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	11/13/2025

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on record review and interview it was determined that the facility failed to treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of her/his quality of life, recognizing each resident's individuality for 1 resident in a sample of 9 residents. (Resident #4).Findings include:Per record review, Resident #4 has diagnoses that include Alzheimer's disease, dementia, bipolar disease, schizophrenia, and need for assistance with personal care. Per Resident #4's care plan, revised 11/4/25, EATING: [She/he] requires extensive assist from staff participation to eat. Staff please encourage resident to open hand to engage in self-feeding and holding cup during meals. On 11/4/25 at 12:55 PM, an observation was conducted of Resident #4 during lunch. An LNA (licensed nursing assistant) was observed assisting the resident with eating. She/he was standing next to resident and leaning over to place the food in the resident's mouth. The LNA repeated the process of standing next to the resident and assisting with feeding. On 11/4/25 at 12:57 PM, an interview was conducted with the LNA. She/he was asked if they should be sitting at eye level with the resident. She/he stated, I choose not to do that. Upon further inquiry about facility practice with regard to sitting next to residents while assisting in eating, She/he responded, 'I don't do that. Facility policy titled Resident Rights, revised June 2023, states that Federal and state laws guarantee basic rights to all residents of this facility. These rights include the right to a dignified existence and to be treated with respect, kindness and dignity. On 11/4/25 at 2:45 PM, an interview was conducted with the Administrator. They confirmed that facility practice is to sit at eye level with a resident while assisting them with eating, and that this was communicated to staff when they go through orientation.

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based upon observation, interview, and record review, the facility failed to ensure that areas used for bathing/showering, resident rooms, and a resident gathering area were clean, safe, and homelike. This deficient practice has the potential to affect all residents residing in the facility. This is a repeat deficiency for this facility, with the violation cited during the previous two recertification surveys, dated 6/25/25 and 5/9/24, and partial survey dated 4/17/25. Findings include: During the initial tour of the facility on 11/4/25 at approximately 10:40 AM the following observations were made: Wing 1 short hall, room [ROOM NUMBER] and room [ROOM NUMBER] appeared dirty with loose debris on the floor. At the end of Wing 1 short hall there was a room that contained a tub room, a bathroom, and a shower room. The tub room revealed a tub chair that had a loose white powdery substance on the seat and the foot pedals had a thick white and gray substance within the pattern of both foot pedals. The shower room area contained a rolling cart with the top shelf containing 3 bottles of hair conditioner, 2 bottles of shampoo, a bottle of body wash, a bottle of quaternary ammonium chloride disinfectant cleaner (a concentrated cleaning formula use to cut cleaning time and quickly wipe out a broad spectrum of bacteria, like viruses and fungi) and a handful of unboxed gloves. The second shelf on this rolling cart contained 2 boxes of gloves and 4 razors. The shower room revealed a lift bar/rail with a disposable rubber glove tied to the rail. The corner bead (a protective strip, typically made of vinyl or metal, that is installed on outside corners where two pieces of drywall meet to reinforce and protect the corner) going into the shower room revealed broken, rusted, and jagged metal. Many broken floor and wall tiles were noted throughout this area between the shower room, the tub room, and the bathroom. Per interview on 11/4/25 at approximately 10:55 AM with the travel LPN #1, they confirmed the noted concerns listed above. Observation on 11/4/25 at approximately 11:05 AM of the Sun Room on Wing 1 revealed trash cans without trash bags inside; a coffee carafe that was dirty with a brown substance on all sides; a drawer within a cabinet that contained packets of condiments noted to have what appeared to be food debris throughout the drawer and a puddle of a brown sticky substance; a chair with fabric back, armrests and seat that had a dried reddish brown substance in droplet form on the seat that was still accessible for use; a yellow substance that appeared to be scrambled eggs under a table and on the windowsill next to the table; a pillow without a pillow case on the steam table; the floors appeared dirty with spills and debris; and a cooler of ice with a gray coffee cup sitting on a cart next to the and the inside of the cooler cover was dirty. Outside the sunroom was a small area with a counter and a fridge. Upon the counter was a blue tray with partially eaten breakfast foods, coffee cups, and miscellaneous silverware. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Per interview on 11/4/25 at approximately 11:30 PM with the travel LPN #1, they confirmed the above noted concerns. S/he stated that this sunroom is used as a dining area and housekeeping does not have enough staff. S/he stated, if I knew where they kept the brooms and mops, I could help when I had some time to do so. S/he confirmed that the tray with various partially eaten breakfast foods was there from breakfast and had to be taken down to the kitchen or they may wait until the next meal and send it back to the kitchen on one of the carts. Observation on Wing 1 of the nurse's station revealed a thick pile of crumbs/debris in front of the nurse's station that went the length of the nurses' station. Interview on 11/4/25 at approximately 11:50 AM with the travel LPN #1, they confirmed that these were cookie crumbs and that staff will give the residents cookies when they are sitting out in this area. S/he was asked about housekeeping staff, and s/he responded that s/he is aware that there are not enough housekeeping staff to keep the area clean and neat. Observation on 11/4/25 at approximately 12:10 PM residents were being brought to the sunroom for their lunch meal. The room had not been cleaned prior to the residents arriving to the sunroom for this meal. On 11/4/25 at approximately 12:20 PM the physician was asked about the poor conditions and how dirty the facility currently is, and s/he explained that s/he will be addressing that in her/his 6-month plan. S/he was asked for a copy of the 6-month plan and s/he stated, it's in draft form at this point. The physician confirmed that the facility was dirty and stated, yes, the residents here do have a right to live in a clean facility. S/he was asked if s/he considered the facility clean enough for the residents that lived there and s/he stated, no, it needs to be better. Observation on 11/4/25 at approximately 12:45 PM of Wing 1 Long Hall revealed room [ROOM NUMBER] with dirty floors, the overbed lights had 2 inch pull chords (used to turn the light on), a fan with a thick coat of dust on the back and front fan piece, the bathroom exhaust fan covered in a thick coat of dust, and cobwebs in all 4 corners of the bathroom. Observation on 11/4/25 at approximately 12:50 PM of room [ROOM NUMBER], the door to the room was broken at the hinge and revealed splintered wood fragments, there was a used blood glucose test strip on the floor, the overbed table by the door bed was covered on the wheels and metal support with a thick dried white milky type substance, the privacy curtains had a dried brown substance on the outer edge and about 2 feet in from the outer edge, the overbed lights for both beds only had a 2 inch pull chord, and there was an uncovered pillow on the bed next to the window with its plastic cover torn in many areas revealing the pillows contents. Observation on 11/4/25 between 1 PM and 1:20 PM of rooms 165 through 176 revealed various housekeeping issues specific to the cleanliness of each room. Floors were dirty, a lot of various types of debris were noted, bathroom fans were noted to be covered with thick dust, toilets were dirty and not clean inside or out or the floor around the toilets. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of the housekeeping schedule from 11/9/25 to 11/15/25 revealed the following: 11/9/25 - 8 hours of housekeeping (1 staff); 11/10/25 - 13 hours between 2 staff; 11/1/25 - 8 hours (1 staff); 11/12/25 - 7 hours (staff orientee and no other staff listed to orient this new staff); 11/13/25 - 10 hours (1 staff); 11/14/25 - 7 hours (staff orientee and no other staff listed to orient this new staff); 11/15/25 - 7 hours (staff orientee and no other staff listed to orient this new staff). Per interview on 11/4/25 at approximately 3 PM with the Administrator, s/he confirmed that they did not have many housekeeping staff, 2 had recently walked out, and both the maintenance director and assistant maintenance director had left employment at this facility. S/he confirmed that the facility was not clean and that there was not enough housekeeping staff to clean the facility or maintain the facility at this time. 2. During the initial tour of the facility on 11/13/25 at approximately 10:00 AM the following observations were made: Wing 2 Long Hall, there was a trail of liquid down the hallway, and debris on the floor by the medication cart. Wing 2 Showers in the bathroom, the toilet safety bar was noted to have paper tape covering two holes. Light-colored caulk between tiles on both floors and walls was noted to have a buildup of black debris, which appears to be mold and mildew. A shower chair had a pinkish-orange buildup of debris at the connections. There was debris behind the doors, including spider webs and rust on the doorframes, with holes where the frames met the floors. The room with the bathtub had a Hoyer lift and cardboard boxes being stored in it. Wing 2 Short Hall, Resident room [ROOM NUMBER] revealed a strip of plastic-like material approximately 4-6 inches wide at chair rail level, which runs the full length of the right-hand side of the Residents' room. The strip was falling off the wall. In one of the alcoves, a dirty spoon was on the seat of a wheelchair In the Crossover area, a chair was noted to have worn off vinyl on both arms. Wing 1 Showers, the shower floors and walls had dark debris, which appeared to be mold and mildew, and there was a breach in the tile wall on the corner. The ceiling vent had a buildup of dust. The doorframe metal had a hole at the base, and debris is visible behind the door. There was yellow colored debris on the shower chair. In the bathroom, the call bell pull is a shoelace covered with paper tape, and the end has the shoelace material exposed. In the whirlpool room, there was a sticker, and a medication cup with white powder was located on the frame of the bathtub. Hair is in the wheels of a bath chair, and two black bundles of unknown substance were on the floor under the chair. There is a box of gloves on the floor, and a Broda chair (a type of wheelchair) with a resident gown. The bathtub chair foot supports have a white residue, and there is a walker with a used bedsheet. A chair located in the corner had used resident socks. Debris and a brown, dried liquid were noted in the whirlpool. Per interview on 11/13/25 at 3:00 PM, the Infection Prevention staff member confirmed housekeeping concerns. She stated two staff members had left abruptly and the Administrator has implemented leadership members assisting the remaining housekeeping staff with their duties by selecting five resident rooms weekly to clean. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Per interview on 11/13/25 at 3:50 PM, the Administrator confirmed housekeeping staffing to be inadequate, and the leadership team is assisting the department with cleaning. When asked if there were education or audits for cleaning, she stated, all had to do it before. 3. During the initial tour of the facility on 11/13/25 at approximately 10:00 AM the following observations were made: In room [ROOM NUMBER] a trail of crumbs were on the floor, with a small partially crushed plastic cup. There was a trail of visible black residue on the floor from the doorway and extended approximately two feet out of the room In between room [ROOM NUMBER] and room [ROOM NUMBER] an alcohol wipe package was observed on the floor with a red piece of plastic and a white piece of plastic lying beside it In room [ROOM NUMBER] there were orange crumbs observed by the bottom of the bed Outside of room [ROOM NUMBER] there was a rubber band on the floor and a small piece of paper In room [ROOM NUMBER], the brown bumper guard against the wall was falling off the wall and was observed partially on the empty bed There was a clump of hair observed at the nurse's station by room [ROOM NUMBER] A dead brown, multilegged insect was observed on the floor and a partial footprint was noted adjacent to the insect The entrance to room [ROOM NUMBER] at the base on the doorframe was black and grey with residue on the floor, visible footprints and black and grey marks that appeared to be from shoes observed in the room and immediately outside of the room Outside room [ROOM NUMBER], immediately to the left, were brown stains extending down from the wall below the handrail. Additionally, there was a cluster of hair against the exterior frame of the door Between room [ROOM NUMBER]-119 two clumps of hair observed on the floor room [ROOM NUMBER] had black residue coming off the floor to the left and right of the doorframe room [ROOM NUMBER] had crumbs below the two dressers with one piece of paper balled up in front of the trash can near the door room [ROOM NUMBER] had visible brown and black matter on the floor that appears to be dirt The sunroom (near room [ROOM NUMBER]) had a clump of hair on the floor by the door. Next to the windows facing a small green yard, there was multiple brown clumps and crumbs on the floor. Additionally, the resident bedside table by the windows had brown matter on it. Opposing the windows facing the green yard, on the other side of the room, there was a rubber band on the floor. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Outside room [ROOM NUMBER], to the left of the exterior door frame, below the handrail, there was a circular blob of a white and grey substance. There was one primary circular blob of this substance with two smaller circles of white and grey matter immediately next to it. Three circular like blobs of an unknown substance in total. In the shower room there was hair observed on the floor, brown residue smeared onto the wall, and brown residue on the shower chair. Additionally, hair was observed in the shower drain and there was a large amount of a brown smelly substance in the toilet that had not been flushed, on the seat of this toilet, there was also a brown residue. The shower wall had specks of black and grey on the tile and wall and the shower vent was covered in a thick white and grey substance.

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F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate foot care. Based on observation, staff interview, and record review the facility failed to ensure that 1 resident in the applicable sample (Resident #6) received proper foot care.Findings include:Per observation on 11/13/25 at 10:21 AM, Resident #6 was sitting barefoot at the edge of the bed with his/her feet on the floor. Resident #6's feet appeared to be dry and had long discolored toenails that were thick.Per interview with Resident #6 on 11/13/25 at 10:21 AM, they reported that their toenails are very long and that it is an issue, they haven't had their nails trimmed in a long time or seen a podiatrist.Per record review of Resident #6's care plan dated 9/19/25, s/he is care planned for skin breakdown due to impaired mobility, DM (Diabetes Mellitus), and peripheral vascular disease. Interventions include Podiatry consult as needed with a date of 3/8/23. The care plan also identifies that the resident has an ADL (activities of daily living) self-care performance deficient and requires assistance with personal hygiene, dated 3/8/23.Per review of the facilities policy titled Fingernails/Toenails, Care of with a revision date of 2/18, it states that the purpose of this procedure is to clean the nail bed, to keep nails trimmed, and to prevent infections. Nail care includes daily cleaning and regular trimming.Per interview with the Physician on 11/13/25 at 3:30 PM, he reported that he is having to triage work and is prioritizing the most urgent visits as there is only one provider for the residents. He reported that he hasn't time to do anything except for crisis management.Per interview with the Administer and Director of Nursing (DON) on 11/13/25 at 6:17 PM, they reported they don't have a podiatrist here and that the provider trims nails in house.Per interview with a Register Nurse (RN) on 11/13/25 at 6:29 PM, she confirmed that Resident #6's toenails were long and should be trimmed.

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F 0712 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that the resident and his/her doctor meet face-to-face at all required visits. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, it was determined that the facility failed to ensure physician visits occurred every 30 days for the first 90 days after admission, and at least once every 60 thereafter for 12 of 25 residents (Resident # 1, 2, 3, 6, 7, 8, 11, 12, 13, 15, 16, and 17). Findings include: Per review of the facility policy titled Physician Services dated 2/21, it states that the medical care of each resident is supervised by a licensed physician and that supervising the medical care of residents includes. conducting routine required visits. Physician visits, frequency of visits, emergency care of residents, etc., are provided in accordance with current OBRA regulations and facility policy. 1.Review of Resident #6's medical record shows that Resident #6 has not had a regulatory visit since 8/7/25, which was with a Nurse Practitioner (NP), and as of 11/13/25 did not have a regulatory visit within sixty days with a Physician. 2.Review of Resident #7's Physician visits revealed that Resident #7 was admitted on [DATE] and had their initial visit with a NP on 1/24/25 and then only had visits with a NP up until 10/23/25 with the current Physician, which was not a regulatory visit. 3. Review of Resident #8's Physician visits revealed that their last regulatory visit was on 5/30/25, with a Physician's Assistant (PA), and there was no in-person visit with a Physician until 10/16/25, which was not a regulatory visit. Resident #8 has not had a regulatory visit since 5/30/25. Per interview with the Medical Director on 11/13/25 at approximately 2:15 PM, he reported that he's aware that the regulatory visits are well behind and that the onsite Physician is trying to catch up stating there is no excuse it has to be done. Per interview with the facilities Physician on 11/13/25 at 3:30 PM, he reported that he is behind on regulatory visits. The Physician stated that he inherited an absolute just medical disaster here and that he hasn't had time to do anything except for crisis management. He reported that he has a choice of seeing a sick patient like someone with covid, an urgent medical need, or a regulatory visit, he is going to take care of the sick patients. The Physician also stated he has a list of residents that he knows need to be seen for their regulatory visits. The Physician also stated that they had a Nurse Practitioner (NP) but that they only lasted a week, but they have a new NP starting on Monday, 11/17/25. He reported his plan is to start doing regulatory visits once the NP starts, and that he has a list of residents who need to be seen. He also reported that he does not count acute care visits as regulatory visits, as regulatory visits are much more comprehensive than acute care visits, so that if it doesn't say regulatory visit, then he has not completed a regulatory visit for that resident. The Physician would not speak to if regulatory visits were performed prior to him being there, but he did confirm that Resident #7 needs a regulatory visit and has not had one yet, that Resident #8 needs a regulatory visit and he has not done one yet, and that for Resident #6 he has not done a regulatory visit and needs one, and he also confirmed the facilities policy states one of his responsibilities as a physician is supervising the medical care of residents includes. conducting routine required visits. 4. Review of Resident #2's Physician visits revealed that they were admitted on [DATE] and they did not receive an in-person regulatory visit with a Physician by 5/19/25. (continued on next page)

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F 0712 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	5. Review of Resident #3's Physician visits revealed that their last regulatory visit was on 6/13/25 with a Physicians Assistant (PA) and there was no in-person regulatory visit with a Physician by 9/23/25. 6. Review of Resident #1's medical record shows that Resident #1 was admitted on [DATE] and her/his first regulatory visit was on 10/28/25 which does not meet the regulatory requirement of this regulation. 7. Review of Resident #11's Physician visits revealed that Resident #11 was admitted on [DATE] and had their initial physician visit on 11/13/25, which does not meet the regulatory requirement of this regulation. 8. Review of Resident #12's Physician visits revealed that Resident #12 was admitted on [DATE] and had their initial physician visit on 11/13/25, which does not meet the regulatory requirement of this regulation. 9. Review of Resident #13's Physician visits revealed that Resident #13 was admitted on [DATE] and had their initial physician visit on 11/10/25, which does not meet the regulatory requirement of this regulation. 10. Review of Resident #15's Physician visits revealed that Resident #15 was admitted on [DATE] and had their initial physician visit on 11/4/25, which does not meet the regulatory requirement of this regulation. 11. Review of Resident #16's Physician visits revealed that Resident #16 was admitted on [DATE] and had their initial physician visit on 9/23/25, which does not meet the regulatory requirement of this regulation. 12. Review of Resident #17's Physician visits revealed that Resident #17 was admitted on [DATE] and had their initial physician visit on 8/25/25, which does not meet the regulatory requirement of this regulation. Per interview on 11/13/25 at approximately 11:45 AM, the facility Physician confirmed that regulatory visits had not been completed timely and that s/he was working on getting them caught up. S/he stated that a new PA would be starting next week on Monday and this would help her/him stay caught up on visits. Per interview on 11/13/25 at approximately 2:00 PM, the Medical Director confirmed that s/he was aware that regulatory visits were behind and that the facility physician was working to get them all caught up. S/he stated they were working on the process and considering getting a tracking tool/system for regulatory visits but at this time had not secured any type of system for doing this. S/he stated, There is no excuse for these visits to not have been completed on time.

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to implement interventions to address the residents' dementia care needs for 1 of 1 residents (Resident #10).Findings include:Per an observation on [DATE] at 6:43 PM at a nurse's station, Resident #10 was asking to call his/her family member. A Licensed Practical Nurse (LPN) was observed telling Resident #10 that she couldn't call his/her family member because they had died. Upon hearing this, Resident #10 got visibly upset and again asked for the LPN to call Resident #10 ‘s family member and called the LPN a liar. The phone started ringing and Resident #10 was asking for them to pick it up saying it might be their family member, and the nurse was dismissive towards the Resident saying that it couldn't be. At 6:45 PM, the Resident #10 again asked to call the family member to which the LPN again stated that they had passed and that we told you this months ago, but you keep on forgetting. Resident #10 then stated that they were going to try and walk home and hoped they would be killed.Per interview with the LPN on [DATE] at 6:48 PM, when asked how she redirects Resident #10 when s/he forgets that their family member has died, the LPN reported that sometimes we say maybe later, sometimes we tell her the truth, and that the Resident #10 calls us liars when we tell him/her that their family member is dead. The LPN also reported Resident #10 has dementia and s/he just gets like this sometimes. The LPN confirmed that each time she reminded Resident #10 that the family member had died, that Resident #10 became visibly upset.Per record review of Resident #10 medical diagnosis on [DATE], s/he has a diagnosis of Alzheimer's disease, adjustment disorder with anxiety, and depression. Per review of a progress note dated [DATE], the resident was informed by their family of a family member's death.The Resident's progress notes from [DATE] to [DATE] document that the Resident was reminded by staff of his/her family member's death on seven different documented occasions since [DATE], with resulting behaviors of yelling, crying, wandering, and exist seeking.Per Review of the Resident #10 care plan, it revealed they are care planned for a family member's death on [DATE] with interventions of assisting the resident with their grief to help the resident identify care needs, encourage the resident to express feelings of anger and concern, encourage the resident to recognize grief situation, observe for contributing factors that may delay the grief process, assist the resident to identify, access and use support systems, for consults to be placed to pastoral care, social services, home health, psychiatry as needed, describe to the resident the stages and how to identify grief, and to assist the resident with problem solving. The Resident #10 is also care planned for dementia, for which interventions include allowing the resident time to talk and express feelings. An intervention related to the Resident #10's anxiety and trauma is to engage the resident in conversations that will help them to remain calm.The observation on [DATE] did not demonstrate that care plan interventions were being utilized for this resident regarding assisting with grief, allowing time to talk and express feelings, or engaging the resident in conversation to help them remain calm.

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	475037	A. Building B. Wing	11/13/2025

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

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation and interview, the facility failed to ensure only authorized personnel had access to the medication storage rooms. This is a repeat deficiency for this facility, with the violation cited during the previous recertification surveys, dated 6/25/25. Findings include:Per observation on 11/4/25 at 12:45 PM, a pharmacy delivery was accepted by an LPN (Licensed Practical Nurse). The delivery person and LPN went into the medication room together. The LPN emerged without the delivery person who remained alone in the medication room for approximately 5 minutes before exiting.Per interview on 11/4/25 at 1:00 PM, the LPN confirmed that the delivery person should not go into the medication room alone. The LPN confirmed that he/she was left alone in the medication room. Per interview with the Administrator on 11/4/25 at 2:45 PM, they confirmed the delivery person should not have been in the medication room alone.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation and interview, the facility failed to ensure that all food was stored safely and to ensure that sanitary conditions for safe food handling were maintained. This has the potential to impact all residents. This is a repeat deficiency for this facility, with violations cited during the previous three recertification surveys, dated 4/26/23, 5/9/24, and 6/25/25. Findings include:A kitchen tour was conducted with a Dietary Staff Member on 11/13/25 at 11:40 AM. Per observation of the dry food storage area, the following items were found improperly stored:Gluten free pasta, (1) expired June 11, 2024, (3) expired July 20, 2024; Baking mix, expired 4/24/24; Pasta, expired May 3, 2025; Hormel Thick & Easy Clear Thickened Cranberry Juice Cocktail, dated 10/24, instructions on back of label discard if not used within 10 days of opening; andHormel Thick & Easy Clear Thickened Orange Juice Cocktail, dated 10/24, instructions on back of label discard if not used within 10 days of opening. Per interview on 11/13/25 at 11:55 AM, the Dietary Staff Member stated the above items should have been discarded and confirmed they were expired.Per observation of the walk-in refrigerator, the following item was found improperly stored: Two packages of deli ham stored on a tray with raw hamburger, sitting in raw meat juices. Per observation of the walk-in freezer, the following item was found improperly stored: A box of hamburger patties left open to air and not sealed. The Dietary Staff Member confirmed the observations in the walk-in refrigerator and freezer and stated that ready-to-eat foods should not be stored with/on/in raw meat and stated that prepared and open food containers and packages should be sealed. She/he confirmed that the above items were improperly stored. Per observation of the kitchen area the following were noted:Preparation trays, cups, and dishes were noted to be wet nesting (stored wet and not air dried). The floor fan facing the food preparation area noted to be covered with dust and debris. The Dietary Staff Member confirmed these observations.

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F 0841 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Designate a physician to serve as medical director responsible for implementation of resident care policies and coordination of medical care in the facility. Based on interview and record review, the facility failed to ensure that the Medical Director fulfilled his/her responsibility to coordinate medical care with facility providers and assist the facility with the development and implementation of resident care policies. This deficient practice has the potential to affect all residents residing in the facility.Findings include:Per review of the facility's Medical Director Services policy [policy undated] on 11/13/25, the scope of services for the Medical Director will include:-Ensuring that each resident's responsible physician attends to the resident's medical needs--Periodic review and development of medical care policies and procedures as required to ensure compliance with Federal, State, and local laws, rules, and regulations.An interview was conducted with the facility's Medical Director on 11/13/25 at 2:02 PM. The Medical Director [MD] stated there was no system in place to monitor regulatory visits by physicians, and that they were working on a process regarding required regulatory visits. The MD stated, There is no excuse, they [regulatory visits] have to be done.Further review of the Medical Director Services policy includes: -Participation in policy decision-making and direct supervision regarding quality of care and delivery of medical services to residents-Performance of all necessary general administrative tasks including assigning medical duties and scheduling, and communication of this information to appropriate staff.Per interview on 11/13/25, the Medical Director [MD] stated there is no consistent or scheduled communication between medical providers regarding facility issues or resident status. The MD stated s/he had reviewed the Facility Assessment, dated 6/5/25. Per the facility assessment, Medical/Physician Services list Dr. [A] and Dr. [B] as Attending Physicians. The Medical Director stated s/he was not familiar with those physicians. The MD stated the facility's Acting Physician [APhys] was the eyes and ears of the facility. The MD stated we are working on a process regarding reporting on a weekly basis with [APhys] and other providers, but there was no process currently in place.Review of the Medical Director Services policy also includes: -Supervision of high-level quality of care delivered to residents, with supervision exercised over medical, nursing, and pharmaceutical services.Per interview with the Medical Director [MD] the MD stated the facility's Attending Physician [APhys] notified h/her this morning [11/13/25] of a COVID outbreak in the facility. The MD stated [APhys] reported the first case was identified as 7- 10 days ago. The MD said h/her expectation was to be notified when the first case appeared. Per facility Infection Control records, the first COVID cases were identified 11 days prior on 11/2/25: one resident and one staff member. As of the day of the extended survey [11/13/25], 8 staff members and 16 residents had tested positive for COVID infection.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Based on observations, record reviews, and interviews, the facility failed to provide a system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to S483.71 and following accepted national standards. This has the potential to impact all residents. Findings include: A review of the facility's Coronavirus Disease-Infection Prevention and Control Measures Policy Statement [Version 2.0 Revised 2023] includes: This facility follows infection prevention and control (IPC) practices recommended by the Centers for Disease Control and Prevention to prevent the transmission of COVID-19 within the facility. Policy Interpretation and Implementation:1.The infection prevention and control measures that are implemented to address the SARS-CoV-2 pandemic are incorporated into the facility infection prevention and control plan. These measures include: a. encouraging staff, residents and visitors to remain up-to-date with all COVID-19 vaccine doses; and following current environmental infection prevention and control recommendations.A review of the facility's documented COVID-19 outbreak line listing revealed that 16 residents tested positive for COVID-19 between 11/2/25 and 11/13/25.1. An interview was conducted with the facility's Medical Director on 11/13/25 at 2:02 PM.The Medical Director [MD] stated the facility's Acting Physician [APhys] notified him this morning [11/13/25] of a COVID outbreak in the facility. The MD defined an outbreak as a single case. The MD stated [APhys] reported the first case was identified as 7- 10 days ago. The MD said his expectation was to be notified when the first case appeared. Per facility Infection Control records, the first COVID cases were identified 11 days prior, on 11/2/25: one resident, one staff member. As of the day of the extended survey [11/13/25], 8 staff members and 16 residents had tested positive for COVID infection.Per record review, 10 of 16 residents who tested positive for COVID as of 11/13/25 were sampled regarding having signed consent forms in October to receive the COVID vaccine and then having received the vaccine. Per record review, 2 of the 10 residents sampled refused consent to be vaccinated. Further review revealed the remaining 8 sampled residents had all consented to be administered the COVID vaccine, but none had received it prior to being infected by the virusPer interview with the Director of Nursing on 11/13/25, the facility had only begun vaccinating residents for COVID on 11/12/25, 10 days after the initial infection was identified, and 55 days after the Quality Assurance Performance Improvement meeting noting the facility would be receiving the COVID vaccine.See F887 for more information.2. Multiple observations of environmental conditions on 11/4/25 and 11/13/25 demonstrated a lack of overall sanitation and cleanliness affecting infection prevention in the facility. On 11/4/25, the corridors and residents' rooms' floors were dirty; various types of debris were noted; bathroom fans were covered with thick dust; and toilets were dirty, not clean inside or out, or the floor around the toilets. In one of the shower rooms, a lift bar/rail with a disposable rubber glove tied to the rail, a corner bead (a protective strip, typically made of vinyl or metal, that is installed on outside corners where two pieces of drywall meet to reinforce and protect the corner) going into the shower room revealed broken, rusted, and jagged metal. Many broken floor and wall tiles were noted throughout this area between the shower room, the tub room, and the bathroom. Sun Room on Wing 1 revealed trash cans without trash bags inside, a coffee carafe that was dirty with a brown substance on all sides; a drawer within a cabinet that contained packets of condiments noted to have what appeared to be food debris throughout the drawer and a puddle of a brown sticky substance; a chair with fabric back, armrests and seat that had a dried reddish brown substance in droplet form on the seat that was still accessible for use; a yellow substance that appeared to be scrambled eggs under a table and on the windowsill next to the table; a pillow without a pillow case on the steam table; the floors appeared dirty with spills and debris; and cooler cover was dirty. Wing 1 of the nurse's station revealed a thick pile of crumbs/debris in front of the nurse's station that went the length of the nurses' station. There was a used blood glucose test strip on the floor. The overbed table by the door bed was covered on the wheels and the metal support with a thick, dried, white, milky substance. The privacy curtains had a dried, brown substance on the outer edge and about 2 feet in from it. There was an uncovered pillow on the bed next to the window, with its plastic cover torn in several places, revealing its contents. On 11/13, Floors were dirty; various types of debris were noted; bathroom fans were covered with thick dust; toilets were dirty, not clean inside or out, or the floor around the toilets. In the bathrooms, observations included light-colored caulk between tiles on both floors and walls, with a buildup of black debris that appears to be mold and mildew. A shower chair had

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. Based on interview and record review, the facility failed to develop and implement policies and procedures to ensure when COVID-19 vaccine is available to the facility, each resident and staff member is offered the COVID-19 vaccine unless the immunization is medically contraindicated or the resident or staff member has already been immunized.Findings include:A review of the facility's Coronavirus Disease- Infection Prevention and Control Measures Policy Statement [Version 2.0 Revised 2023] includes: This facility follows infection prevention and control (IPC) practices recommended by the Centers for Disease Control and Prevention to prevent the transmission of COVID-19 within the facility. Policy Interpretation and Implementation:1.The infection prevention and control measures that are implemented to address the SARS-CoV-2 pandemic are incorporated into the facility infection prevention and control plan. These measures include: a. encouraging staff, residents and visitors to remain up-to-date with all COVID-19 vaccine doses.A review of the facility's documented COVID-19 outbreak line listing revealed that 16 residents tested positive for COVID-19 between 11/2/25 and 11/13/25. An interview was conducted with the facility's Medical Director on 11/13/25 at 2:02 PM. The Medical Director [MD] stated the facility's Acting Physician [APhys] notified him this morning [11/13/25] of a COVID outbreak in the facility. The MD stated [APhys] reported the first case was identified as 7- 10 days ago. The MD said his expectation was to be notified when the first case appeared. Per facility Infection Control records, the first COVID cases were identified 11 days prior, on 11/2/25: one resident, one staff member. As of the day of the extended survey [11/13/25], 8 staff members and 16 residents had tested positive for COVID infection.Per record review, 10 of 16 residents who tested positive for COVID as of 11/13/25 were sampled regarding having signed consent forms in October to receive the COVID vaccine and then having received the vaccine. Per record review, 2 of the 10 residents sampled refused consent to be vaccinated. Further review revealed the remaining 8 sampled residents [Resident #4, #11, #12, #13, #14, #15, #16, & #17] had all consented to be administered the COVID vaccine, but none had received it prior to being infected by the virus.Per interview with the Director of Nursing on 11/13/25, the facility had only begun vaccinating residents for COVID on 11/12/25, 10 days after the initial infection was identified, and 55 days after the Quality Assurance Performance Improvement meeting noting the facility would be receiving the COVID vaccine.

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F 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. Based on review of employee training records and interview, the facility failed to provide evidence of the minimum 12 hours of nurse aide training per year required to ensure the continuing competence of the LNAs (Licensed Nursing Assistants) for 1 (LNA #1) of 3 LNAs sampled. Findings include:Per review of the training records, three LNAs sampled were noted to have start dates before the 2025 calendar year. LNA #1's education file lacked documentation of evidence of the 12 hours of training per year required to meet identified staff or resident needs.Per interview on 11/13/25 at 5:18 PM, the Director of Nursing (DON) was unable to provide evidence that the LNA #1 had completed their required 12-hour annual training.