

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

February 2, 2016

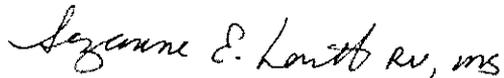
Mr. William White, Administrator
Greensboro Nursing Home
47 Maggie's Pond Road
Greensboro, VT 05841-8800

Dear Mr. White:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **January 6, 2016**. 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,



Suzanne Leavitt, RN, MS
Assistant Division Director
Director State Survey Agency

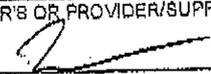


DEPARTMENT OF HEALTH AND HUMAN SERVICES
 ENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 475043	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 01/06/2016
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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
F 000	INITIAL COMMENTS	F 000		
F 281 SS=D	<p>An unannounced onsite recertification survey and investigation of 3 entity self-reported incidents was conducted by the Division of Licensing and Protection on 1/4/16 - 1/6/16. The following regulatory violations were identified:</p> <p>483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS</p> <p>The services provided or arranged by the facility must meet professional standards of quality.</p> <p>This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility failed to assure that nurses met professional standards of nursing practice regarding following physician orders and for monitoring and reassessing a resident's skin following an incident for 1 of 3 residents involved in entity reported events (Resident #19). Findings include:</p> <p>1. Per 1/5-1/6/16 record review, Resident #19 has a diagnosis of Alzheimer's disease and a history of sundowning with periods of increased anxiety and agitation. Per his/her current care plan, the resident is dependent on staff for meeting his/her physical needs, has urinary incontinence and has the potential for pressure ulcer development. Physician orders (dated from 11/08/15 to the time of the survey) state to "Assess skin weekly on bath day, weekly every [Saturday] for potential skin breakdown." Per review of the record, a skin assessment was last documented as completed on 12/18/15. On 1/6/16 at approximately 8:30 AM, the DNS (Director of Nursing Services) confirmed</p>	F 281	<p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><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></p> <p>F281</p> <p>For resident #19 and all residents of the facility, to assure that services provided meet professional standards, licensed nurses have been in-serviced on the procedure for the ordering of skin assessments and the process for monitoring and re-assessing therein.</p> <p>The Director of Nursing or designee will conduct three random audits per week of resident records to assure the proper process for skin assessments is being followed.</p> <p>The Director of Nursing is responsible for this plan of correction.</p> <p><i>Docant 22:16 SD/SD</i></p>	2/6/16

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE Administrator	(X8) DATE 1/28/16
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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 281 Continued From page 1
 that there was no evidence that a skin assessment was completed during the following two weeks (assessments would have been due on 12/26/15 and 1/2/16) and no evidence that the physician orders were followed.

F 281

2. Per review of a facility reported incident, on 12/18/15 Resident #19 reportedly became very agitated, pulling staff hair and striking out during the provision of incontinence care. Per review of the internal investigation and witness statements, there were conflicting reports of whether the resident's wrists were held to prevent the staff from being struck or whether staff held arms up to prevent contact by the resident. Immediately following the incident, a skin assessment was completed on 12/18/15 which identified bruises on the dorsal area of the resident's right hand which the DNS described as 2 areas, one a half moon shape and the other a pink area. There were no injuries reported to the wrists. Per interview with the DNS on 1/8/16, s/he confirmed that there is no evidence that the resident's skin was reassessed or monitored following the incident or checked for further bruises that might develop over the day following the 12/18/15 incident.

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

F 282

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

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F 282	<p>Continued From page 2</p> <p>This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility failed to provide services in accordance with the plan of care for 2 of 3 residents related to nutritional needs (Resident #20 and #23). Findings include:</p> <p>1. Resident #20 was identified during record review on 01/04/16 as having lost weight during the last quarter, September-December 2015 from 135 lbs to 129 lbs. In addition there was a lost of 5% in the last 30 days (October 10, 2015 weight was listed as 138 lbs.) The Dietary Assessment dated 10/19/16 states for the goal and interventions respectively to keep weight at 135# +/- 5 lbs; continue with a Regular diet; Multivitamins with minerals, fortify food with dry skim milk; offer finger foods if [resident] starts to wander; healthy snacks; monitor weight every week; shakes three times a day [TID] and as needed [PRN]. The Dietary assessment note of 01/04/15 shows that the resident has a fair appetite; Significant weight loss noted, down 5.2% x 1 month, currently has issues with 2 teeth which is likely impacting intake and to continue with the health shakes. The resident care plan dated 10/19/15 [revised 01/04/16] shows that the resident has the potential for alteration in nutrition/hydration and is totally unaware of the need for proper nutrition or hydration; tends to wander a lot which can affect eating; and significant weight loss with the goal to maintain adequate nutrition and interventions to include "Provide and serve supplements as ordered: TID and PRN, Provide, serve diet as ordered, Monitor intake and record every meal</p>	F 282	<p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><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></p> <p>F282</p> <p>For resident #20, resident #23 and all residents of the facility, nursing and dietary staff have been in-serviced on the process for communicating and implementing dietary orders as per the plan of care and documentation of such, including tracking mechanisms. Nursing staff have also been in-serviced on correct weight procedures including data collection, monitoring, and communication to nursing and dietary team members.</p> <p>The Director of Nursing or designee will conduct three random audits per week of residents to compare care plans, doctor's orders, dietary orders and weight documentation to verify they match and are being implemented.</p> <p>The Director of Nursing is responsible for this plan of correction.</p> <p><i>Account 22.16 D/R</i></p>	2/6/16

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F 282	<p>Continued From page 3</p> <p>report significant weight loss: 3 lbs in 1 week, >5% in 1 month."</p> <p>Per interview the Dietary Manager on 01/05/16 at 3:03 PM stated that the resident gets a regular diet as well as a peanut butter sandwich in case the resident starts to of wander. [When asked if the residents get a supplemental shake, the Dietary Manager said It would be recommended by the dietician or physician order.] There was no physician order for the nutritional shake nor was this noted on the nursing administration record. The Director of Nursing on 01/05/16 at 3:15 PM confirmed that the care plan as written, was not followed regarding supplemental nutritional shake.</p> <p>2. Per 1/6/16 record review, Resident #23 was identified on his/her 11/23/15 nutrition assessment as being at nutritional risk related to a diagnosis of dementia and the resident's complete unawareness of the need for proper nutrition or hydration. The resident's care plan for potential for nutritional/hydration problems states to "Monitor/record/report to MD pm [as needed] signs and symptoms of malnutrition...significant weight loss: 3 lbs. in 1 week, >5% in 1 month, >7.5% in 3 months, >10% in 6 months." Per review of the resident's weight history, on 12/14/15 Resident #23 weighed 120.2 pounds; one week later, on 12/21/15 the resident weighed 114 pounds (a 6.2 pound loss). On 1/4/16 the resident weighed 110.2 pounds (an 8.6% weight loss from 12/7/15 when the resident weighed 120.8)</p> <p>Per 1/6/16 at 9:23 AM interview, the facility DNS (Director of Nursing) confirmed the above information. S/he reported that LNAs (Licensed Nursing Assistants) obtain resident weights and</p>	F 282		
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PRINTED: 01/19/2016
FORM APPROVED
OMB NO. 0938-0391

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F 282	Continued From page 4 the medication nurse is expected to verify the weights. The DNS reported that an LNA staff member had suggested that there might be an inaccuracy in the way the resident's weights were measured; however, the DNS confirmed that there was no evidence that a process had been developed to determine if measurements were accurate and confirmed that there was no evidence that the resident's physician was notified of the resident's weight loss as directed per care plan. S/he further identified that the facility did not have a system in place to assure that the attending physician and Registered Dietician were notified of resident weight losses.	F 282		
F 465 SS=E	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation and staff confirmation the facility failed to ensure that the facility was maintained to provide a safe, functional and sanitary environment for staff and the public. The findings includes the following: 1. During the initial facility tour on 01/04/16 between 9:20 - 10:30 AM the following were observed: The South wing hall, near the shower room, was noted to have equipment such as a sera lift, a reclining wheel chair (Broda-type) and several	F 465	<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> F465 For all residents of the facility, facility staff have been in-serviced on the requirement of maintaining clear hallways for safety. Housekeeping staff have been in-serviced on cleaning procedures and expectations for ceiling vents. Maintenance will repair the baseboard in the shared bathroom between Rm 9 and 10 and will effect repair to the wall in Rm 14. The Administrator or designee will conduct three random audits per week of residents rooms and bathrooms to verify that an appropriate environment is maintained. The Administrator is responsible for this plan of correction.	2/6/16

Account 2-2-16 SD/RA

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F 465	<p>Continued From page 5</p> <p>regular wheelchairs in front of the fire pull switch, impeding the potential use of it. On the North Wing, a chair with arms for sitting, was directly in front of the fire pull station with a night stand just left of the chair. There are signs posted above each fire pull switch directing staff not to block them. In addition, observations on 01/04/16 between 1:19 - 3:55 PM in resident shared bathrooms 9-10 & 11-12, the ceiling vents had dust and cob-webs. The baseboard in bathroom 9-10 to right of toilet was pulling away from wall, discolored, with a small area of water noted near the baseboard. Room 14 had torn wallpaper on the wall near the beds.</p> <p>During the environmental tour with the Maintenance Manager (MM) on 01/05/16 at 3:00 PM observed the resident's bathroom as noted above as well as the sitting chair partially in the fire exit door egress and the night stand in the corner. The MM stated "this has been an ongoing situation with getting staff to keep the fire pulls and exit doors free". The MM promptly removed the night stand and moved the sitting chair out of the way. The MM confirmed the above findings at that time.</p>	F 465		