STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	475037	A. Building B. Wing	06/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Barre Gardens Nursing and Rehab, LLC	378 Prospect Street Barre, VT 05641

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. Based on interview and record review, the facility failed to review and revise resident care plans for 2 residents related to falls (Residents #34 and #1) and for 2 residents related to pressure ulcers (Residents #39 and #9), of a sample of 23 residents. This is a repeat deficiency for this facility, with the violation cited during the previous recertification survey, dated 5/9/24. Findings include: 1) Per record review, Resident # 39 has diagnoses that include: hemiplegia and hemiparesis (paralysis and weakness on one side of the body), chronic kidney disease stage 3 (moderate kidney damage), and osteomyelitis (infection of the bone) of the pelvis. On 6/2/25, a Weekly Skin Review notes a blister on the right heel. Skin prep is applied, and the wound is covered with a foam dressing. On 6/9/25, a weekly skin check revealed a blister on the right heel with a 1 cm x 1 cm red area in the center. A progress note dated 6/15/2025 reveals a hospital transfer, where it was noted that resident #39 had a Deep Tissue Injury to the right heel, measuring 4 centimeters (cm) in length, 5 cm in width, and 0.1 cm in depth. Per review of the Care Plan, there is no mention of a right heel ulcer or interventions until 6/17/2025 when s/he returned to the facility from the hospital. Per the facility's Skin and Wound Management System with a revised date of 9/2022, the Interdisciplinary Care Plan will be developed, and will identify the contributing risks for breakdown, or the actual skin impairment, and the interventions implemented and updated as needed. An interview on 6/25/2025 at 8:51 AM with the Director of Nursing revealed that she was not aware of the wound until the 6/15/2025 hospital admission. The care plan should have been revised to reflect the wound and interventions, and the facility did not follow its Skin and Wound policy. 2)Per review of Resident #1's care plan, there was no documented evidence of revision or interventions related to a fall out of bed on 4/13/25, when Resident #34 attempted to climb into bed with him/her. A nursing note dated 4/13/25 revealed [Resident #1] was in bed, roommate [Resident #34] was trying to get into [his/her] bed, resident tried to stop the roommate, which resulted in an unwitnessed fall. [Resident #1] was on the floor when this writer arrived, a large hematoma to the left elbow noted as well as pain . (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A facility risk management completed on 4/13/25 stated Resident #1 reported to the nurse [his/her] roommate was on [his/her] side of the room, pushing [his/her] bed side table and running into [him/her]. [S/he] tried to get [him/her] away from the bed which caused [him/her] to slip on the floor . Per review of the care plan for Resident #1 his/her care plan was not revised, and there was no evidence that the care plan included measures to prevent Resident #1 from sustaining a second injury related to a resident to resident altercation. A nursing note dated 6/7/25 revealed the following Res [Resident #1] sitting on floor leaning back against bed and left elbow. Lg hematoma on left eye brow, getting larger. C/O pain in left hip and left elbow. Per hospital physician note dated 6/8/25, Resident #1 reported to the physician that s/he was struck several times by his/her roommate's [Resident #34] wheelchair, causing him/her to fall. Per facility investigation of Resident-to-Resident Altercation dated 6/13/25, LNA [Licensed nursing assistant] heard [Resident #1] say, I hate you [to] [Resident #34] . Upon entering the room, [the LNA found Resident #1] leaning up against [his/her] bed, slightly slouching toward the left . When asked what happened, [Resident #1] stated [s/he] made me fall referring to [his/her] roommate . [S/he] stated [Resident #34] pushed [his/her] wheelchair into [him/her]. Per facility records there were two incidents between Resident #1 and Resident #34, and no care plan updated until after the second incident on 6/8/25. 3)Per record review, Resident #34 has a history of dementia with agitated and aggressive behaviors, with a history of wandering into other resident rooms and biting staff. According to the APRN note dated 10/4/24, Resident #34 presented with agitated behaviors, including swinging their walker at other residents and wandering into other residents' rooms. A Psychiatric Consult note dated 6/12/25, revealed the following regarding recommendations for Resident #34, [S/he] requires 1:1 supervision, is not redirectable, is impulsive, intentionally harms others. [S/he] has numerous documented refusals to take medications for depression, anxiety, agitation, aggression, and has hurt other residents, tried to bite a staff member, pushed a resident down causing serious injury, climbs on counters and beds, and is a risk to him/herself and others. For all of these reasons, It is my opinion that [Resident #34] lacks the Capacity to make [his/her] own healthcare decisions, and requires IM medication to protect him/herself and others. Per care plan review there was no evidence of updates related to the need for 1:1 and no evidence of orders related to the recommendations by the psychiatrist. Per the interview of the Director of Nursing on 6/27/25 at approximately 12:15 PM, s/he confirmed that Resident #1's care plan did not have evidence of the previous altercation between Resident #1 and Resident #34. 4) Per record review, Resident #9 has a wound assessment of the left heel on 4/22/25 by Integrated Wound Care. The assessment of the left heel indicates a stage 2 pressure ulcer of the heel, and a treatment plan includes wound care and to offload pressure of the resident's heels whenever in bed. The care plan doesn't indicate this treatment change. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Per interview on 6/24/25 at approximately 2:23 PM, the Wing 2 Unit Manager (UM) confirmed resident's care plan doesn't include the need to offload pressure of the heels whenever in bed or wound care for the resident's heels. The UM stated it should be included and stated she would add this to the plan.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure residents remained as free from accidents as possible related to resident altercations and falls for 2 of the 9 sampled residents (Residents #1 and #34) by failing to provide adequate supervision and create and implement effective, timely interventions that would reduce the likelihood of future accidents related to supervision. As a result, Resident #1 suffered a fall that resulted in pain, a large hematoma above his/her left eye, and a fracture of the left hip, which required surgery. Findings include: 1. Per record review, Resident #1 has diagnoses that include a history of falls, osteoporosis, and failure to thrive. Resident #1 is alert and oriented, and per record review, an MDS dated [DATE] revealed Resident #1 was independent for ambulation with a walker prior to the incident on 6/7/25. Per hospital physician note dated 6/8/25, Resident #1 reported to the physician that s/he was struck several times by his/her roommate's [Resident #34] wheelchair, causing him/her to fall. Per interview with Resident #1 on 6/23/24 and 6/24/25 at approximately 2:00 PM and again at 8:30 AM, s/he stated s/he was worried about his/her safety at the facility and describes being hit by a wheelchair several times. S/he stated that s/he is fearful that it will happen again, and s/he would only feel safe in his/her own home. Resident #1 is observed to have a large hematoma to his/her left eye that is covering the lid, and s/he is unable to open his/her eye completely. Resident #1 has a large hematoma on his/her left elbow. S/he stated that it is painful and rubs the area with his/her right hand. S/he stated that s/he is hopeful the pain will not be the same in his/her eye as it remains in his/her elbow. A nursing note dated 6/7/25 revealed that Resident #1 was found with his/her back against the bed, on the floor, a large hematoma over his/her left eyebrow and complained of pain in his/her left hip. Per interview on 6/24/25 at approximately 2:15 PM with the License Nursing Assistant caring for Resident #1 on the evening of the fall, she stated she did not witness the fall; however, she heard the resident holler at his/her roommate I hate you and that Resident #34 had pushed his/her wheelchair into him/her. A primary care physician's note dated 6/24/25 revealed Resident #1 had a mechanical fall on [6/7/25] after an assault by [his/her] roommate [Resident #34], s/p fixation [of the left hip], controlled discomfort with tramadol . (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	According to a record review, this was not the first incident of a resident-to-resident altercation between Residents #1 and #34 resulting in a fall and injury to Resident #1. A nursing note dated 4/13/25 revealed [Resident #1] was in bed, roommate [Resident #34] was trying to get into [his/her] bed, resident tried to stop the roommate which resulted in an unwitnessed fall. [Resident #1] was on the floor when this writer arrived, a large hematoma to the left elbow noted as well as pain . A facility risk management completed on 4/13/25 stated Resident #1 reported to the nurse [his/her] roommate was on [his/her] side of the room, pushing [his/her] bed side table and running into [him/her]. [S/he] tried to get [him/her] away from the bed which caused [him/her] to slip on the floor . A nurse practitioner's note dated 6/2/25 revealed that Resident #1 continued to have swelling and pain in the left elbow after the injury sustained on 4/13/25. 2. Per record review, Resident #34 has a history of dementia with agitated and aggressive behaviors, with a history of wandering into other resident rooms and biting staff. According to the APRN note dated 10/4/24, Resident #34 had a history of agitated behaviors, including swinging their walker at other residents and wandering into other resident's rooms. A Psychiatric Consult note dated 6/12/25, revealed the following regarding recommendations for Resident #34, [S/he] requires 1:1 supervision, is not redirectable, is impulsive, intentionally harms others. [S/he] has numerous documented refusals to take medications for depression, anxiety, agitation, aggression, and has hurt other residents, tried to bite a staff member, pushed a resident down causing serious injury, climbs on counters and beds, and is a risk to him/herself and others. For all of these reasons, It is my opinion that [Resident #34] lacks the Capacity to make [his/her] own healthcare decisions, and requires IM medication to protect him/herself and others. Per Resident #34's care plan focus dated 12/10/22, [Resident #34] is at risk for/demonstrates physical/combative behaviors at times r/t Anger, Dementia, MDD [Major Depression Disorder], Anxiety, Poor impulse control . [An intervention includes] Psych consult as ordered. Resident #34's care plan also reveals that s/he becomes agitated when others are in his/her space. According to an interview with the Director of Nursing on June 25, 2025, at approximately 3:30 PM, the Director of Nursing stated that Resident #34 does not have a 1:1 for supervision and that at times, the nurse on the medication cart acts as a 1:1 while in the hall, passing medications. She further stated this was not added to the care plan for Resident #34 after the 6/12/25 psychiatric consult. According to record review, there were no documented orders for 1:1 care as per the consultants' recommendations. 3). Per observation on 6/24/25 at 8:45 AM, Resident #34 was in his/her wheelchair, unable to reach the table to eat his/her breakfast. Physical Therapy (PT) entered the room and placed Resident #34 in a chair with a large blue cushion. Per observation, Resident #34's feet were dangling approximately 4 inches off the floor. According to an interview with PT on 6/24/25 at approximately 8:50 AM, she stated that she was using the chair temporarily so that Resident #34 could eat their meal. Per further observation at 12:15 PM, Resident #34 remained in the chair in the dining area without supervision. His/her feet were unable to touch the floor, and the wheelchair was locked in place. During observation, Resident #34 attempted to stand 3 times, without staff presence or intervention. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	According to an interview with the Director of Nursing on 12/24/25 at 12:25 PM, she stated that the resident can self-propel in his/her wheelchair and confirmed that Resident #34's feet were unable to touch the ground, DON also observed Resident #34 attempting to stand from the wheelchair and confirmed that s/he had a history of falls and that Resident #34 did not appear safe in the wheelchair. DON contacted PT and requested the wheelchair be exchanged due to safety concerns. Upon reviewing facility risk management reports, it was noted that Resident #34 has experienced multiple falls, with the most recent incident occurring on 6/20/25. A 6/20/25 progress note reads, LNA reported that she found resident lying on floor. When this nurse went to assess resident, [s/he] had got up off the floor and laid in the bed. Resident alert and ROM [range of motion] WNL [within normal limits]. Several skin tears noted as well as 2 large blood filled blisters and abrasions on bilateral knees .[sic]. According to an interview with a licensed practical nurse (LPN) on June 25, 2025, at 3:00 PM, she stated that Resident #34 exhibits restlessness at times, primarily at night, and can be challenging to redirect. She said that s/he can move around the room and wanders at times into other resident rooms and spaces. She stated that Resident #34 recently attempted to climb onto their bureau in his/her room and the nurse station desk. She stated that Resident #34 had a fall on 6/20/25 and sustained a skin tear to the left arm and right shin. Per facility fall policy titled Falls Management System last revised 2016, The center is committed to promoting residents autonomy by providing an environment that remains as free of accidents and hazards as possible. Each Resident is assisted in attaining or maintained their highest practicable level of functions through providing the resident adequate supervision, assisted devices and functional programs to prevent accidents.