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	06/17/2026

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 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 food items were stored in accordance with professional standards, that the kitchen was kept neat and orderly, and that food service equipment were clean or dry. This is a repeat deficiency for this facility, with the violation cited during the previous three recertification surveys, dated 6/25/25, 5/9/24, and 4/26/23, and partial survey dated 11/13/25. Findings include:During a tour of the kitchen with the Kitchen Manager on 6/15/2026 at approximately 9:56 AM, the following observations were made:sandwiches on a plate in the walk-in fridge, not dated. The Kitchen Manager confirmed that they were not dated.a bag of opened chicken cutlets in freezer, not dated. The Kitchen Manager confirmed that they were not dated.multiple juice spill puddles in the kitchen fridge. Per interview with the kitchen manager, he stated that the fridge gets cleaned at the end of each day.the standing mixer had dried food particles on it. The Kitchen Manager stated that they don't use it often, but confirmed that it was dirty and could use some attention.the kitchen floors were audibly sticky and dirty with particles on the floor. The kitchen manager verbalized that the floor is cleaned 2x day after lunch and at the end of the day.in the dry food storage room two dented cans were found, one of which was holding the door open as a door stop. The Kitchen Manager stated that they should not be there or used as a door stop.stored wet pans stacked on each other were found. The Kitchen Manager verbalized that he will educate his staff to ensure that they are completely dry before storing.The following kitchen observations were made on 6/16/2026 at approximately 8:28 AM:the kitchen floor was still audibly sticky, the standing mixer was still dirty. The Kitchen Manager confirmed that the floor and the mixer were still dirty.the pots were found to be stacked and stored wet. The Kitchen Manager confirmed that the pots were still wet and that he had not reviewed with the staff the importance of drying them before storing them. the kitchen fridge still had the same spill puddles as the previous day. The Kitchen Manager confirmed that the fridge was still dirty and that they did not get to clean it the day before.two more dented cans were found as a door stopper for the dry food storage room. The Kitchen Manager confirmed that the cans should not be there. Per observation on 6/17/2026 at approximately 12:00 PM, the kitchen floor was still sticky and the standing mixer was still dirty. Per the facility General Food Preparation and Handling Policy Revision Date 7/2023: 1. The kitchen is kept neat and orderly. A. the kitchen and equipment are clean.2. Food Storage. a. Foods are received, checked and stored properly as soon as they are delivered.c. Food in broken packages or swollen cans, cans with a compromised seal.4. Food Services.Leftovers must be dated, labeled.Use leftovers within 3 days or discard . 5. Equipment. a. All food service equipment should be cleaned, sanitized, dried, and reassembled after each use.

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. Based on observation, interview, and record review, the facility failed to follow, maintain, implement their legionella water management plan and implement the use of personal protective equipment when required. This has the potential to impact all residents. This is a repeat deficiency for this facility, with the violation cited during a previous partial survey, dated 11/13/25. Findings include: 1. Review of the facility's Legionella Water Management Plan included an assessment to identify areas for Legionella spread and measures to prevent growth and how to monitor them. Per interview with the Maintenance Director on 6/17/26 at 10:30 AM and 1:09 PM, he was unable to provide evidence of measures to prevent Legionella growth put in place and how the facility was monitoring them. He was unable to say what standards the facility was following for water safety practices. He said he disagreed with the plan and had thrown it away. Per interview with the Infection Preventionist and Director of Nursing (DON) on 06/16/2026 at 9:49 AM, when asked what water safety standards they were following, the DON reported that she would have to ask the Administrator and look to find out. Per review of the Legionella Water Management Plan, the first page identifies numerous dead legs (areas of water with no or minimal water movement that increases the risk for microbial growth) and states that the dead ends should be eliminated; however doing so is difficult because there is no practical way to isolate and valve them individually. It then states that stored water temperature is being stored at 120 degrees Fahrenheit and that the laundry storage tank is experiencing temperature issues and that it's temperature of 110 degrees Fahrenheits is below the expect range. It then states to effectively control Legionella, hot water should reach at least 140 degrees Fahrenheit, and states that the bacteria thrive in temperatures between 77-degree Fahrenheit and 122-degree Fahrenheit. It then states that unused fixtures and eyewash stations will be identified and incorporated into a routine flushing schedule as part of preventative maintenance. Additionally, it states All visible dead-end lines will be identified and documented. We will maintain records of their locations and obtain estimates for their removal to eliminate stagnant sections of the system. The plan then identifies that standardized forms and logs will be created and maintained like cleaning logs documenting dates, times, and specific access points serviced, as well as records of chlorine levels and overall sanitation . Per interview with the Administrator on 6/17/26 at 11:50 AM, she was unable to provide evidence that all identified measures and monitoring plans were being implemented from their Legionella Water Management Plan, other than the plans for the eye wash station and ice machine. Per review of the facility policy titled Legionella Water Management Program revised 9/2022 it states that the water management plan includes A system to monitor control limits and the effectiveness of control measures. It also identifies water storage tanks, water heaters, water stagnation, and water temperature fluctuations as being contributors to potential Legionella growth. It identifies that the water management team is the infection preventionist, the administrator, medical director or designee, the director of maintenance, and the director of environment services. 2.) Per observation of the laundry area on 6/16/26 at 8:54 AM, there were multiple washed Hoyer sling pads drying on top of each other. Additionally, there were cleaned mop heads drying in the dirty (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	clothing/linen processing section of the laundry room. Per interview with a laundry staff employee on 6/16/26 at 8:54 AM, she reported that those were clean mop heads drying in the dirty section of the linen processing room. She also confirmed that there were multiple Hoyer Sling pads drying wet on top of each other. 3.) Per interview with a laundry staff employee on 6/16/26 at 8:54 AM, When asked how she processes dirty linen, she reported that she rolls up her sleeves and wears gloves. When asked if she wears a gown, she reported that she typically only wears gloves and that you can't always tell if linens are soiled until you are already handling them. Per interview with the Infection Preventionist on 06/16/2026 at 9:49 AM, when asked about the process for laundry staff handling dirty linens, she reported that she expected staff to wear gloves when handling linen and if there was a concern of bodily fluids that they should be wearing a gown. When discussing the potential for dirty linen to come in contact with the staff members clothes and then the staff member transitioning to handle clean clothes, she confirmed that it could be an infection control concern if the staff members clothes came in contact with dirty linen, and then handled clean clothes. She also confirmed that dirty linen should be kept away from clean linen. Per interview with the Infection Preventionist and Director of Nursing (DON) on 6/17/26 at 10:57 AM, they both confirmed that it's an infection control concern having wet Hoyer slings drying on other wet Hoyer slings. Per review of Centers for Disease Control and Prevention (CDC) G.Laundry and Bedding recommendations posted on 1/8/24, it states that Laundry workers should wear appropriate personal protective equipment (e.g., gloves and protective garments) while sorting soiled fabrics and textiles. Per review of the facility policy titled Laundry Department Administration with an effective date of 3/2015, it states 13. Infection control rules and regulations shall be enforced for the laundry service .19. The collection, packaging, transportation and storage of soiled, contaminated, and clean linen is in accordance with all applicable infection control rules and procedures. Per review of the facility policy titled Personal Protective Equipment- Using Gowns revised on 9/2010 it states that the purpose is to guide the use of gowns with the identified objectives being to prevent the spread of infections, prevent soiling of clothing with infectious material, prevent splashing or spilling of blood or body fluids onto clothing or exposed skin. 4.) Per record review, Resident #10's care plan, last revised on 3/16/26, reveals s/he is on Enhanced Barrier precautions related to indwelling catheter use and nephrostomy tube. Interventions include: Implement Enhanced Barrier Precautions per CDC guidance [related to] foley catheter, nephrostomy. Staff to wear gown and gloves during high-contact care (e.g., bathing, dressing, toileting, wound or device care). Per observation on 6/15/2026 at approximately 12:43 PM, a nurse came into Resident #10's room without performing hand hygiene and moved the catheter bag, which was on the floor, without the appropriate protective personal equipment (PPE) and hooked it on to the bed.

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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 observation, interviews, and record review, the facility failed to ensure that a resident was treated with dignity for 1 of 27 sampled residents (Resident #41). This is a repeat deficiency for this facility, with the violation cited during a previous partial survey, dated 11/13/25. Findings include:1.) Per interview on 6/15/2026 at approximately 11:28 AM, Licensed Nurse Aide (LNA) #1 was asked to bring Resident #41 to their room to speak in private. LNA #1 stated that the resident only answers the same things over and over again and is not all there. When in the room with Resident #41 they stated that they needed to go to the bathroom and became a little agitated worrying about the chair and floor getting wet.At approximately 11:37 AM, LNA #1 and #2 were transferring Resident #41 with the Hoyer lift. During this process the resident was becoming more agitated, upset, and concerned about getting the floor wet and stated that they didn't know what they were doing around here. LNA #1 then responded, in hearing range of Resident #41, that she knew asking all of those questions would agitate them and again stated that the resident was not all there after having a stroke.Per record review resident has a traumatic brain injury (TBI) and did not have a stroke. Per care plan last revised on 5/9/26, the resident is care planned for history of trauma related to life experience-TBI. Interventions include: If resident becomes upset during care, stop, ask what the resident needs, validate feelings and follow instructions of the resident. Encourage resident participation and encourage decision making.2.) Per observation on 6/16/2026 at approximately 8:22 AM, during breakfast Resident #41 requested for more coffee and was told no by LPN (Licensed Practical Nurse) #1 who stated that they already had 3 cups and was asked if they wanted some juice or water. Resident #41 stated no, more coffee please. The nurse said no and offered some water instead.Per record review Resident #41 is not on fluid restrictions and per their care plan, last revised on 5/9/26, Resident #41 has nutrition problem or potential nutritional problem related to hemiplegia, epilepsy, depression, anxiety, and TBI. Interventions include: Provide.with personal preferences.Per interview on 6/17/2026 at approximately 9:05 AM, the nurse verbalized that Resident #41 isn't difficult to understand and does not need any special tools of communication. She verbalized that the resident is able to verbalize their needs with no problem and that they love their coffee.Per the facility's Resident Rights Policy Revised Date June 2023: Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the residents' right to:a. a dignified existenceb. be treated with respect, kindness, and dignity.h. exercise his or her rights as a resident of the facility and as a resident or citizen of the United Statesi. be supported by the facility in exercising his or her rights.t. be informed of and participate in development, planning and implementation of the resident's person-centered plan of care and treatment. receive the services and items included in the president's plan of care.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. Based on observation, interviews, and record review, the facility failed to keep nails trimmed for 1 of 27 residents (Resident #39). Findings include:Per interview on 6/15/2026 at approximately 10:37 AM, Resident #39 was observed to have very long nails and verbalized that they do not like it. Per record review, Resident #39's care plan states that they need assistance with personal hygiene/care. Per interview on 6/17/2026 at approximately 10:26 AM, the Licensed Nursing Assistant (LNA) verbalized that nails are done with resident care. Per interview on 6/17/2026 at approximately 10:34 AM, the Registered Nurse (RN) explained that residents' nails get done as needed on shower days. When in the residents' room the nurse confirmed that Resident #39's nails were too long and probably had not been done in some time.Per interview on 6/17/2026 at approximately 11:31 AM, the RN showed the shower list with the resident listed for every Tuesday evening. Per record review Resident #39's last shower was on 6/16/26.Per the facility's Fingernails/Toenails, Care of Policy, last revision in February 2018, .1. Nail care includes daily cleaning and regular trimming.

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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, interview, and record review, the facility failed to ensure resident medications were properly stored for 2 out of 27 residents (Resident #70 and Resident #71). This is a repeat deficiency for this facility, with the violation cited during the previous recertification survey, dated 6/25/25 and partial survey dated 11/13/25. Findings include: 1.) Per observation on 6/15/26 at 2:57 PM, Resident #70 had a bottle of Artificial Tears at their bedside table. Per interview on 6/15/26 at 3:00 PM with a Registered Nurse (RN), he reported that the bottle of Artificial Tears should be in the medication cart. Resident #70 indicated that they were again due for more drops and then self-administered in front of the RN. The RN showed no indications that he knew when the next drops were due. The RN then left the room leaving the bottle of drops behind after stating that they should be in the medication cart. Per interview on 6/15/26 at 3:36 PM with the Licensed Practical Nurse (LPN) assigned to the medication cart, she reported that a prescription medication like the Artificial Tear Drops should not be at the bedside and discarded the bottle. Per review of the Medication Labeling and Storage policy revised on 2/2023, it states that The Facility stores all medications and biologicals in locked compartments under proper temperature, humidity and light controls . 2. Per observation of medication administration for Resident #71 on 6/17/2026 at 8:10 AM, the nurse placed medications on the bedside table and then left the room. Per observation, the resident self-administered the medications while the nurse was absent. Upon reentering the room, the nurse did not ask the resident if s/he had taken the medications. Per interview with the nurse on 6/17/2026 at 8:15 AM, she confirmed she should have remained with the resident to ensure medications were administered. Per interview with the Director of Nursing (DON) on 6/17/2026 at 8:20 AM, she confirmed that the nurse should have stayed with the resident to ensure medication administration. Per review of the facility's policy on medication administration, it states that a resident may self-administer medications with a written order from the physician. Per review of Resident #71's physician orders, there is no order for self-administration of medications.