

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

PRINTED: 06/17/2015
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 R-C 06/09/2015
NAME OF PROVIDER OR SUPPLIER GREENSBORO NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 47 MAGGIE'S POND ROAD GREENSBORO, VT 05841	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 000}	INITIAL COMMENTS An unannounced on-site follow-up survey was completed by the Division of Licensing and Protection on 6/9/15. The following regulatory violations were identified: F 241 SS=D 483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to promote care for 2 of 4 residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality (Resident #3 and #4). Findings include: 1. Per observation on 6/9/15 at 8:38 AM, there were two 8 1/2 x 11 inch signs with large bold, capital lettering stating, "Notice Activate Alarm Before Leaving" posted outside of Resident #3's room. One sign was positioned at eye level on the door and the second was positioned to the left of the door frame at eye level. On 6/9/15 at 12:44 PM, the facility DNS (Director of Nursing) reported that the signage was implemented to "instruct staff" to reset an infrared alarm upon exiting Resident #3's room. S/he confirmed that the signs were visible to visitors and other residents who use the common hallway and those visitors and other residents did not need to know about the alarm. During the observation, the DNS reported that the signs could have been	{F 000}	F 241 <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> F241 For all residents, staff will be in-serviced on resident dignity as relates to the placement of signs as well as the appropriate setting for blood draws. This process will be implemented for Resident #3, Resident #4 and all residents. The Administrator or designee will conduct three random audits per week of the building to assure any signage is appropriately placed. The Director of Nursing or designee will conduct three random audits per week of blood draws to assure they are drawn in an appropriate setting. The Administrator is responsible for this plan of correction.	6/27/15

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE Administrator DATE 6/24/15

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 241	Continued From page 1 fastened to the inside of the doorway (in the resident's room) so they would not be visible to others and yet still remind staff to reset the alarm. 2. On 6/9/15 at 2:21 PM, a staff nurse was observed performing a venipuncture (blood draw) on Resident #4 while s/he was seated in the facility living room. The resident was heard to yell out during the procedure. At the time, there were 3 other residents in the area within visual and auditory distance of the procedure as well as other staff members. The DNS confirmed the above observations and that performing the procedure in the living room with other residents present was a dignity issue for Resident #4 and it was his/her expectation that the procedure was going to be performed in the resident's room.	F 241	<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 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of 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.	F 280	F280 For all residents and for Resident #3, the facility will assure that all residents with identified pressure areas have current nutritional intervention by qualified personnel. Licensed nurses and the registered dietitian will be educated on the importance of nutrition in wound healing and the requirement for nutritional assessments in care planning on a timely basis. The Director of Nursing or designee will conduct three random audits per week of resident records to verify nutritional intervention is in place including revision of care plans. The Director of Nursing is responsible for this plan of correction.	6/27/15	

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F 280	Continued From page 2 This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to revise the plan of care for 1 of 3 residents (Resident #3) related to nutritional recommendations following the development of a pressure ulcer. Findings include: Per record review, Resident #3 who had a right sided hemiparesis (partial paralysis) used a seated, crossed-leg pulling motion for mobility which put pressure on his/her right ankle. On 4/12/15, 6 days following his/her admission to the facility, the resident was identified as having a Stage II pressure ulcer (a partial thickness skin loss) on the right outer malleolus (ankle bone). Wound care followed a treatment plan and healing was complicated by signs and symptoms of infection necessitating treatment with Clindamycin (an antibiotic) on 5/20/15 and a concern for the risk of osteomyelitis (a bone infection) which was ruled out. Per review of the resident's nutrition assessment, on 4/13/15 the Registered Dietician (RD) reported that Resident #3 was unaware of the need for proper nutrition and/or hydration, had a variable appetite, a history of a 10% weight loss while in the hospital [prior to admission to the nursing home] and required assistance/supervision and cueing at all meals. Although the pressure ulcer was identified on 4/12/15, the RD's nutrition assessment on 4/13/15 identified Resident #3's skin as "dry and intact." The nutrition assessment also listed that the RD was to "be informed of significant changes" for Resident #3. On 6/9/15 at 12:00 PM, the facility wound care nurse reported that Resident #3's pressure ulcer	F 280		

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F 280	Continued From page 3 was currently unstageable (unstageable = full thickness tissue loss in which the actual depth of the ulcer is obscured) though it was improving in size. S/he reported that it would be a recommendation that a skin risk team to have nutritionist input for wound treatments. On 6/9/15 at 12:23 PM, the Director of Nursing (DNS) confirmed that the facility RD had not been consulted for Resident #3 once the pressure ulcer was identified. S/he also reported that there is no process in place to ensure that the RD reviews the medical records of residents who have wounds to identify any nutritional recommendations to promote wound healing. During interview on 6/9/15 at 12:23 PM, the DNS (Director of Nursing) confirmed that Resident #3's nutrition care plan had not been revised related to the pressure ulcer/wound healing since the ulcer was identified on 4/12/15 (an almost 2 month interval). (Refer F314)	F 280	<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 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the	F 314	F314 For all residents and for Resident #3, the facility will assure that all residents with identified pressure areas have current nutritional intervention by qualified personnel. Licensed nurses and the registered dietician will be educated on the importance of nutrition in wound healing, the requirement for nutritional assessments therein, and the requirement to notify the dietician promptly of both new identified areas and changes in condition of existing areas. The Director of Nursing or designee will conduct three random audits per week of resident records to verify nutritional intervention is in place. The Director of Nursing is responsible for this plan of correction.	6/27/15

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F 314	<p>Continued From page 4</p> <p>facility failed to ensure that a resident with a pressure ulcer received all the necessary treatment and services to promote healing for 1 of 3 residents sampled (Resident #3). Findings include:</p> <p>Per record review, Resident #3 who had a right sided hemiparesis (partial paralysis) used a seated, crossed-leg pulling motion for mobility which put pressure on his/her right ankle. On 4/12/15, 6 days following his/her admission to the facility, the resident was identified as having a Stage II pressure ulcer (a partial thickness skin loss) on the right outer malleolus (ankle bone). Wound care followed a treatment plan but was complicated by signs and symptoms of infection necessitating treatment with Clindamycin (an antibiotic) on 5/20/15 and a concern for the risk of osteomyelitis (bone infection) which was ruled out.</p> <p>Per review of the resident's nutrition assessment, on 4/13/15 the Registered Dietician (RD) reported that Resident #3 was unaware of the need for proper nutrition and/or hydration, had a variable appetite, a history of a 10% weight loss while in the hospital [prior to admission to the nursing home] and required assistance/supervision and cueing at all meals. Although the pressure ulcer was identified on 4/12/15, the RD's nutrition assessment on 4/13/15 identified Resident #3's skin as "dry and intact." The nutrition assessment also listed that the RD was to "be informed of significant changes" for Resident #3.</p> <p>On 6/9/15 at 12:00 PM, the facility wound care nurse reported that Resident #3's pressure ulcer was currently unstageable (unstageable = full thickness tissue loss in which the actual depth of the ulcer is obscured) though it was improving in size. S/he reported that it would be a</p>	F 314		

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F 314	Continued From page 5 recommendation for a skin risk team to have nutritionist input for wound treatments. On 6/9/15 at 12:23 PM, the Director of Nursing (DNS) confirmed the above information and that there was no evidence that the facility RD had been consulted for Resident #3 once the pressure ulcer was identified on 4/12/15. S/he also reported that there is no process in place to ensure that the RD reviews the treatment plan for residents who have wounds to identify whether there are additional nutrition recommendations that might promote wound healing. (Refer F280)	F 314		



Greensboro Nursing Home

"A Living Center"

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(802) 533-7051 • Fax (802) 533-7054
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June 24th, 2015

Pamela M. Cota, RN
Licensing Chief
State of Vermont DAIL, Div. of Licensing & Protection
103 South Main Street
Waterbury, VT 05671-2306

VIA FACSIMILE - 802-871-3318

Dear Ms. Cota,

This letter is in response to the investigation concluded by your staff on June 9th, 2015. Please find enclosed the plan of correction for the alleged deficiencies.

Please note that the filing of this plan of correction does not constitute any admission as to any of the alleged deficiencies set forth in the statement of deficiencies. This Plan of Correction is filed as evidence of the facility's continued compliance with all applicable laws.

Sincerely,

William E. White, MBA, LNHA
Administrator