

Division of Licensing and Protection
103 South Main Street, Ladd Hall
Waterbury VT 05671-2306
<http://www.dail.vermont.gov>
Voice/TTY (802) 241-2345
To Report Adult Abuse: (800) 564-1612
Fax (802) 241-2358

January 5, 2011

John O'Donnell, Administrator
Greensboro Nursing Home
47 Maggie's Pond Road
Greensboro, VT 05841

Provider ID #:475043

Dear Mr. O'Donnell:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on
December 1, 2010.

Follow-up may occur to verify that substantial compliance has been achieved and maintained.

Sincerely,



Pamela M. Cota, RN
Licensing Chief

PC:jl

Enclosure



STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER # 475043	MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	DATE SURVEY COMPLETE: 12/1/2010
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NAME OF PROVIDER OR SUPPLIER GREENSBORO NURSING HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 47 MAGGIE'S POND ROAD GREENSBORO, VT	RECEIVED Division of DEC 2 0 10 Licensing and Protection
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ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
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F 514	<p>483.75(I)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE</p> <p>The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.</p> <p>The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.</p> <p>This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility failed to maintain complete and accurately documented clinical records for 1 of 12 residents in the applicable sample. (Residents #15 & #18) Findings include:</p> <ol style="list-style-type: none"> 1. During closed medical record review for Resident # 18 on 12/01/2010, there were no Social Service notes regarding the discharge of this resident, who was transferred to another skilled nursing facility. This was confirmed with Social Services staff during interview on 12/01/2010 at 9:30 am.
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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

The above isolated deficiencies pose no actual harm to the residents

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/07/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 475043	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 12/01/2010
NAME OF PROVIDER OR SUPPLIER GREENSBORO NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 47 MAGGIE'S POND ROAD GREENSBORO, VT 05841	
(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
F 000	INITIAL COMMENTS	F 000		
F 272 SS=D	<p>The Division of Licensing and Protection conducted an unannounced on-site annual recertification survey from 11/29/10 to 12/1/10 with 2 complaint investigations. The following regulatory deficiencies were identified.</p> <p>483.20, 483.20(b) COMPREHENSIVE ASSESSMENTS</p> <p>The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity.</p> <p>A facility must make a comprehensive assessment of a resident's needs, using the RA specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed through the resident assessment protocols; and Documentation of participation in assessment.</p>	F 272	<p>No resident has any adverse Reaction to this alleged Deficient practice.</p> <p>All staff will be in-serviced By Debra Choma (an out Source) on the signs of Sexuality in the elderly</p> <p>New abuse prevention Policy is in place and will Be part of the in-service</p> <p>All care plans will be Revised by DON or Designee when any Inappropriate behavior Occurs.</p> <p>Psychological referrals will Be made after any person To person incidents</p> <p>The DON or designee Will be responsible to Tracking and following up On all procedures</p> <p>Per phone call with the Administrator on 11/5/11, the completion date is 1/3/11. FA 72 POC Accepted 11/5/11 Pmcoturn</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

[Signature]

Administrator

1-5-11

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.

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F 272	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based upon interview and record review, the facility failed to reassess 1 of 12 residents following a resident to resident incident with the potential to cause harm (Resident # 3). Findings include: 1. Per record review on 12/1/10, Resident # 3 was not assessed for psychosocial well-being following an alleged sexual assault by Resident # 38. Per review of the Facility Incident Report, the alleged resident to resident sexual assault occurred on 11/5/10 at 2100 PM. Per interview on 12/1/10 at 2:04 PM, the DON (Director of Nursing) stated the resident was assessed for physical injury following the event, but no assessment for psychological well-being was done following the event.	F 272		
F 280 SS=D	Refer also to F280. 483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of	F 280		

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F 280	Continued From page 2 the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based upon interview and observation, the facility failed to revise the plan of care for 1 of 12 residents following a resident to resident incident with the potential to cause harm (Resident # 3). Findings include: 1. Per record review on 12/1/10, the care plan for Resident # 3 was not revised to include monitoring the resident for psychosocial well-being following an alleged sexual assault by Resident # 38. Per review of the Facility Incident Report, the alleged resident to resident sexual assault occurred on 11/5/10 at 2:00 PM. Per interview on 12/1/10 at 2:04 PM, the DON stated the care plan was not revised to include monitoring for psychosocial well-being.	F 280	No resident has any adverse Reaction to this alleged Deficient practice. All staff will be in-serviced By Debra Choma (an out Source) on the signs of Sexuality in the elderly New abuse prevention Policy is in place and will Be part of the in-service All care plans will be Revised by DON or Designee when any Inappropriate behavior Occurs. Psychological referrals will Be made after any person To person incidents The DON or designee Will be responsible to Tracking and following up On all procedures	
F 323 SS=D	Refer also to F272. 483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.	F 323	Per phone call with the Administrator on 11/5/11, completion date is 1/3/11. F280 POC Accepted 11/5/11 JMCotard	

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F 323	Continued From page 3 This REQUIREMENT is not met as evidenced by: Based upon interview and record review, the facility failed to ensure that 1 applicable resident (Resident #38) received adequate supervision and monitoring as directed by the nurse following an alleged resident to resident incident. Findings include: 1. Per record review, a nursing note dated 11/5/10, every 30 minute checks for Resident # 38 were increased to every 15 minute checks and constant visual contact. Per review of the "Resident Where About Tracker", staff documented every 30 minute checks from 9:30 PM to 11:00 PM on 11/5/10 for Resident # 38. On 12/1/10 at 11:15 AM, the DON confirmed that every 15 minute checks with constant visual contact were implemented by the nurse on 11/5/10 for Resident # 38, but that staff documented every 30 minute checks on 11/5/10 from 9:30 PM to 11:00 PM for Resident # 38.	F 323	No resident has any adverse reaction to this alleged Deficient practice all licensed staff will be in-serviced on the importance of checks and the policy of moving them from 15 to 30 minutes and back Copies of all 15/30 minute checks will be made and left in the DON office as well as the nurses station The DON or designee will be responsible for monitoring this process <i>Per phone call with the Administrator on 11/5/11, completion date is 11/3/11. F323 POC Accepted 11/5/11 Pmcoturn</i>	
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by:	F 371		

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F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by:	F 371	No resident had any adverse affects from this alleged deficient practice. Refrigerator has been cleaned out of any product with out a date and/or name. Twice a week activities will check and record the temp of the fridge. Any temp not within proper standards will be reported to maintenance for repair The administrator, for three months, will check the temp log every week to verify proper quality assurance. After three months the administrator will check the log one time per month to assure compliance.	

Per phone call with the Administrator on 11/5/11, Completion date is 1/3/11.
F371 PDC Accepted 1/5/11 Amotarn