

Division of Licensing and Protection  
103 South Main Street  
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 4, 2014

Mr. Melvin Aaron, Administrator  
Greensboro Nursing Home  
47 Maggie's Pond Road  
Greensboro, VT 05841-8800

Dear Mr. Aaron:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **November 10, 2014**. 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,



Pamela M. Cota, RN  
Licensing Chief

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

03 2014

PRINTED: 11/19/2014  
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 11/10/2014
--	--	--	---

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	PRVIDER'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 225 SS=D	<p>483.13(c)(1)(ii)-(iii), (c)(2) - (4)</p> <p>INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS</p> <p>The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.</p> <p>The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.</p> <p>The results of all investigations must be reported to the administrator or his designated</p>	F 225	<p>F225 INVESTIGATIVE/REPORT ALLEGATIONS/INDIVIDUALS</p> <p>1. Resident 1 and 3 will be included in corrective policies that ensure timely reporting of abuse allegations. Resident 2 is deceased. Regarding the specific incidents, the care plans were updated to safeguard the residents from injury by addressing the potential for altercations (Resident 1) and bruising (Resident 3).</p> <p>2. Changes will be implemented to accelerate identification and reporting of abuse incidents. These changes are detailed in items 3 and 4 below. All residents of the facility will receive the benefit of this improved system.</p> <p>3. The entire staff will be re-educated on abuse, neglect, mistreatment of residents and misappropriation of possessions by December 10, 2014. The facility will adopt a new-employee abuse-reporting orientation, presented by the DON in an interactive format, with emphasis on immediate notification of alleged abuse to the appropriate charge nurse, DON,</p>	12/10/2014

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Meh Aaron</i>	TITLE <i>Administrator</i>	(X6) DATE <i>12/1/14</i>
---	-------------------------------	-----------------------------

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.

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

PRINTED: 11/19/2014  
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 11/10/2014
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 225	<p>Continued From page 1</p> <p>representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p> <p>This REQUIREMENT is not met as evidenced by: Based on staff interview and record review the facility failed to report an incident of alleged resident to resident abuse immediately to the State Agency (SA) within the required time frame for 1 of 4 reportable incidents (Resident # 1 and Resident #2) and failed to complete and submit the results of the facility investigation for 2 of 4 reportable incidents within five working days per regulation (Resident #1, Resident #2 and Resident #3). Findings include: 1. Per 11/4/14 medical record and facility investigation review, on 7/30/14 a staff LNA (Licensed Nursing Assistant) witnessed Resident #1 hitting Resident #2 on the right forearm several times after Resident #2 had reached behind Resident #1's chair to touch the straps of his/her hoyer pad (a pad used to assist in transfers or positioning). The facility reported the incident by fax to the SA on 8/8/14, 9 days after the incident and faxed the results of the internal investigation on 8/15/14, 16 days after the incident. The DON (Director of Nursing) who submitted the report is no longer employed at the facility and on 11/4/14, the current DON could not provide evidence of timely reporting. 2. On 9/27/14, the facility reported to the SA that Resident #3 had unexplained bruising on his/her upper extremities. Per 11/4/14 review of the medical record and internal investigation, staff</p>	F 225	<p>Administrator, or State Hotline number. This will be in addition to the standard new -employee orientation. Staff will receive updates regarding abuse reporting as needed. Prominent signage will be posted in staff break areas to increase awareness of reporting requirements.</p> <p>A revised incident and accident report and investigation form has been adopted to facilitate immediate investigation and response at incident discovery. All incident and accident reports will be brought before an interdisciplinary team meeting for care plan review and update within 48 hours. Education of all charge nurses, nursing administrators, and department heads will be conducted to orient them to these new procedures.</p> <p>Charge nurses will be re-educated on the necessity of reporting alleged abuse, neglect, mistreatment and misappropriation within 24 hours. Education update will be provided on a quarterly basis. Newly hired nurses will discuss this reporting requirement with the DON before assuming work responsibilities. Completion and submission of the 5-day investigation will be tracked through a calendar maintained by both the DON and the Administrator.</p>	

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

PRINTED: 11/19/2014  
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 11/10/2014	
NAME OF PROVIDER OR SUPPLIER  GREENSBORO NURSING HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 47 MAGGIE'S POND ROAD GREENSBORO, VT 05841		
(X4) IO 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 225	Continued From page 2 noted bruises on Resident #3's "right heel of the thumb" measuring approximately 4 x 3 cm and left medial wrist, measuring 5 x 4 cm. At the time of the 11/4/14 survey, the facility had not completed or submitted the results of their internal investigation to the SA. On 11/4/14 at 12:47 PM, the DON stated that s/he was not the DON at the time of the incident but confirmed that there was no evidence the investigation was completed or sent to the SA in 5 working days. (see F 226)	F 225	4. An abuse reporting committee will be established to evaluate the effectiveness of the above interventions through an incident-tracking log, and the results reported to the Administrator and quarterly at the QA meetings. This committee will prepare and review educational materials on abuse reporting.	12/10/2014
F 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES  The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.  This REQUIREMENT is not met as evidenced by: Based on staff interviews and record review the facility failed to operationalize their abuse policies regarding identifying and reporting an incident of alleged resident to resident abuse immediately to the State Survey Agency within the required time frame for 1 of 4 reportable incidents (Resident #1 and #2) and failed to complete and submit the results of their internal investigation to the State Agency (SA) for 2 of 4 reportable incidents within 5 working days (Resident #1 and #2 and Resident #3). Findings include: Per 11/4/14 review of the medical record and facility investigation, on 7/30/14 a staff LNA (Licensed Nursing Assistant) witnessed Resident #1 hitting Resident #2 on the right forearm	F 226	1. Resident 1 will be included in the implementation of all corrective action listed below to improve the facility abuse policy.  2. Changes to the abuse policy language will benefit all residents by creating a rapid response to abuse allegation.  3. The Greensboro Nursing Home abuse policy will be reviewed and revised by the abuse reporting committee to develop a concise, clear document emphasizing the reporting requirement and its time constraints. This revision will be presented to the Board of Directors for further review and adoption into the official policies of the Greensboro Nursing Home Employee Handbook. The first revision of the abuse policy will be completed by December 10, 2014, and will be presented to the Board of Directors	

*F2015 FCC accepted 12/14/14 Dennis APRN/AVE*

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

PRINTED: 11/19/2014  
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 11/10/2014
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 226	Continued From page 3 several times after Resident #2 had reached behind Resident #1's chair to touch the straps of his/her hoyer pad (a pad used to assist in transfers or positioning). The facility reported the incident by fax to the SA on 8/8/14, 9 days after the incident and faxed the results of the internal investigation on 8/15/14, 16 days after the incident. The DON (Director of Nursing) who submitted the report is no longer employed at the facility and on 11/4/14 the current DON could not provide evidence of timely reporting. On 9/27/14, the facility reported to the SA that Resident #3 had unexplained bruising on his/her upper extremities. Per 11/4/14 review of the medical record and internal investigation, staff noted bruises on Resident #3's "right heel of the thumb" measuring approximately 4 x 3 cm and left medial wrist, measuring 5 x 4 cm. At the time of the 11/4/14 survey, the facility had not completed or submitted the results of their internal investigation to the SA. Per 11/4/14 review of the facility policy, Abuse Prevention Policy and Procedures (12/15/10 R), the section labeled Reporting and Investigation states that a "written report describing all evidence obtained shall be submitted to Adult Protective Services [includes the SA] within 5 days of the initiation of the investigation." On 11/4/14 at 12:47 PM, the DON confirmed that there was no evidence that the incident of alleged abuse between Resident #1 and Resident #2 was reported immediately or that the investigation for either of the above reportable incidents was completed or sent to the SA within 5 working days as required by regulation and per facility policy. (see F 225)	F 226	Personnel Committee at their first meeting following this date. The newly adopted policy will be maintained in the GNH Policy and Resource Book with copies available in the Nurse's Station, DON office, Administrator's office, and in the Business Office. The location of these resource books will be made known to all staff members. A copy of the abuse policy will be posted in a prominent location within the Nurse's Station.  4. Incidents will be reviewed by the abuse reporting committee on a quarterly basis to track report timeliness and reported at the QA meetings. This committee will be formed by December 10, 2014, and review of documented incidents for the previous quarter will begin at this time.  <i>Fax to POC accepted 12/4/14 SDennis AFRW/PMU</i>  1. The revised incident and accident reporting process will be implemented to promote response following a
F 280	483.20(d)(3), 483.10(k)(2) RIGHT TO SS=D PARTICIPATE PLANNING CARE-REVISE CP	F 280	12/10/2014

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 11/10/2014
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 280	Continued From page 4  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 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 on staff interview and record review, the facility failed to revise the Plan of Care to reflect the needs of 1 of 5 residents in the survey sample following a fall with a suspected fracture and upon return to the facility following hospitalization for the repair of the hip fracture and continued risk for falls (Resident #4). The findings include: Per medical record review on 11/4/14, Resident #4 had diagnoses that included significant mental health issues, hypertension, glaucoma, seizures and other chronic medical conditions. His/her fall risk assessment score was identified as 15 on 6/8/14 and 20 on 9/9/14 (a score greater than or equal to 10 indicates a high risk for falls).	F 280	resident fall or other incident. Immediate safeguards will be facilitated through this process. Incidents will be reviewed by the IDT within a short interval. Responses include update of pertinent assessments, rehabilitation screen by therapy, care-plan update, and resident-at-risk meeting.  2. Residents who show high scores on scheduled fall risk assessments, or who experience falls/near falls will receive review and care planning process conducted by the IDT. An automatic rehab screen will be requested to enlist the recommendations and services of therapies. Update of applicable nursing assessments will be performed. Resident-at-risk meetings will be held to develop comprehensive care plans.  3. Care alert reporting, incident and accident reporting, and scheduled assessments will all trigger the review by the interdisciplinary team (IDT) followed by the care plan update process. During review of incident, necessary updates to the care plan will be identified and implemented immediately or as soon as supplies and equipment are available	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIDN	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  475043	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  C 11/10/2014
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 CORRECTIDN (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 280	<p>Continued From page 5</p> <p>Per 11/4/14 review of the nursing progress notes, on 8/23/14 Resident #4 was found on the floor following an unwitnessed fall. A skin tear was identified but the resident was identified as "very strong." On 8/25/14 the resident "put self on the floor x 1. No injuries." On 8/26/14 the resident complained of "...[Right] inguinal/hip pain from my bad fall [8/23/14]...refused to [bear weight] on R leg....continues to point to R inguinal/hip area as source of pain....knee appears slightly [abducted] out." The resident's doctor was notified and on 8/27/14 wrote that the resident had a likely crack or break in hip...refused offer to go to the hospital." On 8/30/14 staff observed the resident "sliding out of chair onto floor, landing on bottom when [s/he] attempted to stand and NWB [non weight bearing]". 8/31/14 the nurses progress notes lists paranoid statements ...continues to roll off mattress ...pad placed besides mattress. On 9/2/14 the resident agreed to obtain an x-ray and was admitted to the hospital following the identification of a right hip fracture. On 9/9/14 Resident #4 returned to the facility following surgical repair of the right hip fracture. Per review of Resident #4 's care plan, there were no revisions to the nursing care plan to indicate specific care needs related to the resident's fall on 8/23/14 and subsequent strong suspicion of a right hip fracture and interventions taken to reduce the risk of further falls. After the resident returned to the facility on 9/9/14 (following the surgical repair of the right hip fracture), the resident's care plan was not revised until the time of the survey on 11/4/14. On 11/5/14 at 4:40 PM, the DON (Director of Nursing) confirmed the above information.</p>	F 280	<p>4. Assessments and care plan updates will be summarized and reported to the Administrator and at quarterly QA meetings where they will be evaluated for effectiveness based on subsequent incidents or injuries. The initial development of this plan will commence as of December 10, 2014.</p> <p><i>F280 POC accepted 12/4/14 SDennis/APR/PML</i></p>	