

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

March 2, 2015

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

Dear Mr. White:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **January 28, 2015**. 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

PRINTED: 02/09/2015
FORM APPROVED
OMB NO. 0938-0391

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

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| 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 01/28/2015 |
| | 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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F 000 INITIAL COMMENTS

F 000

An unannounced onsite re-certification survey was completed by the Division of Licensing and Protection from 1/26-28/15. Based on information gathered, there were regulatory violations cited as follows.

F 242 SS=D 483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES

The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident.

This REQUIREMENT is not met as evidenced by:
Based on resident and staff interview and record review, the facility failed to provide 1 of 16 residents with the right to make choices about aspects of his/her life in the facility that are significant to the resident (Resident #29). The findings include:
Per interview on 1/26/15 at 11:20 AM, Resident #29 responded "No" when asked if s/he was able to choose how many times a week s/he took a bath or shower. S/he reported washing him/herself daily but reported needing assistance from staff and the use of a "lift sit" to get into the tub. S/he reported s/he did not know why s/he was not getting a tub bath or shower but reported that s/he liked them and had not received either for a long time.
Per 1/27/15 record review, Resident #29's Nurse Aide's Information Sheet indicated that the

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F242

2/28/15

Resident #29's bathing choice has been updated. For all residents, to assure their right to make choices about aspects of their life that are significant to them, all will be queried as to their choice of bathing. Care plans will be updated as needed to reflect these choices. Staff have been educated on a resident's right to make choices about their care and how care plans are to be followed to assure those choices are implemented, including tracking forms.

The Director of Nursing or designee will conduct three random audits per week of resident care plans to assure the proper process is being followed.

The Director of Nursing is responsible for this plan of correction.

F242 POC accepted 2/26/15 JHamer | PML

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE 2/23/15

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 242 Continued From page 1 F 242

resident is to have 1 whirlpool bath per week on the 3-11 shift. Per review of the CNA-ADL Tracking Form, for the month of November 2014, LNA staff documented that Resident #29 had 1 shower (11/14/14) and no baths; for the month of December 2014, LNA staff documented 3 tub baths (12/6, 12/13, and 12/27/14) and no showers; for the month of January 2015, LNA staff documented 1 tub bath (1/10/15) and no showers. There were no notations indicating refusals on the forms.

On 1/27/15 at 1:08 PM, LNA #1 stated that the resident refused a tub bath this past Saturday so s/he gave the resident a "partial bath" but did not document the refusal since the resident had the "partial bath" in his/her room. On 1/28/15 at 8:19 AM, LNA #2 reported that though s/he is not Resident #29's usual caregiver, if a resident refuses a tub bath/shower, the bath should be re-offered later in the day or the following day and the charge nurse should be notified. S/he also reported that refusals should be documented on the CNA-ADL Tracking Form with an "R" to indicate that the bath was refused. The LNA confirmed there were no "R's" entered on the form for Resident #29.

On 1/27/15 at 1:21 PM, the facility Director of Nursing (DNS) indicated that the resident has memory issues; however, s/he confirmed that there is no evidence that tub baths or showers were given to the resident once per week as planned and confirmed the entries on the CNA-ADL Tracking Form as listed above. The DNS reported that if a resident refused a tub bath, s/he would expect staff to re-offer the bath on another shift/day and confirmed that there was no evidence that this had occurred with Resident #29.

(CNA = Certified Nursing Assistant; ADL =

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F 242 Continued From page 2
Activities of Daily Living; LNA = Licensed Nursing Assistant)

F 242

F 280 483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP
SS=D

F 280

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 care plan for 1 of 16 residents to reflect the resident's and family's wish for a change in dietary restrictions that were felt to be contributing to weight loss. (Resident #15) Findings include:

Per medical record review, Resident #15 had a diagnosis of Parkinson's Disease and had difficulty chewing and swallowing. Per review of

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F280

2/28/15

For Resident #15, the nutritionist and physician were notified of the family's request to modify the resident's diet and to focus on weight gain and not limiting proteins. These changes have been implemented and the care plan has been revised to reflect the resident and family's nutritional choices. All residents have been reviewed for the same guidelines and corrections made as noted. Staff have been educated on a resident's and family's right to provide input and direction of their care and how care plans are to be followed to assure those choices are captured and implemented.

The Director of Nursing or designee will conduct three random audits per week of resident care plans to assure the proper process is being followed.

The Director of Nursing is responsible for this plan of correction

F280 POC accepted 2/26/15 JHosmer RN/PML

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F 280 Continued From page 3

the Registered Dietician's 8/18/14 note, the resident's diet was changed to a "Low Protein" diet by a neurologist and his/her healthy shakes [high calorie high protein drinks] were discontinued. The RD noted "anticipate further weight loss on low protein diet" and recommended weekly weights. On 10/20/14 and 11/17/14, the consultant neurologist continued to recommend the low protein diet to allow the resident's Sinemet (a medication used in the treatment of Parkinson's disease) the "best chance of working." On 11/18/14 the RD nutrition note stated that the resident had had a low weight and was still on the low protein diet. The RD reported that the resident takes from 2-4 hours to eat [a meal].

Per review, the resident's care plan for "Alteration in nutrition/hydration" was revised on 7/14/14, to a low protein diet. Per nursing progress note review, on 12/18/14, a staff nurse documented that Resident #15's family member [who is his/her Power of Attorney for health care] was visiting and "expressed concerns about the resident's wt. loss and protein restrictions." The family member shared that Resident #15 and his/her family would like [him/her] "to concentrate on increasing Kcals (calories), not limiting proteins." On 12/29/14 Resident #15 was seen for a physician follow up visit. The physician reported that the nurses raised concerns about the resident's overall wellbeing...and that his/her "weight has gone steadily down and [his/her] quality of life seems poor." The physician wrote that Resident #15's "weight is 112 pounds; it was 119 a month ago; it was 125.2 2 months ago; it was around 129-130 three months ago." Per record review, his/her weight on 1/26/15 was 110.8 pounds.

F 280

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F 280. Continued From page 4

Per record review, Resident #15's weight on 1/26/15 was 110.8; his/her height was recorded as 68" and his/her calculated BMI (Body Mass Index) is 16.8. A BMI that falls between 18.5-24.9 is considered normal weight; a BMI below 18.5 is considered underweight.

On 1/28/15 at 10:20 AM, the Dietary Manager (DM) reported that Resident #15 is still on the low protein diet and because of it, cannot have high calorie healthy shakes (which were stopped as they are also high in protein).

On 1/28/15 at 11:10 AM, the facility Director of Nursing (DNS) confirmed knowledge of the family's 12/18/14 request to stop the low protein diet and focus on weight gain. S/he confirmed that the resident's physician and or neurologist had not been notified of the family's wish to stop the low protein diet due to their concerns of weight loss. The DNS also confirmed that the nutritionist was not notified of the family's request to modify the resident's diet and to focus on weight gain and not limiting proteins and confirmed that the resident's nutrition care plan was not revised to reflect the resident and family's nutritional choice.

(Refer F325)

F 281 483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS

SS=D

The services provided or arranged by the facility must meet professional standards of quality.

This REQUIREMENT is not met as evidenced by:
Based on staff interview and record review, the facility failed to follow physician orders for 1 of 16 sampled residents (Resident # 39). Findings

F 280

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F281

Resident #39 is no longer a resident of the facility. For all residents, to assure that services provided meet professional standards, licensed nurses have been inserviced on the procedure for transcribing standing orders to the MAR.

2/28/15

F 281

The Director of Nursing or designee will conduct three random audits per week of resident MAR's to assure the proper process for transcribing standing orders is being followed.

The Director of Nursing is responsible for this plan of correction

F281 POC accepted 2/26/15 JHamer RN/PML

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F 281 Continued From page 5 include:

Per record review on 1/27/14 at 12:40 PM, Resident # 39 did not receive a medication as ordered by the physician. There is a signed physician standing order dated 1/22/15 for multivitamin with minerals - 1 tab every day unless prescribed differently. Review of the Medication Administration Record (MAR) for January 2015 showed that the order had not been transcribed to the MAR. On 1/27/15 at 12:50 PM, a facility nurse confirmed that the standing order was a valid physician order and that the Resident had not been receiving the medication as ordered.

Reference: Lippincott Manual of Nursing Practice (9th ed.), Wolters Kluwer Health/Lippincott Williams & Wilkins.

F 282 SS=D 483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN

The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.

This REQUIREMENT is not met as evidenced by:
Based on staff interview and record review, the facility failed to assure that services were provided in accordance with the resident's plan of care for 1 of 16 residents (Resident #29).
Findings include:
Per 1/27/15 record review and staff interviews, on both 9/22/14 and 12/1/14, Resident #29 was identified by the Registered Dietician (RD) as

F 281

F 282

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F282

2/28/15

For resident #29 and all residents, nursing and dietary staff have been in-serviced on the process for communicating and implementing dietary orders and documentation of such, including tracking forms.

The Director of Nursing or designee will conduct three random audits per week of residents to compare care plans, doctor's orders, and dietary orders to assure they match and are being implemented.

The Director of Nursing is responsible for this plan of correction

FAP2 not accepted 2/26/15 Jitana R/H/AMC

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F 282 Continued From page 6

having both a pressure ulcer on his/her left ankle and weight loss that "seems to be dropping at the rate of about 1 pound per month." The RD added that "we will encourage extra protein with shakes and ice cream if [s/he] will accept." On the 9/22/14 nutrition note, the RD wrote, "I have spoken with this resident and [s/he] tells me that [s/he] would happily accept a shake with [his/her] meal".

Per 1/27/15 review, on 9/22/14 the resident was care planned to receive "shakes with all meals and with snacks." On 1/27/15, a staff nurse reported giving the resident a shake with his/her morning medications and that s/he leaves the shake with the resident to finish with his/her breakfast; LNA (Licensed Nursing Assistants) are then supposed to document the amount that the resident drinks on a food/fluid intake sheet. Per review of the intake form which includes a specific column for shakes, the staff nurse confirmed that there was no evidence that the resident consumed or refused the AM shakes or refused/consumed shakes with his/her other meals.

On 1/27/15 at 1:45 PM, the Dietary Manager (DM) stated Resident #29 was to get a shake with all meals. The DM stated that a reminder to give the shakes had been posted on a white board in the kitchen, though had been erased in anticipation of the shake order being written on the resident's meal card. The DM confirmed that the shake order was not present on the resident's meal card and that the order for shakes with meals was initiated approximately 3 months ago. The DM confirmed that s/he was not present when all meals were plated and that dietary staff had no reminder to give the shakes to the resident; s/he confirmed there was no evidence that shakes were offered to the resident with

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meals.
On 1/27/15 at 1:50 PM, the Director of Nursing (DNS) confirmed the resident had a care plan for nutrition risk related to a pressure ulcer and weight loss. S/he confirmed that the resident's weight in October 2014 was approximately 140 pounds and that his/her current weight on 1/24/15 was 133.9 pounds. S/he confirmed that Resident #29 was care planned to receive shakes with all meals and that there was no evidence that the resident's care plan was implemented and that the resident was given the shakes with meals.

F 325 483.25(i) MAINTAIN NUTRITION STATUS
SS=D UNLESS UNAVOIDABLE

Based on a resident's comprehensive assessment, the facility must ensure that a resident -
(1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and
(2) Receives a therapeutic diet when there is a nutritional problem.

This REQUIREMENT is not met as evidenced by:
Based on staff interview and record review, the facility failed to coordinate care related to nutrition for 2 of 16 residents to ensure the resident maintained acceptable parameters of nutrition status when there is a nutritional problem (Resident #15 and #29). Findings include:
1. Per 1/28/15 medical record review, Resident #15 had a diagnosis of Parkinson's Disease and

F 282

F 325

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F325

2/28/15

For Resident 15, Resident 29, and all residents, nursing and dietary staff have been in-serviced on the purpose and implementation of a therapeutic diet, including capturing resident and family input in that process, as well as tracking forms.

The Director of Nursing or designee will conduct three random audits per week of residents to compare care plans, doctor's orders, and dietary orders to assure they match and are being implemented.

The Director of Nursing is responsible for this plan of correction

F325 POC accepted 2/26/15. Hosmer RN/PML

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F 325 Continued From page 8

had difficulty chewing and swallowing. Per review of the Registered Dietician's 8/18/14 note, the resident's diet was changed to a "Low Protein" diet by a neurologist and his/her healthy shakes [high calorie high protein drinks] were discontinued. The RD noted "anticipate further weight loss on low protein diet" and recommended weekly weights. On 10/20/14 and 11/17/14, the consultant neurologist continued to recommend the low protein diet to allow the resident's Sinemet (a medication used in the treatment of Parkinson's disease) the "best chance of working." On 11/18/14 the RD nutrition note stated that the resident had had a low weight and was still on the low protein diet. The RD reported that the resident takes from 2-4 hours to eat [a meal] and that dietary is to include lots of butter and other fats with meals to keep the resident's weight stable.

Per 1/28/15 nursing progress note review, on 12/18/14, a staff nurse documented that Resident #15's family member [who is his/her POA for health care] was visiting and "expressed concerns about the resident's wt. loss and protein restrictions." The family member shared that Resident #15 and his/her family would like [him/her] "to concentrate on increasing Kcals [calories], not limiting proteins."

On 12/29/14 Resident #15 was seen for a physician follow up visit. The physician reported that the nurses raised concerns about the resident's overall wellbeing...and that his/her "weight has gone steadily down and [his/her] quality of life seems poor." The physician wrote that Resident #15's "weight is 112 pounds; it was 119 a month ago; it was 125.2 2 months ago; it was around 129-130 three months ago."

Per record review, Resident #15's weight on 1/26/15 was 110.8; his/her height was recorded

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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 325 Continued From page 9
 as 68" and his/her calculated BMI (Body Mass Index) is 16.8. A BMI that falls between 18.5-24.9 is considered normal weight; a BMI below 18.5 is considered underweight.
 On 1/28/15 at 10:20 AM, the Dietary Manager (DM) reported that Resident #15 is still on the low protein diet and because of it, cannot have high calorie healthy shakes (which were stopped as they are also high in protein).
 On 1/28/15 at 11:10 AM, the facility Director of Nursing (DNS) confirmed knowledge of the family's 12/18/14 request to stop the low protein diet and focus on weight gain. S/he confirmed that the resident's physician and or neurologist had not been notified of their wish to stop the low protein diet due to their concerns of weight loss. The DNS also confirmed that the nutritionist was not advised of the family's request to modify the resident's diet and to focus on weight gain and not limiting proteins.
 2. Per 1/27/15 record review and staff interviews, on both 9/22/14 and 12/1/14, Resident #29 was identified by the Registered Dietician (RD) as having both a pressure ulcer on his/her left ankle and weight loss that "seems to be dropping at the rate of about 1 pound per month." The RD added that "we will encourage extra protein with shakes and ice cream if [s/he] will accept." On the 9/22/14 nutrition note, the RD wrote, "I have spoken with this resident and [s/he] tells me that [s/he] would happily accept a shake with [his/her] meal.
 Per 1/27/15 review, on 9/22/14 the resident was care planned to receive "shakes with all meals and with snacks." On 1/27/15, a staff nurse reported giving the resident a shake with his/her morning medications and that s/he leaves the shake with the resident to finish with his/her breakfast; LNA (Licensed Nursing Assistants) are

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F 325 Continued From page 10
 then supposed to document the amount that the resident drinks on a food/fluid intake sheet. Per review of the intake form which includes a specific column for shakes, the staff nurse confirmed that there was no evidence that the resident consumed or refused the AM shakes or refused/consumed shakes with his/her other meals.
 On 1/27/15 at 1:45 PM, the Dietary Manager (DM) stated Resident #29 was to get a shake with all meals. The DM stated that a reminder to give the shakes had been posted on a white board in the kitchen, though had been erased in anticipation of the shake order being written on the resident's meal card. The DM confirmed that the shake order was not present on the resident's meal card and that the order for shakes with meals was initiated approximately 3 months ago. The DM confirmed that s/he was not present when all meals were plated and that dietary staff had no reminder to give the shakes to the resident; s/he confirmed there was no evidence that shakes were offered to the resident with meals.
 On 1/27/15 at 1:50 PM, the Director of Nursing (DNS) confirmed the resident had a care plan for nutrition risk related to a pressure ulcer and weight loss. S/he confirmed that the resident's weight in October 2014 was approximately 140 pounds and that his/her current weight on 1/24/15 was 133.9 pounds. S/he confirmed that Resident #29 was care planned to receive shakes with all meals and that there was no evidence that the resident was given the shakes with meals.
 (Refer F280, F282)

F 325

F 329 483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS

F 329

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F 329 Continued From page 11
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 record reviews and staff interviews, the facility failed to ensure that the drug regime for 1 of 16 residents' was free from unnecessary drugs. (Residents # 25) Findings include:

Per record review on 1/27/14, there is no evidence that an attempt for a Gradual Dose Reduction (GDR) of Divalproex 250 mg daily was recommended by the consulting pharmacist after the resident was observed to have days where s/he was too sleepy/not arousable to safely take

F 329
This Plan of Correction is the center's credible allegation of compliance.

Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.

F329 2/28/15

For Resident #25 and all affected residents, facility consultant pharmacist has conducted a review off all resident's on anti-psychotic drugs. Findings have been shared with the attending physician to assure medications are appropriate and to assess the possibility of gradual dose reduction or changes as appropriate.

The Director of Nursing or designee will conduct three random audits per week of resident's on anti-psychotic drugs to assure the proper process has been followed.

The Director of Nursing is responsible for this plan of correction.

F329 POC accepted 2/26/15 JHK/mer Ral/PMC

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F 329 Continued From page 12

his/her medications. (Divalproex is a mood stabilizer for which drowsiness or somnolence is a common side effect). Per review of the Medication Administration Record (MAR), in October 2014 there were 6 entries in the MAR where the resident was documented as having medications held secondary to "difficulty to swallow," "sleepy, unsafe to administer," "unable to wake, held" and "asleep." In November 2014, there were 9 entries where the resident had medications held for "unable to wake", "sleepy," "Resident not arousable," "Sleepy, unable to wake," and "refused to swallow." In December 2014, there were 7 entries that medications were held for the resident being "sleepy" or "not arousable." In January 2015, there were 4 entries where the resident was not arousable. On 1/28/15 at 8:48 AM, the staff medication nurse reported that Resident #25 has days when it is not safe to administer his/her medications. Sometimes the resident is "not arousable." Other days, if you speak to [Resident #25], s/he opens his/her eyes, is looking but "does not acknowledge you"... "so hold the medications" as feel it's "not safe" to give them. The nurse reported that it is not often that the resident actually refuses medications, but sometimes record it as a refusal when the resident does not respond or does not acknowledge [the request to take medications]. (There were 11 entries in the MAR that medications were refused in November; 5 entries for refusals in December and 8 entries for refusals in January 2015). The nurse reported that s/he had not spoken to the resident's physician about the resident's arousability issues. On 1/27/14, Resident #25's behavior monitoring sheets from 10/1-1/26/2015 were reviewed.

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| F 329 | Continued From page 13 There was no documentation that the resident had had any episodes of anxiety (striking out/hitting or yelling/screaming) during the 4 months listed. The sheets were copied and the documentation confirmed by the DNS on 1/27/15. On 1/27/15 at 10:05 AM, the Director of Nursing (DNS) confirmed the MAR entries and the resident's documented sedation and confirmed that the pharmacist had not made a recommendation for an attempt at a GDR for Divalproex. The DNS stated that it would be logical to consider a GDR of the Divalproex based on the resident's sleepiness and inability to rouse to take medications. On 1/28/15 at 8:57 AM, the DNS stated that at one time s/he had written a note to the resident's physician that the resident was having difficulty taking medications, but had not indicated that it was specific to arousability or whether a GDR of the Divalproex might be considered. | F 329 | <i>This Plan of Correction is the center's credible allegation of compliance.</i> <i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i> |
| F 371 SS=F | 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: Based on observation and staff interview, the facility failed to store and prepare food under | F 371 | F371 2/28/15 For all residents of this facility and to assure the the storing, preparing, distributing, and serving of food under sanitary conditions all dietary task assignments have been reviewed. Items 1 thru 11 have been addressed and rectified. Dietary staff have been in-serviced on kitchen task assignments and on kitchen sanitary procedures and expectations. The Dietary Manager or designee will conduct at least three random audits per week of the kitchen to assure task assignments are complete and sanitary standards are met. The Administrator will be responsible for this plan of correction. |

F371 POC accepted 2/26/15 Jitendra Ravi/MLC

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F 371 Continued From page 14 F 371

sanitary conditions. Findings include:

During the initial tour of the facility on 1/26/15 starting at 8:59 AM, the following observations were made in the kitchen:

1. A wire cleaning brush and a grill type scraper were stored on the same shelf as unwrapped coffee filters and clean aprons. The aprons were situated in contact with dust and particulate matter on the shelf.
2. Dried spatter was observed on the underside of the small standing mixer. On the large standing mixer, crumbly brownish debris was present on the end of the mixer shaft (where the blades attach).
3. There was dust and debris and thick dried brown stains on the top surface of the coffee machine, surrounding the area where water is added.
4. Two employee coats were observed hanging on a rack that held kitchen utensils.
5. The vent cover on the ice machine was not attached exposing the filter compartment; heavy soiling and cobwebs were observed on the switches and in the filter area.
6. The air conditioner vents (situated above the work area kitchen sink) were heavily soiled with loose dust.
7. The shelf over a prep counter (that held the microwave) was heavily soiled with food crumbs and particles. Dried spatter was observed on the ceiling over the microwave/prep area.

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F 371 Continued From page 15

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8. The top of the knife block (containing the kitchen knives) was soiled with dust.

9. Clean meal tray covers were observed stored on a dust soiled shelf.

10. In the walk-in refrigerator where resident food was stored, the plastic wrap was not secured on a large pan of meatballs leaving part of the pan uncovered. The foil wrap on a bowl with salad leftovers was torn and the food was removed by the Registered Dietician at the time of the tour.

11. In the dry goods storage room, 2 popcorn snack bags were open and loose popcorn was observed in the box with the other snack bags.

The above findings were confirmed by the facility Registered Dietician at the time of the tour.

On 1/27/15 at 2:51 PM, the Dietary Manager (DM) reported that though there is a posted cleaning schedule in the kitchen, staff had not been required to sign off that the tasks were completed and that it "fell through the wayside". S/he also reported there had been some staffing issues that have also been corrected. During a second tour following the interview, the areas mentioned above had been cleaned.

F 428 483.60(c) DRUG REGIMEN REVIEW, REPORT SS=D IRREGULAR, ACT ON

F 428

The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist.

The pharmacist must report any irregularities to

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F 428 Continued From page 16
the attending physician, and the director of nursing, and these reports must be acted upon.

This REQUIREMENT is not met as evidenced by:
Based on record review and staff interview, the pharmacist failed to report an irregularity to the facility and attending physician so that it might be acted upon for 1 of 16 residents (Resident #25). Findings include:

Per record review on 1/27/14, there is no evidence that an attempt for a Gradual Dose Reduction (GDR) of Divalproex 250 mg daily was recommended by the consulting pharmacist after the resident was observed to have days where s/he was too sleepy/not arousable to safely take his/her medications. (Divalproex is a mood stabilizer for which drowsiness or somnolence is a common side effect).

Per review of the Medication Administration Record (MAR), in October 2014 there were 6 entries in the MAR where the resident was documented as having medications held secondary to "difficulty to swallow," "sleepy, unsafe to administer," "unable to wake, held" and "asleep." In November 2014, there were 9 entries where the resident had medications held for "unable to wake," "sleepy," "Resident not arousable," "Sleepy, unable to wake," and "refused to swallow." In December 2014, there were 7 entries that medications were held for the resident being "sleepy" or "not arousable." In January 2015, there were 4 entries where the resident was not arousable.

F 428 *This Plan of Correction is the center's credible allegation of compliance.*

Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.

F428 2/28/15

Resident's 25's medications have been reviewed by the consultant pharmacist and attending physician. An attempt is ongoing at a gradual dose reduction.

For resident #25 and all residents of the facility, the Director of Nursing and Medical Director have in-serviced the consultant pharmacist on facility policy regarding medication reviews and required communication thereafter.

The Director of Nursing or designee will conduct three random audits per week of resident records to assure a pharmacy review has been completed and any recommendations have been communicated to the attending physician.

The Director of Nursing is responsible for this plan of correction.

F428 POI accepted 2/26/15 Hpsmer Ruffme

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On 1/28/15 at 8:48 AM, the staff medication nurse reported that Resident #25 has days when it is not safe to administer his/her medications. Sometimes the resident is "not arousable." Other days, if you speak to [Resident #25], s/he opens his/her eyes, is looking but "does not acknowledge you" ... "so hold the medications" as feel it's "not safe" to give them. The nurse reported that it's not often that the resident actually refuses medications, but sometimes record it as a refusal when the resident does not respond or does not acknowledge [request to take medications]. (There were 11 entries in the MAR that medications were refused in November; 5 entries for refusals in December and 8 entries for refusals in January 2015). On 1/27/14, Resident #25's behavior monitoring sheets from 10/1-1/26/2015 were reviewed. There was no documentation that the resident had had any episodes of anxiety (striking out/hitting or yelling/screaming during the 4 months listed. The sheets were copied and the documentation confirmed by the DNS on 1/27/15. On 1/27/15 at 10:05 AM, the Director of Nursing (DNS) confirmed the MAR entries and the resident's documented sedation and confirmed that the pharmacist had not made a recommendation for an attempt at a GDR for Divalproex. The DNS stated that it would be logical to consider a GDR of the Divalproex based on the resident's sleepiness and inability to take medications.

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DEPARTMENT OF HEALTH AND HUMAN SERVICES
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ALL
"A" FORM

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| STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NPs | PROVIDER # 475043 | MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____ | DATE SURVEY COMPLETE: 1/28/2015 |
| NAME OF PROVIDER OR SUPPLIER GREENSBORO NURSING HOME | | STREET ADDRESS, CITY, STATE, ZIP CODE 47 MAGGIE'S POND ROAD GREENSBORO, VT | |

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| PREFIX 156 | SUMMARY STATEMENT OF DEFICIENCIES |
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483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES

The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing.

The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section.

The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate.

The facility must furnish a written description of legal rights which includes:
A description of the manner of protecting personal funds, under paragraph (c) of this section;
A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels.
A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements.

The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care.

The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits.

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

If continuing sheet 1 of 2

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

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE
NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM
FOR SNPs AND NPs

PROVIDER #
475043

MULTIPLE CONSTRUCTION
A. BUILDING: _____
B. WING: _____

DATE SURVEY
COMPLETE:
1/28/2015

NAME OF PROVIDER OR SUPPLIER
GREENSBORO NURSING HOME

STREET ADDRESS, CITY, STATE, ZIP CODE
47 MAGGIE'S POND ROAD
GREENSBORO, VT

ID
PREFIX
TAG

SUMMARY STATEMENT OF DEFICIENCIES

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Continued From Page 1

This REQUIREMENT is not met as evidenced by:
Based on record review and staff interview, the facility failed to provide a liability and beneficiary notice with appeal information to 1 of 3 residents in the applicable sample (Resident #35) when Medicare skilled services ended. Findings include:

1. During an interview on 1/27/15 at 9:45 AM, the Administrator confirmed that the facility could not provide evidence that Resident #35 was provided a required liability and beneficiary notice with appeal information when skilled Medicare services ended.

*This is an "A" level citation.

This Plan of Correction is the center's credible allegation of compliance.

Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.

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2/28/15

Resident #35 is no longer a resident. For all residents, Medicare covered stays will be tracked via a weekly Medicare meeting, to include remaining available days of Medicare coverage. Medicare cut letters will be prepared and issued by the Social Services department. Copies will be placed in the resident's record, compiled in a binder to be maintained in the Social Services office, and a copy given to the business office for their records.

The Administrator will audit Medicare discharges to assure the required paperwork is completed.

The Administrator is responsible for this plan of correction.