antibiotics as recommended by VDH. 2 residents (1 who tested positive and one who was not tested prior to the start of antibiotic treatment) were not tested 7-10 days post their initial GAS antibiotic treatment as recommended by VDH and became symptomatic again. 4 additional resident cases did not have post treatment testing. There were 7 total hospitalizations related to GAS symptoms for the positive and suspected cases. See F880 for more information. Facility policy titled "Medical Director Responsibilities," undated, reads, "The facility retains a physician designated as Medical Director, to coordinate the medical care provided by attending physicians, and to assist with development and implementation of resident care policies." 1. Per phone interviews on 1/21/26 at 1:04 PM and 1/26/26 at 8:08 AM, the Medical Director explained the following: While he is available by phone, the last time he was in person at the facility was 11/18/25. Regarding the GAS outbreak in the facility, he explained that he was aware of the first case of iGAS at the end of October, and a few other cases after but did not know the status of the GAS outbreak since December. He was not aware of all the symptomatic residents in the facility. He was unaware of the guidance given by VDH. Regarding infection prevention and control measures, he explained that he was unaware of infection control issues. He did not know who was or is the infection preventionist. He said that he has reviewed the infection control policy but was unsure the last time he reviewed it. He has not been a part of any facility education regarding infection prevention and control practices.	F0841		

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 02/02/2026

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
F0841 SS = L	Continued from page 7 When asked if he was aware that the facility did not implement VDH testing guidance, he said he was not aware. When asked about how he was giving feedback to other providers about residents' medical care, he said he would speak to other providers if an issue was brought up but did not have a system in place at this time. He stated that he was not in attendance for the 11/4/25, 12/23/26, or 1/5/26 QAPI meetings and does not have a designee. When asked how he was working with the clinical team to provide surveillance and help design or approve data collection instruments such as infection control reports, he explained that he is only involved if the facility asks for a review or alerts him to issues. See 865 for more information. 2. Per phone interviews on 1/22/26 at 8:39 AM and 1/23/26 at 3:19 PM, the Administrator revealed the following: The last time the Medical Director was in the facility was 11/18/25. The Medical Director and the Infection Preventionist did not discuss the recommendations made by the Vermont Department of Health. The Medical Director has not worked with the facility's clinical team to provide surveillance and develop policies to prevent the potential infection of residents or ensured that infection control policies have been implemented. The Medical Director was not in attendance for the 11/4/25, 12/23/26, or 1/5/26 QAPI meetings and is unaware of a designee for him when he is not in attendance.	F0841		
F0865 SS = L	QAPI Prgm/Plan, Disclosure/Good Faith Attmpt CFR(s): 483.75(a)(1)-(4)(b)(1)-(4)(f)(1)-(6)(h)(i) §483.75(a) Quality assurance and performance improvement (QAPI) program. Each LTC facility, including a facility that is part of a multiunit chain, must develop, implement, and maintain an effective, comprehensive, data-driven QAPI program that focuses on indicators of the outcomes of care and quality of life. The facility must: §483.75(a)(1) Maintain documentation and demonstrate evidence of its ongoing QAPI program that meets the requirements of this section. This may include but is not limited to systems and reports demonstrating systematic identification, reporting, investigation,	F0865	See attached **Tag F 865 POC accepted on 2/23/26 by T. Dougherty/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 02/02/2026

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
F0865 SS = L	Continued from page 8 analysis, and prevention of adverse events; and documentation demonstrating the development, implementation, and evaluation of corrective actions or performance improvement activities; §483.75(a)(2) Present its QAPI plan to the State Survey Agency no later than 1 year after the promulgation of this regulation; §483.75(a)(3) Present its QAPI plan to a State Survey Agency or Federal surveyor at each annual recertification survey and upon request during any other survey and to CMS upon request; and §483.75(a)(4) Present documentation and evidence of its ongoing QAPI program's implementation and the facility's compliance with requirements to a State Survey Agency, Federal surveyor or CMS upon request. §483.75(b) Program design and scope. A facility must design its QAPI program to be ongoing, comprehensive, and to address the full range of care and services provided by the facility. It must: §483.75(b)(1) Address all systems of care and management practices; §483.75(b)(2) Include clinical care, quality of life, and resident choice; §483.75(b)(3) Utilize the best available evidence to define and measure indicators of quality and facility goals that reflect processes of care and facility operations that have been shown to be predictive of desired outcomes for residents of a SNF or NF. §483.75(b) (4) Reflect the complexities, unique care, and services that the facility provides. §483.75(f) Governance and leadership. The governing body and/or executive leadership (or organized group or individual who assumes full legal authority and responsibility for operation of the	F0865		

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 02/02/2026

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
F0865 SS = L	Continued from page 9 facility) is responsible and accountable for ensuring that: §483.75(f)(1) An ongoing QAPI program is defined, implemented, and maintained and addresses identified priorities. §483.75(f)(2) The QAPI program is sustained during transitions in leadership and staffing; §483.75(f)(3) The QAPI program is adequately resourced, including ensuring staff time, equipment, and technical training as needed; §483.75(f)(4) The QAPI program identifies and prioritizes problems and opportunities that reflect organizational process, functions, and services provided to residents based on performance indicator data, and resident and staff input, and other information. §483.75(f)(5) Corrective actions address gaps in systems, and are evaluated for effectiveness; and §483.75(f)(6) Clear expectations are set around safety, quality, rights, choice, and respect. §483.75(h) Disclosure of information. A State or the Secretary may not require disclosure of the records of such committee except in so far as such disclosure is related to the compliance of such committee with the requirements of this section. §483.75(i) Sanctions. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is NOT MET as evidenced by: Based on interview, record review of the facility's Quality Assurance and Performance Improvement Program (QAPI), and facility policy review, the facility failed to address all systems of care in a comprehensive manner by identifying problems and opportunities for	F0865		

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 02/02/2026

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
F0865 SS = L	Continued from page 10 improvement in the areas of infection control, environment, and Medical Director. As a result, GAS (group A strep) spread through the facility and 12 residents developed symptoms of GAS. 2 of 3 sampled residents with symptoms of GAS were hospitalized with sepsis due to cellulitis (Residents #1 and #2). This citation is at the Immediate Jeopardy level as these failures put all residents at risk for serious harm and/or death. Findings include: Facility policy titled "Quality Assurance and Performance Improvement," last revised 9/2022, reads "Our facility will... Present documentation and evidence of its ongoing QAPI program's implementation and the facility's compliance with requirements to a State Survey Agency, Federal surveyor or CMS upon request." Steps for designing and implementing QAPI include, "Our leadership team, which consists of the administrator, director of nursing, medical director, and key department managers, is responsible for creating and sharing the focus of QAPI... The leadership team in collaboration with QAPI teams will determine what data to monitor routinely so that performance targets can be established and benchmarks identified." Systemic action will be "Based on the identified root cause of a problem, corrective action will be taken. The goal is to achieve improvement and prevent recurrence of the problem." Regarding QAPI Feedback, Data Systems, and Monitoring, "Performance indicators will be developed for each aspect of care and services being monitored... A data collection and monitoring plan will be developed... Goals will be established." A complaint survey dated 11/13/25 revealed that the facility was found to have deficient practice related to the following regulatory requirements: safe, clean, comfortable, homelike environment (F584), food storage (F812), responsibilities of the Medical Director (F841), and infection prevention and control (F880). During a revisit and complaint survey dated 1/26/26, the facility remained out of compliance with the above regulatory requirements. See F584, F812, F841, and F880 for more information. 1. Review of QAPI meeting notes reveals the following: On 11/4/25, the team met to discuss a QAPI plan initiated on 11/3/25. Meeting notes reveal the areas of focus to be Group Strep A Outbreak/Prevention and IP (infection prevention) implementation. The plan	F0865		

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 02/02/2026

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
F0865 SS = L	Continued from page 11 identified action items for testing and discussion of education for "hand hygiene, appropriate use of PPE (personal protective equipment) and appropriate cleaning methods were discussed to help stop the spread." The plan does not discuss performance indicators, a data collection plan, or goals. 12/23/25 and 1/5/26 "QAPI monthly Meeting" notes include sections for regulatory issues, infection control, housekeeping, maintenance. Discussion notes describe regulatory deficiencies from the 11/13/25 and briefly describe some action items for housekeeping and maintenance. Notes do not include performance indicators, a data collection plan, or goals for these areas. Infection control notes do not include any information about the GAS outbreak. There is no evidence that the Medical Director or a designee participated in any of the 3 QAPI meetings listed above. 2. Per phone interviews on 1/22/26 at 8:39 AM and 1/23/26 at 3:19 PM, the Administrator confirmed she was unable to provide performance indicators, a monitoring plan, or goals for the areas above in QAPI documentation. In regard to the GAS outbreak not being addressed in either the 12/23/25 or 1/5/26 QAPI meeting, she reveled that it was not addressed in QAPI as it was discussed during morning meetings. She confirmed that Vermont Department of Health recommendations were not incorporated into the QAPI meetings. 3. Per phone interviews on 1/21/26 at 1:04 PM and 1/26/26 at 8:08 AM, the Medical Director confirmed he was not in attendance for the 11/4/25, 12/23/26, or 1/5/26 QAPI meetings and does not have a designee. When asked how he was working with the clinical team to provide surveillance and help design or approve data collection instruments such as infection control reports, he explained that he is only involved if the facility asks for a review or alerts him to issues.	F0865		
F0880 SS = L	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.	F0880	See attached **Tag F 880 POC accepted on 2/23/26 by T. Doughert/S. Stem**	12/28/2025

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 02/02/2026

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
F0880 SS = L	Continued from page 12 §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 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.	F0880		

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 02/02/2026

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
F0880 SS = L	Continued from page 13 §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. §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 observation, interview, record review, and policy review, the facility failed to maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment to help prevent the development and transmission of communicable diseases and infections while there were cases of group A strep (GAS) in the facility. The facility failed to follow infections control and preventions measures on 2 of 2 units, failed to monitor and audit the adherence to infection control and prevention practices, and failed to follow testing guidance while managing the GAS outbreak. As a result, GAS spread through the facility and 12 residents developed symptoms of GAS. 2 of 3 sampled residents with symptoms of GAS were hospitalized with sepsis due to cellulitis (Residents #1 and #2). This citation is at the immediate jeopardy level as these failures put all residents at risk for serious harm and/or death. This is a repeat deficiency for this facility, with the violation cited during a previous complaint survey dated 11/13/25. Findings include: Per review of Vermont Department of Health (VDH) infectious disease situation notes, starting on 10/31/25, VDH gave the facility guidance on how to manage a confirmed case of iGAS (invasive group A strep) in the facility. Per the Centers for Disease Control and Prevention (CDC), group A strep (GAS) is a bacteria that can cause a spectrum of syndromes and severity of infections in nursing home residents including cellulitis and wound infections (most common), and bloodstream infections and Streptococcal Toxic Shock Syndrome (less common but more severe). GAS spreads easily in nursing homes once introduced. Strong infection prevention and control practices are critical to stopping GAS transmission and preventing outbreaks.	F0880		

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 02/02/2026

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
F0880 SS = L	Continued from page 14 On 11/3/25, VDH and the facility discussed infection prevention and control guidance and assessing the adherence to infection control measures by staff, including hand hygiene, appropriate selection/donning/doffing of PPE (personal protective equipment), and appropriate cleaning and disinfection of environmental surfaces and reusable equipment. Testing included surveillance testing, testing of symptomatic staff and residents, and testing 7-10 post GAS antibiotic treatment. The CDC GAS toolkit for LTCF (long term care facilities) was reviewed and sent. On 11/10/25, VDH and the facility discussed the status of the situation, including a positive result of GAS in another resident. Further testing recommendations were made as there was a concern of transmission within the facility. On 11/25/25, VDH's HAI (Healthcare-Associated Infection) team conducted an ICAR (Infection Control Assessment and Response; a tool used on an onsite visit to systematically assess a healthcare facility's IPC practices and guide quality improvement activities). On 12/3/2025, the facility was notified both during a meeting and by email of critical infection control measures to implement immediately based on the ICAR visit, including increasing effective hand hygiene practices proper PPE use by staff, and increasing the frequency of disinfection of high touch surfaces. VDH recommended regular monitoring and auditing of these practices to ensure adherence. However, these same issues were discussed in prior meetings as well. On 12/12/25, the facility was again notified in a meeting and by email that if GAS is clinically suspected (sore throat, skin infection, including cellulitis, and fever) in a resident or staff, that they should be considered symptomatic and should be tested. On 1/5/26, the facility reported to VDH that they had not performed any audits to make sure TBP (transmission based precautions) and hand hygiene procedures were appropriately followed. The facility was notified in the meeting and by email of the recommendation for "doubling down on hand hygiene interventions, especially audits," and "reiterated the importance of collecting a culture specimen on symptomatic folks before they start them on antibiotics." On 1/7/26, a Healthcare-Associated Infection Epidemiologist (HAIE) from the VT Department of Health	F0880		

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 02/02/2026

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
F0880 SS = L	Continued from page 15 completed an unannounced onsite infection prevention and control assessment. This unannounced visit was agreed upon by the facility. The HAIE observed zero out of ten successful handwashing events for frontline staff and other infection compliance issues regarding following posted precautions and disinfecting high contact surfaces. These observations were communicated to the facility's Infection Preventionist before the AHIE exited the facility. Per review of the outbreak line list, from 10/26/25 through 1/20/26, 5 residents tested positive for GAS, 2 staff tested positive for GAS, and there were 9 suspected residents cases based on GAS symptoms. 8 of the 9 resident cases were not tested before the start of antibiotics as recommended by VDH. 2 residents (1 who tested positive and one who was not tested prior to the start of antibiotic treatment) were not tested 7-10 post their initial GAS antibiotic treatment as recommended by VDH and became symptomatic again. 4 additional resident cases did not have post treatment testing. There were 7 total hospitalizations related to GAS symptoms for the positive and suspected cases. The above information was confirmed to be accurate by the HAI Infectious Disease Program Manager by email on 1/21/26. 1. The following observations of staff failing to adhere to infection prevention and control practices were made on 1/20/26 by the survey team: At 10:06 AM, 2 LNAs (Licensed Nursing Assistant) left room #155, marked with an EBP (enhanced barrier precautions; gown and glove use during high contact resident care activities) sign, without performing hand hygiene. At 10:15 AM, an LNA was assisting a resident with toileting without wearing a gown in room #157, marked with an EBP sign. At 10:41 AM, an LNA removed trash from room #106, brought the trash bag to the trash room and went back into room #106 without performing hand hygiene. This room did not have a precaution sign on the door, but was later confirmed by an LPN at 12:17 PM, that the resident was on EBP and should have signage to indicate such. At 10:45 AM, an LNA was gathering clothes and linens on her chest and putting them into a bag in room #161, marked with an EBP sign. She was not wearing a gown.	F0880		

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 02/02/2026

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
F0880 SS = L	Continued from page 16 At 12:20 PM, an LNA was changing bed linens in room #109, marked with an EBP sign, wearing a gown and gloves. A resident walked into the room and the LNA placed her gloved hands on the resident's shoulders to guide them out of the room. The LNA removed the gown and gloves and walked down the hall. On return she put on a gown and gloves and continued to change the resident's bed. She then removed her gown and glove and picked up the linens and trash. The LNA did not do hand hygiene at any point during this observation. At 12:39 PM, the Unit Manager, who was present for this observation, confirmed the LNA lacked hand hygiene for three different opportunities. At 1:23 PM, an LNA entered room #175 without performing hand hygiene, changed the resident's shirt, and then left the room without performing hand hygiene. She then went directly into room #163 without performing hand hygiene. At 1:25 PM, an LNA left a resident's room marked with an EBP wearing a pair of gloves and continued down the hallway without removing them or performing hand hygiene. At 1:29 PM, a therapy staff left room #161, marked with an EBP sign, went to the nurse's station, and returned to the room and then exited again, without doing hand hygiene at any point in the observation. At 1:35 PM, a staff member coughed into their hand, wiped their nose with the back of their hand and entered a resident's room on Unit 2. The staff did not perform hand hygiene before placing a pulse oximeter on the resident's finger. At approximately 4:20 PM, an RN (Registered Nurse) and a hospice staff were performing wound care in room #152, marked with a contact precaution sign (gown and gloves for all patient interactions), without wearing gowns. The RN confirmed that she should be wearing a gown. Facility policy titled "Infection Prevention and Control Program," last revised 12/2023, reads, "Important facets of infection prevention include: ...(3) educating staff and ensuring that they adhere to proper techniques and procedures...(7) implementing appropriate enhanced barrier and transmission based precautions when necessary; and (8) following established general and disease specific guidelines such as those of the Cenerse for Disease Control (CDC)." Facility policy titled "Handwashing/Hand Hygiene," last	F0880		

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 02/02/2026

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
F0880 SS = L	Continued from page 17 revised 10/2023, reads "All personnel are expected to adhere to hand hygiene policies and practices to prevent the spread of infections to other personnel, residents, and visitors." The policy reveals that hand hygiene is indicated before and after touching a resident, after contact with blood, body fluid, or contaminated surfaces, after touching the resident's environment, and before and immediately after wearing gloves. Per interview on 1/20/26 at approximately 2:30 PM, the Unit Manager confirmed that her staff were not following infection control measures and needed education. Per interview on 1/20/26 at 4:33 PM, the Infection Preventionist confirmed that staff should wash their hands before and after leaving a resident's room and before and after donning PPE. She confirmed that staff should be wearing gowns and gloves when performing high contact care for residents on contact precautions and EBP. 2. The facility did not follow VDH guidance to conduct regular monitoring and auditing of hand washing and PPE practices to ensure adherence. The facility was unable to provide evidence of handwashing or PPE audits of the staff from any point during the GAS outbreak. Per interview on 1/20/26 at 4:33 PM, the Infection Preventionist confirmed that audits had not been completed. 3. The facility did not follow VDH testing guidance while managing the GAS outbreak. Per review of the outbreak line list, from 10/26/25 through 1/20/26, 5 residents tested positive for GAS, 2 staff tested positive for GAS, and there were 9 suspected resident cases based on GAS symptoms. 8 of the 9 resident cases were not tested before the start of antibiotics as recommended by VDH. 2 residents (1 who tested positive and one who was not tested prior to the start of antibiotic treatment) were not tested 7-10 post their initial GAS antibiotic treatment as recommended by VDH and became symptomatic again. 4 additional resident cases did not have post treatment testing. There were 7 total hospitalizations related to GAS symptoms for the positive and suspected cases. Per an email response dated 1/26/26, the HAI Infectious Disease Program Manager explained that her team helped	F0880		

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 02/02/2026

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
F0880 SS = L	Continued from page 18 facilitate testing residents and staff with the VDH laboratory in addition to their regular clinical testing. She explained that the facility could have and should have tested symptomatic individuals right away prior to starting antibiotics and conduct testing 7-10 after treatment ends. VDH arranged certain testing days for surveillance testing, in which the facility could also include symptomatic and post treatment tests if they already had testing scheduled but were instructed to use their clinical lab if they were not already having a testing event with VDH. Facility policy titled "Infection Prevention and Control Program," last revised 12/2023, reads, "Outbreak management a. Outbreak management is a process that consists of: … (3) preventing the spread to other residents… c. The medical staff will help the facility comply with pertinent state and local regulations concerning the reporting and management of those with reportable communicable diseases." 4. The 3 most recent cases on the GAS outbreak line list were reviewed and it was found that 2 of the 3 residents suffered harm related to cellulitis complications. a. Per record review, Resident #1 has diagnoses that include congestive heart failure and dementia. S/He is care planned for assistance for most activities of daily living and the potential for skin integrity impairment. A progress note dated 1/6/26 reveals that Resident #1's arm is red, warm, and tender to touch, has an increased temperature of 99.9 F, and oxygen is 91% on room air. The Nurse Practitioner gave orders to start antibiotics. Per record review, there was no evidence that the facility conducted testing prior initiating antibiotic treatment on 1/6/26. Per review of Resident #1's Medication Administration Record (MAR), Resident #1 received two doses of antibiotics on 1/6/25. A provider note dated 1/7/26 reveals that Resident #1's condition became critical and was sent to the emergency department (ED). An ED Physician note dated 1/7/26 reveals that Resident #1 was febrile (feverish) and unresponsive. S/He was admitted to the hospital for treatment of severe sepsis (sepsis plus organ dysfunction) and shock secondary to cellulitis. A 1/15/26 Hospital Physician assessment note reveals	F0880		

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 02/02/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Barre Gardons 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
F0880 SS = L	Continued from page 19 that Resident #1 suffered severe sepsis with septic shock, right arm cellulitis, acute renal insufficiency (loss of kidney function), likely secondary to shock), and acute metabolic encephalopathy (acute brain dysfunction), likely secondary to infection. A 1/16/26 progress note reveals that Resident #1 returned to the facility on 1/16/26 after being admitted to the hospital for 9 days. b. Per record review, Resident #2 has diagnoses that include Parkinson's disease and epilepsy. S/He is care planned for assistance for activities of daily living and the potential for skin integrity impairment. Per review of the facility GAS outbreak line list and a 12/11/25 admission summary note, Resident #2 was hospitalized from 12/7/25 through 12/11/25 for right lower extremity cellulitis and treated with antibiotics from12/7/25 through 12/16/25. Per record review, there was no evidence that the facility conducted testing 7-10 days post treatment (12/23/25-12/26/25). A 1/3/26 Physician Assistant progress note reveals that Resident #2 has left foot pain, a low grade fever, and significant edema to the left foot with redness, and warmth extending up to the left ankle laterally. Resident #2 was started on antibiotics on 1/3/26 to treat cellulitis of his/her left lower limb. Per record review, there was no evidence that the facility conducted testing prior initiating antibiotic treatment on 1/3/26. A 1/16/26 Hospital Physician Admission note reveals that Resident #2 was readmitted to the hospital on 1/16/26 with "septic shock. Likely due to cellulitis if the left lower extremity." A 1/19/26 Hospital Physician assessment note reveals that Resident #2 suffered septic shock and left lower extremity cellulitis. As of 1/20/26, record review shows that Resident #2 was still admitted to the hospital, 4 days after admission. https://www.cdc.gov/group-a-strep/php/ltcf-toolkit/index.html	F0880		

Barre Gardens– DPOC F865

1. Corrective Action

The facility will contract with a quality improvement specialist (QIS) with nursing home administrator and/or director of nursing experience (see requirements below) to provide consultation and oversight for quality assurance and performance improvement activities. The facility will immediately implement an appropriate quality assurance and process improvement plans consistent with the requirements of §483.75(a)(b)(f) in order to address facility failures in: providing a safe, clean, homelike environment, §483.10(i); providing a sanitary kitchen, §483.60(i)(2); providing adequate Medical Director services, §483.70(g)(2); and establishing and implementing a comprehensive infection prevention and control program; §483.80(a).

The nursing home administrator (NHA), director of nursing (DON), medical director, nursing leadership, and other applicable interdisciplinary team (IDT) members, in conjunction with the QIS, shall review quality assurance performance improvement activities and create performance improvement plans related to environment, medical director, sanitary kitchen, and infection prevention and control. Such action plans will, at minimum, include:

(1) Ensuring systems are in place to guarantee that all residents are provided with a safe, clean, home-like environment, including the necessary housekeeping and maintenance services, in accordance with the requirements for F584.
(2) Ensuring systems are in place to guarantee that food safety practices meet professional standards, in accordance with F812.
(3) Ensuring the Medical Director meets regulatory requirements regarding implementation of resident care policies, coordination of medical care in the facility and active participation in QAPI projects, in accordance with F841 and F865.
(4) Ensuring a comprehensive infection prevention and control program is established and all systems, standards, policies and procedures are implemented in accordance with accepted national standards and local health department guidance, in accordance with F880.

2. Identification of Others

The NHA, DON, and applicable members of the IDT, in accordance with the QIS consultant, shall audit all current performance improvement plans not specific to those mentioned above in "1. Corrective Action" to determine the efficacy of each plan. Plans identified as ineffective will be reviewed and revised with the assistance of the QIS consultant. The QIS consultant will assist the facility leadership with identifying in the root causes of the inefficacy for those plans identified as ineffective.

3. System Changes

On or before **2/28/2026** the facility shall hire a QIS consultant with experience consulting or directing nursing services or nursing home administration duties within nursing facilities. The QIS consultant shall exercise independent judgement in the performance of all duties under the consultant contract. The QIS consultant shall meet the independent judgement requirement if the consultant is not currently an employee of the facility or its corporate organization and has not within a five (5) year period immediately preceding **2/2/2026** been directly or indirectly affiliated with the facility, facility's owner(s), agent(s), or employee(s).

In performance of all services provided, the QIS consultant's status shall be that of an independent contractor and not that of an agent, employee, or representative of the facility, applicant, or owner.

The QIS consultant shall exercise professional, independent judgment in the performance of all such services and shall not be directly or indirectly instructed, guided, influenced or otherwise interfered with by facility, applicant or owners, agents, employees or assigns.

Quality Improvement Specialist Consultant Qualifications
Prior to engagement, the QIS consultant shall be a nursing home administrator and/or registered nurse with nurse leader experience, in possession of a valid occupational license in good standing with the State of Vermont. The QIS consultant must demonstrate recent (within the last five years) experience in providing administrative and care management or consulting services within nursing facilities, as approved by the Department via Pamela Cota [pamela.cota@vermont.gov] or Shannon Stem [Shannon.stem@vermont.gov].

Quality Improvement Specialist Consultant Duties
In conjunction with the nursing home administrator (NHA), director of nursing (DON), medical director, nursing leadership, and other interdisciplinary team members, the QIS consultant shall oversee the development and implementation of an effective quality assurance and performance improvement program. This should include but not be limited to:

(1) Conducting a root cause analysis to determine the reasons the QAPI program was not effectively and efficiently implemented.
(2) Developing, implementing, and monitoring effective, specific action plans for each deficiency identified in the current deficiency list.
(3) Revising any ineffective or underperforming action plan, in accordance with the established performance measures.
(4) Educating applicable staff on:
    a. Their respective roles in completing each action plan developed to address deficient practice identified on the current survey.
    b. Methods for developing, implementing, and tracking the effectiveness of performance improvement plans.
    c. Methods of effectively utilizing scheduled and ad hoc performance improvement meetings to promote quality and prevent performance concerns.
    d. Techniques for identifying potential Quality Assurance and Assessment activities to prevent and remediate quality and performance concerns.
    e. Utilizing the quality improvement network/quality improvement organization for assistance with quality improvement projects.
    f. Utilizing any resident and/or family group to identify quality and performance improvement opportunities.
(5) Overseeing the review, revision, and implementation of the QAPI program policies, to ensure its effectiveness.

4. Monitoring

Monitoring of approaches to ensure compliance with quality assurance and performance improvement activities:

(1) At least weekly, for no less than twelve weeks, across all shifts and units, facility leadership or suitable designees, in conjunction with the QIS consultant, will complete validation audits/observations and record reviews to ensure the following:

a. Quality assurance activities are conducted to verify all residents are provided with a safe, clean, home-like environment, including the necessary housekeeping and maintenance services, in accordance with the requirements for F584.
b. Quality assurance activities are conducted to verify food safety practices meet professional standards in accordance with the requirements for F812.
c. Quality assurance activities are conducted to verify the Medical Director meets regulatory requirements regarding implementation of resident care policies, coordination of medical care in the facility and active participation in QAPI projects in accordance with the requirements for F841 and F865.
d. Quality assurance activities are conducted to verify a comprehensive infection prevention and control program is established and all systems, standards, policies and procedures are implemented in accordance with accepted national standards and local health department guidance, in accordance with the requirements for F880.

(2) The NHA, with the assistance of the QIS consultant, shall track and trend the success of all quality assurance performance improvement activities. Such tracking and trending data shall be reported to the quality assurance process improvement committee monthly for no less than three months and shall continue until all performance plan objectives related to maintaining an effective quality assurance performance improvement program are consistently demonstrated.

The QIS consultant shall make weekly written reports for the first twelve weeks to the Department on all plan implementation, education, training, and monitoring related to quality assurance and performance improvement. Such reports shall be provided to the Department via email, [pamela.cota@vermont.gov and Shannon.stem@vermont.gov] beginning no later than **3/6/2026** then each following Friday with the final weekly report being submitted on Friday, **5/22/2026.**

Reports to the state agency should include any action steps that were taken by the facility, what action steps are needed to achieve or maintain the corrective action per consultant, and the facility's adherence related to corrective action; system changes, including a root cause analysis to identify system failure(s), ensuring adequate QAPI processes are in place, staff education; and a process to monitor compliance and/or progress in achieving compliance.

After the first twelve weeks, with Department approval, reports shall be due on the 15th of each month. Reporting shall then continue to be due monthly on the 15th for a minimum of three months and shall only be discontinued when the facility has demonstrated consistent implementation of all requirements of §483.75(d).

5. Correction Date
2/28/2026

The filing of this plan of correction does not constitute an admission of the 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.

F0584: Safe/Clean/Comfortable/Homelike Environment

All residents who reside in the facility are at risk for the alleged deficient practice.

A house wide has been conducted to ensure compliance with the following alleged deficiencies:

1) Shower curtains are free from tears.
2) Shower rooms are kept clean and orderly.
3) Shower rooms are free from jagged metal and broken tiles.
4) Overbed tables have laminate intact and are free from foreign debris.
5) Dressers are intact with no torn or missing laminate.
6) All window heater encasements can be effectively cleaned and sanitized.
7) All resident rooms and communal areas are clean and free from debris.
8) All handrails are free from rough and/or splintering areas.
9) All pull cords are long enough for residents to reach and all shoestring material pull cords are replaced with chain.

All staff have been reeducated on residents' rights to a clean, safe, comfortable, and homelike environment.

The following corrective actions will occur, or have already occurred, to ensure compliance:

1) All shower curtains in the Wing #1 and Wing #2 shower rooms have been replaced.
2) The housekeeping department has been reeducated on the importance of cleaning the shower room on a daily basis and has been assigned to deep clean both shower rooms every Thursday in addition to their daily cleaning schedules. All LNAs and nurses will be reeducated on cleaning/sanitizing the shower room after each use.
3) All tiles in both shower rooms have been fixed and/or replaced.
4) New overbed tables will be ordered and placed into service within a reasonable timeframe upon delivery to the facility. All overbed tables will be cleaned on a daily basis by housekeeping and nursing staff.
5) New dressers will be ordered and placed into service within a reasonable timeframe upon delivery to the facility.
6) All heaters encased with bare, unpainted, raw wood will be sanded and painted or covered with a protective material that can be easily cleaned/sanitized.

7) The administrator implemented a deep clean schedule for the housekeeping department, including resident rooms and all communal areas. Housekeeping staff are to sign off on their deep cleans as they complete them. Administrator and housekeeping manager to check on these areas to ensure cleaning is properly completed.
8) All rough and splintered handrails will be sanded and restained.
9) All shoestring cords, and short cords will be replaced with long chains that can be cleaned and sanitized effectively.

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.

Audit results will be reviewed at QAPI for further interventions.

Date of completion: February 28, 2026

F812: Food Procurement, Store/Prepare/Serve-Sanitary

All residents who reside in the facility are at risk for the alleged deficient practice.

A house wide audit has been conducted to ensure all expired food items located in the walk-in refrigerator and walk-in freezer have been discarded, and all dented canned foods are placed in a designated area to avoid being used.

The dietary department has been reeducated on the importance of rotating food upon each delivery to avoid food from expiring, as well as ensuring all dented canned food is placed in a designated area to avoid being use.

The dietary manager completed a full inventory of food items in the walk-in refrigerator and walk-in freezer and discarded all existing expired food items. They also created a designated area in the dry food storage for all dented canned foods to be placed to avoid being used.

The administrator or designee will conduct random weekly audits X 4 and monthly X 2 to ensure no expired food items are located in the walk-in refrigerator and walk-in freezer, and all that dented canned foods are located in their designated space.

Audit results will be reviewed at QAPI for further interventions.

Date of completion: February 28, 2026

F0841: Responsibilities of the Medical Director

All residents who reside in the facility are at risk for the alleged deficient practice.

The medical director has been educated on expectations and responsibilities of their role in the facility.

The following corrective actions have been implemented to ensure compliance:

1) The administrator and/or director of nursing sends a daily update to the medical director, Monday through Friday, to inform them of admissions, readmissions, discharges, infection control concerns, outbreaks, VDH correspondences, etc. Weekend updates are included on Monday's update.
2) The medical director, administrator, and director of nursing meet weekly, Monday's at 12:30p via Teams. This meeting is designated for discussion surrounding infection control concerns, education opportunities, and any concerns that are relevant at that time.
3) The director of nursing has been forwarding all correspondences between VDH and the facility to the medical director.
4) The facility has rescheduled all QAPI meetings to the third Wednesday of every month at 1:30p to ensure the medical director participates via Teams or in person.
5) The medical director has met with all of his physicians and midlevel providers to reiterate their responsibilities and to establish his expectations. The medical director plans on holding these meetings quarterly.
6) The medical director has implemented an email thread to include all Vermont providers as a way to communicate policy/procedure implementation, and to clarify processes that exist in facilities, etc.

All corrective actions listed above will be ongoing. The administrator or designee will conduct random weekly audits X 4 and monthly X 2 to ensure all methods of communication are occurring.

Audit results will be reviewed at QAPI for further interventions.

Date of completion: February 28, 2026

F0865: QAPI Prgm/Plan, Disclosure/Good Faith Attmpt

All residents who reside in the facility are at risk for the alleged deficient practice.

1. **Corrective Action**

The facility will contract with a quality improvement specialist (QIS) with nursing home administrator and/or director of nursing experience to provide consultation and oversight for quality assurance and performance improvement activities. The facility will immediately implement appropriate quality assurance and process improvement plans consistent with the requirements of §483.75 (a)(b)(f) in order to address facility failures in: providing a safe, clean, homelike environment, §483.10(i); providing a sanitary kitchen, §483.60(i)(2); providing adequate medical director services, §483.70(g)(2); and establishing and implementing a comprehensive infection prevention and control program;§483.80(a).

The nursing home administrator (NHA), director of nursing (DON), medical director, nursing leadership, and other applicable interdisciplinary team (IDT) members, in conjunction with the QIS, shall review quality assurance performance improvement activities and create performance improvement plans related to environment, medical director, sanitary kitchen, and infection prevention and control. Such action plans will, at minimum include:

1) Ensuring systems are in place to guarantee that all residents are provided with a safe, clean, home-like environment, including the necessary housekeeping and maintenance services, in accordance with the requirements for F584.
2) Ensuring systems are in place to guarantee that food safety practices meet professional standards, in accordance with F812.
3) Ensuring the medical director meets regulatory requirements regarding implementation of resident care policies, coordination of medical care in the facility and active participation in QAPI projects, in accordance with F841 and F865.
4) Ensuring a comprehensive infection prevention and control program is established and all systems, standards, policies and procedures are implemented in accordance with accepted national standards and local health department guidance, in accordance with F880.

2. **Identification of Others**

The NHA, DON and applicable members of the IDT, in accordance with the QIS consultant, shall audit all current performance improvement plans not specific to those mentioned above in "1) CORRECTIVE ACTION" to determine the efficacy of each plan. Plans identified as ineffective will be reviewed and revised with the assistance of the QIS consultant. The QIS consultant will assist the facility leadership with identifying the root cause of the inefficacy for those plans identified as ineffective.

3. System Changes

On or before 2/28/2026 the facility shall hire a QIS consultant with experience consulting or directing nursing services or nursing home administration duties within nursing facilities. The QIS consultant shall exercise independent judgement in the performance of all duties under the consultant contract. The QIS consultant shall meet the independent judgement requirement if the consultant is not currently an employee of the facility or its corporate organization and has not within a five (5) year period immediately preceding 2/2/2026 been directly or indirectly affiliated with the facility, facility's owner(s), agent(s), or employee(s).

In performance of all services provided, the QIS consultant's status shall be that of an independent contractor and not that of an agent, employee, or representative of the facility, applicant, or owner.

The QIS consultant shall exercise professional, independent judgment in the performance of all such services and shall not be directly or indirectly instructed, guided, influenced or otherwise interfered with by facility, applicant or owners, agents, employees or assigns.

Quality Improvement Specialist Consultant Qualifications

Prior to engagement, the QIS consultant shall be a nursing home administrator and/or registered nurse with nurse leader experience, in possession of a valid occupational license in good standing with the State of Vermont. The QIS consultant must demonstrate recent (within the last five years) experience in providing administrative and care management or consulting services within nursing facilities, as approved by the Department via Pamela Cota or Shannon Stem.

Quality Improvement Specialist Consultant Duties

In conjunction with the nursing home administrator (NHA), director of nursing (DON), medical director, nursing leadership, and other interdisciplinary team members, the QIS consultant shall oversee the development and implementation of an effective quality assurance and performance improvement program. This should include but not be limited to:

1) Conducting a root cause analysis to determine the reasons the QAPI program was not effectively and efficiently implemented.
2) Developing, implementing, and monitoring effective, specific action plans for each deficiency identified in the current deficiency list.
3) Revising any ineffective or underperforming action plan, in accordance with the established performance measures.
4) Educating applicable staff on:

a. Their respective roles in completing each action plan developed to address deficient practices identified on the current survey.
b. Methods for developing, implementing, and tracking the effectiveness of performance improvement plans.
c. Methods of effectively utilizing scheduled and ad hoc performance improvement meetings to promote quality and prevent performance concerns.
d. Techniques for identifying potential Quality Assurance and Assessment activities to prevent and remediate quality and performance concerns.
e. Utilizing the quality improvement network/quality improvement organization for assistance with quality improvement projects.
f. Utilizing any resident and/or family group to identify quality and performance improvement opportunities.

5) Overseeing the review, revision, and implementation of the QAPI program policies, to ensure its effectiveness.

4. **Monitoring**

Monitoring of approaches to ensure compliance with quality assurance and performance improvement activities:

1) At least weekly, for no less than twelve weeks, across all shifts and units, facility leadership or suitable designees, in conjunction with the QIS consultant, will complete validation audits/observations and record reviews to ensure the following:
    a. Quality assurance activities are conducted to verify all residents are provided with a safe, clean, home-like environment, including the necessary housekeeping and maintenance services, in accordance with the requirements for F584.
    b. Quality assurance activities are conducted to verify food safety practices meet professional standards in accordance with the requirements for F812.
    c. Quality assurance activities are conducted to verify the medical director meets regulatory requirements regarding implementation of resident care policies, coordination of medical care in the facility and active participation in QAPI projects in accordance with the requirements for F841 and F865.
    d. Quality assurance activities are conducted to verify a comprehensive infection prevention and control program is established and all systems, standards, policies and procedures are implemented in accordance with accepted national standards and local health department guidance, in accordance with the requirements for F880.
2) The NHA, with the assistance of the QIS consultant, shall track and trend the success of all quality assurance performance improvement activities. Such tracking and trending data shall be reported to the quality assurance process improvement committee monthly for no less than three months and shall continue until all performance plan objectives

related to maintaining an effective quality assurance performance improvement program are consistently demonstrated.

The QIS consultant shall make weekly written reports for the first twelve weeks to the Department on all plan implementation, education, training, and monitoring related to quality assurance and performance improvement. Such reports shall be provided to the Department via email, beginning no later than 3/6/2026 then each following Friday with the final weekly report being submitted on Friday 5/22/2026.

Reports to the state agency should include any action steps that were taken by the facility, what action steps are needed to achieve or maintain the corrective action per consultant, and the facility's adherence related to corrective action; systems changes, including a root cause analysis to identify system failure(s), ensuring adequate QAPI processes are in place, staff education; and a process to monitor compliance and/or progress in achieving compliance.

After twelve weeks, with Department approval, reports shall be due on the 15th of each month. Reporting shall then continue to be due monthly on the 15th for a minimum of three months and shall only be discontinued when the facility has demonstrated consistent implementation of all requirements of §483.60(d).

Date of completion: February 28. 2026

F0880: Infection Prevention & Control

All residents who reside in the facility are at risk for the alleged deficient practice.

Resident #1 continues to reside at the facility and Resident #2 discharged from the facility on January 16, 2026.

A house wide infection control audit was conducted including hand hygiene, PPE use, and transmission-based precautions/appropriate signage.

All staff were reeducated on proper hand hygiene, PPE use, transmission-based precautions/appropriate signage, and Strep A testing guidelines as recommended by the Vermont Department of Health (VDH).

The facility consulted with the VDH regarding the Group A Streptococcus outbreak. The VDH reviewed outbreak management protocols, provided testing recommendations, and guided treatment and monitoring practices. The facility implemented the recommended testing and monitoring plan and continues to communicate with VDH as indicated.

All correspondences regarding Group Strep A have been communicated with the medical director. Standardized isolation and EPP signage have been updated.

The DON or designee will conduct random weekly audits X 4 and monthly X 2 to ensure hand hygiene and PPE use is occurring per infection control guidelines.

Audit results will be reviewed at QAPI for further interventions.

Date of completion: February 28. 2026