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DEPARTMENT OF DISABILITIES, AGING AND INDEPENDENT LIVING

Division of Licensing and Protection  
103 South Main Street, Ladd Hall  
Waterbury, VT 05671-2306  
<http://www.dail.vermont.gov>  
Voice/TTY (802) 871-3317  
To Report Adult Abuse: (800) 564-1612  
Fax (802) 871-3318

December 24, 2013

Mr. Melvin Aaron, Administrator  
Greensboro Nursing Home  
47 Maggie's Pond Road  
Greensboro, VT 05841

Dear Mr. Aaron:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **November 13, 2013**. Please post this document in a prominent place in your facility.

We may follow-up to verify that substantial compliance has been achieved and maintained. If we find that your facility has failed to achieve or maintain substantial compliance, remedies may be imposed.

Sincerely,



Frances L. Keeler, RN, MSN, DBA  
Assistant Division Director  
State Survey Agency Director

FK:jl

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

RECEIVED PRINTED: 11/20/2013  
Division of 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 _____	DEC - 3 13  Licensing and Protection	(X3) DATE SURVEY COMPLETED  11/13/2013
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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 05841
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(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
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F 000	INITIAL COMMENTS	F 000		
F 282 SS=O	<p>An unannounced, onsite Recertification survey was conducted by the Division of Licensing and Protection from 11/12/13 to 11/13/13. The following are regulatory violations.</p> <p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</p> <p>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility failed to ensure that services were provided by qualified persons in accordance with the written care plan of 1 of 7 residents identified. (Resident #17) The findings include;</p> <p>1. Per record review, Resident #17 was admitted with diagnoses that included dementia. The resident was observed on 11/12/13 from 10:15 AM until 3:15 PM sitting in a wheel chair with a lap safety belt. The LNA {Licensed Nursing Assistant} shortly after lunch, released only the lap belt briefly, but then fastened it again. Per review of the care plan, it notes a safety device, [lap belt] and directs staff "to check every 30 minutes and to release every two hours while in use for position change". Per interview on 11/13/13 at 9:20 AM the LNA stated that the resident "usually gets off [resident's] bottom by putting [resident] to bed." Two LNAs at that time, confirmed that neither re-positioned the resident after 10:15 AM until 3:15 PM on 11/12/13. The</p>	F 282	<ol style="list-style-type: none"> <li>Resident #17 will have lap belt discontinued, she will also have an evaluation and treatment by physical and occupational therapies as indicated for strengthening and positioning. Her care plan will be reflective of any and all current statuses of the resident.</li> <li>All residents care plans will be reviewed to ensure that they are reflective of their status and that the care plan is being followed.</li> <li>All licensed nursing staff will be re-educated on the need for repositioning, the causes of pressure sores and the importance of prevention. They will also be re-educated on the importance of being familiar with the resident's individual care plan.</li> <li>Random observation audits will be conducted on the staff to ensure that care plans are being followed. These will be done on a weekly basis x 4 weeks, bi-weekly x 2 weeks and monthly x 2 months. The findings will be reported and reviewed by the Director of Nursing and presented to the Quality Assurance team.</li> </ol>	12/13/13

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  <i>Mel... Hero</i>	TITLE  Administrator	(X6) DATE  11/26/13
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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 correction is requisite to continued program participation.

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F 282	Continued From page 1 DNS {Director of Nursing} later that day, stated that the expectation is to actually remove the lap belt and to re-position the resident. S/he confirmed that the care plan was not followed.	F 282			
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS  Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.  Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.  This REQUIREMENT is not met as evidenced by: Based on review of clinical records and interview, the facility failed to ensure that 2 of 5 applicable residents in the sample had adequate	F 329			

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F 329	Continued Frdm page 2 indications, monitoring and/or behavioral interventions for use of psychoactive medications. (Resident #3 and Resident #4) Findings include:  1. Per record review on 11/13/13 Resident #3 has a diagnosis of persistent mental disorder (dementia with impaired decision making), anxiety and pain. A new anti-psychotic medication was prdered on 11/01/13 (Seroquel 12.5 mg in the AM and 25 mg at bedtime) "to decrease assaulting behavior" and to continue Celexa 10 mg daily [antidepressant]. There were no behavior monitoring sheets which quantitatively showed the specific behaviors prior to the new medication orders. Per interview on 11/13/13 at 10:04 AM, the Unit manager stated "I know that you will not find a diagnosis for the psychotropic other than [resident] being combative and has been declining since August" and confirmed there was no specific diagnosis to support the use of an anti-psychotic. The Unit Manager also confirmed that there was no care plan for the use of the anti-psychotic and/or non-pharmacological interventions to use with the resident.  2. Per record review on 11/12/13 and 11/13/13 Resident #4 was admitted on 10/16/13 with diagnoses of congestive heart failure, hypertension, obesity, chronic obstructive pulmonary disease, developmentally delayed/mental retardation [DD/MR], anxiety disorder, sleep apnea O2 retention, and joint/muscle weakness. The resident is noted to have Abilify [an anti-psychotic medication] and zolpidem [hypnotic medication] administered. The initial care plan notes psychotropic medication use related to anxiety disorder/M.R.	F 329	1. Resident #3 had her seroquel decreased on November 15, 2013 and a diagnosis of psychotic depression with combative behavior was added to the medical record and an AIMS tracking tool was initiated. On November 22, 2013 the resident's seroquel was discontinued after being held for several days during declining health. Resident #3 passed away on November 24, 2013.  A diagnosis of psychotic depression with anxiety was determined for resident #4. On November 15, 2013 a gradual dose reduction was started with resident #4's abilify. A behavior tracking log was initiated as well. 2. Staff education and chart audits will be done to identify any other residents affected by this. 3. An in-service will be held for all nurses educating them on the new policy and procedure for taking and receiving orders from the physician as well as the protocols for initiating assessments (AIMS, behaviors, etc.). 4. Random chart audits will be done to ensure diagnosis, assessments and tracking logs are in place and current on a weekly basis x4 weeks, bi-weekly x 2 weeks and monthly x 2 months. The findings will be reported and reviewed by the Director of Nursing and presented to the Quality Assurance team.	12/13/13	

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F 329	Continued From page 3 and directs staff monitor for adverse side effects of the medications, and to observe change in mood/behavior, notify of noted problems and refer for a psychiatric evaluation as needed. There was no documentation of monitoring for behaviors.  Per interview on 11/13/13 at 10:04 AM the Unit manger stated "I don't why [s/he] is on it (Abilify)... [s/he] came from [another living situation] on it, I know [s/he] has a diagnosis of anxiety disorder". However, the Unit manager confirmed that a diagnosis is needed for the use of Abilify and there is no consistent documentation for behavior monitoring.	F 329		
F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE  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.  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.  This REQUIREMENT is not met as evidenced by: The facility failed to maintain clinical records on each resident in accordance with accepted professional standards and practices that are	F 514	1. Resident #17 had a MDS assessment completed on October 7, 2013 for which one fall had occurred that was not coded on that MDS. She had another fall on November 6, 2013 that will be reflected on her next quarterly MDS assessment. Resident's lap belt was discontinued on November 27, 2013 and an order was obtained to have her evaluated and treated by physical and occupational therapies as indicated.  Resident #24's records were not accurately reflecting that he had received the correct medications and treatments at the accurate times and days on several different occasions. After thorough investigation the DNS confirmed that the resident had received all of his medications and treatments as scheduled and the error that occurred was strictly in the documentation.	12/13/13

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F 514	Continued From page 4 complete; accurately documented; readily accessible; and systematically organized for 3 of 17 applicable residents (Residents #17 & #24). Findings include:  1. Per record review of Resident #17 there was a failure to have accurate and/or readily accessible assessments. Per review of the resident's chart, it notes that the resident had at least two falls within the last three months. Per review of the quarterly MDS assessment (minimum data set) dated September 2013 no falls were documented. Per interview on 11/13/13 the MDS coordinator confirmed the two falls were not accurately noted on the MDS, "which should have been". Additionally, there was no assessment found for the use of the lap belt. Although a physician order and family signature was found, the nursing assessment for need and use was not in the chart. The DNS on 11/13/13 at 2:00 PM confirmed that although an assessment was completed, it was not found in either the current chart or thinned records.  2. Per review of Resident #24's records there was a failure to maintain accurate medication administration record (MAR) documentation. Per the review of Resident #24's November MAR on 11/12/13 at 12 Noon, the bolus feeding due at 11:00 PM was signed as being given. Per interview at that time the staff nurse stated "probably what happened is that the night nurse, (who was identified by signature) signed off on the wrong day". Per interview with the on-coming evening nurse at 3:00 PM stated that "that could be confusing because it would appear that [resident] all ready got the feeding". Additionally, upon further review of the November MAR, four medications and three nursing treatments had	F 514	2. A double check system for the MAR and TAR has been developed, the on-coming nurse will review both to ensure that these documentation errors do not continue to occur. This was initiated on November 13, 2013.  3. An in-service will be held educating all nurses on the new policies and procedures for the double check systems with the MARS, TARs and MDS. They will also be re-educated on the importance of accurate and timely documentation.  4. The double check system for the MAR and TAR will be utilized by the on-coming nurse at every change of shift to insure all scheduled tasks have been completed and this will continue indefinitely. MDS double checks will be done on each MDS by a nurse as they are completed. These will be done indefinitely as well. The findings will be reported and reviewed by the Director of Nursing and presented to the Quality Assurance team.		

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F-514	Continued From page 5 missing signatures indicating that the medications and treatments were completed. This was noted for November 7, 9 and 10. Per interview on 11/12/13 at 3:30 PM, with the staff nurse who worked those days, confirmed that although the medications and treatments were given, they were not documented.	F 514		