

Division of Licensing and Protection
103 South Main Street, Ladd Hall
Waterbury, VT 05671-2306
<http://www.dail.vermont.gov>
Voice/TTY (802) 241-2345
To Report Adult Abuse: (800) 564-1612
Fax (802) 241-2358

December 23, 2011

Mr. Lance Comfort, Administrator
Greensboro Nursing Home
47 Maggie's Pond Road
Greensboro, VT 05841

Provider #: 475043

Dear Mr. Comfort:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **November 16, 2011**. 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

PC:ne

Enclosure



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

PRINTED: 11/29/2011
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 11/16/2011
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 279	Continued From page 1 skin condition on the left cheek. (Resident # 8). Finding includes: Per observation on 11/14/11 of Resident # 8 in the Stage I sample, a skin condition was observed on the the resident's left cheek. Per record review of Resident #8's Physician Orders dated 10/28/11, Plan of Care, Physician Progress Note dated 10/28/11, and confirmed with the Director of Nursing (DNS) on 11/15/11 at 1:42 PM, Resident #8 did not have a care plan related to the skin condition on the left cheek. On 10/28/11, the Physician examined Resident # 8, identified a skin condition on the left cheek and prescribed "Barrier Cream three times a day to left cheek". In addition, the DNS stated nursing staff should have initiated the facility's "Temporary Total Care Plan: Alteration in Skin Condition" for Resident #8.	F 279		
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.	F 441	A policy to address the sanitary use and cleaning requirements of urinary measuring devices and bedside commodes was developed on 11/14/11. All of this equipment was labeled with residents name and determined to be stored properly. This has been implemented and is being spot checked on a daily basis by the DNS. The above procedure has been added to the LNA orientation checklist to ensure proper training for all new hires.	1-5-12

F 441 POC accepted
T. Cummins per MS

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

PRINTED: 11/29/2011
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 11/16/2011
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 441	<p>Continued From page 2</p> <p>(b) Preventing Spread of Infection</p> <p>(1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.</p> <p>(2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.</p> <p>(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens</p> <p>Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to develop and implement a written policy & procedure in order to assure that urinary measuring devices and reusable toileting devices are properly cleaned and disinfected before use on another resident. Findings include:</p> <p>1. During the initial tour of the facility on 11/14/11, two unlabeled urinary measuring devices (commonly referred to as "hats") were observed in the bathroom which serves residents in rooms 3 and 4. At 10:03 AM on 11/14/11, Licensed Nurse Assistant A (LNA) confirmed that one unlabeled "hat" was in the toilet, and a second</p>	F 441	<p><i>F 441 POC accepted T. Cummings RN/jms</i></p>	

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

PRINTED: 11/29/2011
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 11/16/2011
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 441	<p>Continued From page 3</p> <p>unlabeled "hat" was in the bedside commode adjacent to the toilet. Also, during the initial tour on 11/14/11, a total of six unlabeled, bedside commode toileting devices were observed adjacent to the toilets in bathrooms serving rooms 3-4, 5-6, 11-12, and 15.</p> <p>During a tour with the Director of Nurses (DON) on 11/14/11, the following observations were confirmed: one unlabeled commode in the bathroom serving room 15, at 10:13 AM; two unlabeled commodes in the bathroom shared by rooms 11-12, at 10:15 AM; one unlabeled commode in the shared bath for rooms 3-4 at 10:19 AM; and one unlabeled commode in the shared bathroom for rooms 5-6, at 10:21 AM. On 11/15/11 at 3:00 PM, LNA B stated that s/he has not been told by the facility how to clean and store toileting devices. During this same interview, LNA C stated that s/he had not been trained by the facility regarding commodes and "hats".</p> <p>During an interview on 11/16/11 at 7:20 AM, the infection control nurse confirmed that the facility has no written policy and procedure, nor written evidence of staff training, regarding the protocol for disinfection and placement of commodes and urinary measuring devices. The infection control nurse confirmed at 7:30 AM on 11/16/11 that the bedside commodes should be washed and disinfected after each use, as well as labeled with the name of the resident and placed near the bedside to avoid inadvertent use by another resident. S/he further confirmed that urinary measuring devices ("hats") should be labeled with the resident's name and should be stored so as to avoid inadvertent use by another resident.</p>	F 441			
F 456	483.70(c)(2) ESSENTIAL EQUIPMENT, SAFE	F 456			

*F441 POC accepted
T. Cummins RN, MS.*

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

PRINTED: 11/29/2011
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 11/16/2011
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 456 SS=E	<p>Continued From page 4 OPERATING CONDITION</p> <p>The facility must maintain all essential mechanical, electrical, and patient care equipment in safe operating condition.</p> <p>This REQUIREMENT is not met as evidenced by: Based upon interview and record review, the facility failed to maintain a Hoyer mechanical lift sling with 4 straps in a safe operating condition, which resulted in 2 sling straps breaking off and the resident falling. (Resident #32). Finding includes:</p> <p>Per record review of the 11/4/11 Facility Incident/Accident report for Resident #32 and confirmed with the Director of Nursing on 11/16/11 at 9:08 AM, 2 straps of the Hoyer sling broke off while 2 Licensed Nursing Assistants were weighing Resident #32 and s/he "sat on the floor, fell back and hit back of head on the window hardware". Per interview with the Administrator (ADM) on 11/16/11 at 8:49 AM, the ADM confirmed there was no Facility policy to inspect Hoyer slings prior to the incident with Resident #32 on 11/4/11. Following the incident, all Hoyer lift slings were immediately inspected, and the "Inspection of Hoyer Slings" policy was implemented immediately. The policy states: 1. When new Hoyer slings are purchased, they will be marked by Housekeeping as to the date they are put into service; 2. Slings will be inspected each time they are washed to assure that they are in proper working condition with no tears or stressed areas; 3. Any sling found to be in question will be immediately disposed of and</p>	F 456	<p>Past noncompliance: no plan of correction required.</p> <p><i>F456 T. Cummings RN, MS. NO POC required</i></p>		

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

PRINTED: 11/29/2011
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 11/16/2011
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 456	Continued From page 5 Nursing will be notified to order a new one for replacement, or take one from supply to put into service; 4. Nursing assistants and Nurses will inspect each Hoyer sling prior to using to assure that they are in proper condition for use; 5. Slings are washed and hung to dry, not put into dryers to reduce potential damage.	F 456	<i>F 456 NO POC required Just need compliance J. Curran MS</i>		