VERMONT
AGENCY OF HUMAN SERVICES
DEPARTMENT OF DISABILITIES, AGING AND INDEPENDENT LIVING

Division of Licensing and Protection
HC 2 South, 280 State Drive
Waterbury, VT 05671-2060
http://www.dail.vermont.gov
Survey and Certification Voice/TTY (802) 241-0480
Survey and Certification Fax (802) 241-0343
Survey and Certification Reporting Line: (888) 700-5330
To Report Adult Abuse: (800) 564-1612

February 22, 2017

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 25, 2017.** 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: 02/08/2017
FORM APPROVED
OMB NO. 0938-0391

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

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 476043 | A. BUILDING _____ B. WING _____ | C 01/25/2017 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| GREENSBORO NURSING HOME | 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 |
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| F 000 | INITIAL COMMENTS<br><br>An unannounced, on-site recertification survey was conducted by the Division of Licensing and Protection between 1/23-25/2017. Also investigated during this survey were 3 self reported events and 1 complaint. There were findings identified and the specifics are listed below: | F 000 | | |
| F 156 SS=B | 483.10(d)(3)(g)(1)(4)(5)(13)(16)-(18) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES<br><br>(d)(3) The facility must ensure that each resident remains informed of the name, specialty, and way of contacting the physician and other primary care professionals responsible for his or her care.<br><br>§483.10(g) Information and Communication.<br>(1) The resident has the right to be informed of his or her rights and of all rules and regulations governing resident conduct and responsibilities during his or her stay in the facility.<br><br>(g)(4) The resident has the right to receive notices orally (meaning spoken) and in writing (including Braille) in a format and a language he or she understands, including:<br><br>(i) Required notices as specified in this section. The facility must furnish to each resident a written description of legal rights which includes -<br><br>(A) A description of the manner of protecting personal funds, under paragraph (f)(10) of this section;<br><br>(B) A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment of | F 156 | *This Plan of Correction is the center's credible allegation of compliance.*<br><br>*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.*<br><br>F156<br><br>For resident #40, Resident #2 and all residents of the facility, to assure that residents are fully informed of their rights and responsibilities, the Social Services director has been in-servived on the requirement of providing residents with this information verbally and in writing and maintaining validation thereof. All current resident files will be audited to assure that this information has been provided.<br><br>The Administrator will audit all new admission agreement packets to assure this information has been provided.<br><br>F156 POC accepted 2/22/17 GColemanRN/pmc | 2/25/17 |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE 2/21/17

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 156 | Continued From page 1<br>resources under section 1924(c) of the Social Security Act.<br><br>(C) A list of names, addresses (mailing and email), and telephone numbers of all pertinent State regulatory and informational agencies, resident advocacy groups such as the State Survey Agency, the State licensure office, the State Long-Term Care Ombudsman program, the protection and advocacy agency, adult protective services where state law provides for jurisdiction in long-term care facilities, the local contact agency for information about returning to the community and the Medicaid Fraud Control Unit; and<br><br>(D) A statement that the resident may file a complaint with the State Survey Agency concerning any suspected violation of state or federal nursing facility regulations, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, non-compliance with the advance directives requirements and requests for information regarding returning to the community.<br><br>(ii) Information and contact information for State and local advocacy organizations including but not limited to the State Survey Agency, the State Long-Term Care Ombudsman program (established under section 712 of the Older Americans Act of 1965, as amended 2016 (42 U.S.C. 3001 et seq) and the protection and advocacy system (as designated by the state, and as established under the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (42 U.S.C. 15001 et seq.)<br>[§483.10(g)(4)(ii) will be implemented beginning | F 156 | | |

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| F 156 | Continued From page 2<br>November 28, 2017 (Phase 2)]<br><br>(iii) Information regarding Medicare and Medicaid eligibility and coverage;<br>[§483.10(g)(4)(iii) will be implemented beginning November 28, 2017 (Phase 2)]<br><br>(iv) Contact information for the Aging and Disability Resource Center (established under Section 202(a)(20)(B)(iii) of the Older Americans Act); or other No Wrong Door Program;<br>[§483.10(g)(4)(iv) will be implemented beginning November 28, 2017 (Phase 2)]<br><br>(v) Contact information for the Medicaid Fraud Control Unit; and<br>[§483.10(g)(4)(v) will be implemented beginning November 28, 2017 (Phase 2)]<br><br>(vi) Information and contact information for filing grievances or complaints concerning any suspected violation of state or federal nursing facility regulations, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, non-compliance with the advance directives requirements and requests for information regarding returning to the community.<br><br>(g)(5) The facility must post, in a form and manner accessible and understandable to residents, resident representatives:<br><br>(i) A list of names, addresses (mailing and email), and telephone numbers of all pertinent State agencies and advocacy groups, such as the State Survey Agency, the State licensure office, adult protective services where state law provides for | F 156 | | |

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| F 156 | Continued From page 3<br>jurisdiction in long-term care facilities, the Office of the State Long-Term Care Ombudsman program, the protection and advocacy network, home and community based service programs, and the Medicaid Fraud Control Unit; and<br><br>(ii) A statement that the resident may file a complaint with the State Survey Agency concerning any suspected violation of state or federal nursing facility regulation, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, and non-compliance with the advanced directives requirements (42 CFR part 489 subpart I) and requests for information regarding returning to the community.<br><br>(g)(13) The facility must 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.<br><br>(g)(16) The facility must provide a notice of rights and services to the resident prior to or upon admission and during the resident's stay.<br><br>(i) 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.<br><br>(ii) The facility must also provide the resident with the State-developed notice of Medicaid rights and obligations, if any. | F 156 | | |

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| F 156 | Continued From page 4 | F 156 | | |

(iii) Receipt of such information, and any amendments to it, must be acknowledged in writing;

(g)(17) The facility must--

(i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of-

(A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged;

(B) 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

(ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in paragraphs (g)(17)(i)(A) and (B) of this section.

(g)(18) 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/ Medicaid or by the facility's per diem rate.

(i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is

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| F 156 | Continued From page 5<br>reasonably possible.<br><br>(ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change.<br><br>(iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements.<br><br>(iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility.<br><br>v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations.<br>This REQUIREMENT is not met as evidenced by:<br>The facility failed to ensure that residents were informed of their rights and of all rules and regulations governing resident conduct and responsibilities, both orally and in writing, for 2 of 3 residents (Resident #40 & #2). Findings include:<br>During interviews on the afternoon of 1/24/17, Social Service staff reported that residents and/or their representatives receive an admission packet which includes resident rights. The information is explained orally and then the resident or their | F 156 | | |

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| F 156 | Continued From page 6<br>representative signs the admission agreement acknowledging receipt of the written rights information.<br>After review of Resident #40 and Resident #2's facility folder, the Social Service staff confirmed that there was no evidence that a written admission agreement detailing resident rights in the facility was given to or signed by either Resident #40 or Resident #2 or their representatives. | F 156 | | |
| F 281 SS=D | 483.21(b)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS<br><br>(b)(3) Comprehensive Care Plans<br><br>The services provided or arranged by the facility, as outlined by the comprehensive care plan, must-<br><br>(i) Meet professional standards of quality.<br>This REQUIREMENT is not met as evidenced by:<br>Based on staff interview and record review, the facility failed to provide services that meet professional standards for 1 applicable resident regarding the completion of neuro vital signs following unwitnessed falls (Resident #11). Findings include:<br><br>Per record review, Resident #11 had a history of falls. A 12/7/16 Morse fall risk scale rated him/her as being at high risk for falling with a score of 80. For scores greater than or equal to 51, the scale suggests to implement high risk fall prevention interventions.<br><br>Per review of the medical record, the resident had 4 falls between 12/23/16- 1/25/17. Per the | F 281 | *This Plan of Correction is the center's credible allegation of compliance.*<br><br>*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.*<br><br>F281<br><br>For resident #11 and all residents of the facility, to assure that services provided meet professional standards, licensed nursing staff will be inserviced on the facility policy and procedure for obtaining and documenting neuro vitals.<br><br>The Director of Nursing or designee will conduct three random audits per week of resident records to assure the proper process for neuro vitals is being followed.<br><br>The Director of Nursing is responsible for this plan of correction | 2/25/17 |



F281 POC accepted 2/22/17 GColeman RN/ pmi

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| F 281 | Continued From page 7<br>nursing progress notes, on 12/23/16 at 1:45 AM, the resident had an unwitnessed fall and was heard calling for help and was found lying on the hall floor. S/he had a small laceration on the left eyebrow, 2 small bruises on the left elbow and a hematoma on the back of the left hand. On 1/3/17, a staff member heard the resident calling for help; the resident was found lying on the hall floor and had a reported fall and injuries like the 12/23/16 incident. On 1/16/17 the resident had an unwitnessed fall after tripping over a bucket in the hallway which was being used by construction contractors who were doing renovations in the facility. Per record review, Neurovital signs (NVS) were completed for the 12/23/16 and 1/10/17 falls.<br><br>Per interviews on the afternoon of 1/25/17, the interim Director of Nursing (DNS) reviewed Risk Management data and confirmed the above fall history. S/he reported that following unwitnessed falls (or falls with head impact), it would be her/his expectation that NVS would be completed by nursing staff. The DNS was not able to provide evidence that NVS were completed following the 1/3/17 or 1/16/17 fall (for the 1/16/17 fall, nursing progress notes document that NVS were discontinued on 1/18/17; however the NVS taken prior to this were not found).<br><br>Refer to F 323 | F 281 | | |
| F 282 SS=E | 483.21(b)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN<br><br>(b)(3) Comprehensive Care Plans<br>The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- | F 282 | | |

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| F 282 | Continued From page 8<br><br>(ii) Be provided by qualified persons in accordance with each resident's written plan of care.<br>This REQUIREMENT is not met as evidenced by:<br>Based on staff interview and record review, the facility failed to provide services in accordance with the plan of care for 2 of 15 residents regarding the monitoring of side effects from psychotropic medications (Resident #32, #20). Findings include:<br><br>1. Per record review, Resident #32 had diagnoses of bipolar disorder, anxiety, progressive dementia and depression. His/her physician prescribed 3 psychotropic medications: Seroquel (an antipsychotic), alprazolam (an antianxiety medication) and Sertraline (an antidepressant) for these conditions. Per review, the resident's care plan stated that staff are to "Administer Psychotropic medications as ordered by the physician. Monitor for side effects and effectiveness Q-shift [Q-shift = each shift]." Per the care plan, staff were to monitor for these adverse side effects: unsteady gait, tardive dyskinesia, EPS (shuffling gait, rigid muscles, shaking), frequent falls, refusal to eat, difficulty swallowing, dry mouth, depression, suicidal ideation, social isolation, blurred vision, diarrhea, and other symptoms which can occur with the use of these medications. Per interview on 1/25/17 at approximately 2:30 PM, the facility Nurse Manager (NM) confirmed that there was no evidence that the care plan was being implemented related to monitoring for side effects of psychotropic medications per shift.<br><br>2. Per Resident #20's medical record, s/he has | F 282 | *This Plan of Correction is the center's credible allegation of compliance.*<br><br>*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.*<br><br>F282<br><br>For resident #32, resident #20 and all residents of the facility, to assure that proper monitoring for the side effects of psychotropic medications has occurred, licensed nursing staff will be in-serviced on the facility policy and procedure.<br><br>The Director of Nursing or designee will conduct three random audits per week of residents receiving psychotropic medications to verify facility policy is being followed.<br><br>The Director of Nursing is responsible for this plan of correction<br><br>F282 POC accepted 2/22/17 Gcoleman RN/PMW | 2/25/17 |

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| F 282 | Continued From page 9<br>diagnoses that include dementia with significant behavioral issues, anxiety and depression. S/he was prescribed 3 psychotropic medications by her physician: Seroquel (an antipsychotic), lorazepam (an antianxiety medication) and Venlafaxine HCL ER (an antidepressant) for her medical conditions. The resident's care plan for use of psychotropic medications stated, "Administer psychotropic medications as ordered by the physician. Monitor for side effects and effectiveness Q-shift [Q-shift = each shift]." Per the care plan, staff were to monitor for these adverse side effects: unsteady gait, tardive dyskinesia, EPS (shuffling gait, rigid muscles, shaking), frequent falls, refusal to eat, difficulty swallowing, dry mouth, depression, suicidal ideation, social isolation, blurred vision, diarrhea, and other symptoms which can occur with the use of these medications. Per interview with the nurse manager (NM) on 1/24/17 at approximately 2:30 PM, s/he confirmed that there was no evidence that the care plan was being implemented for monitoring for side effects for psychotropic medications per shift. The NM reported that s/he had become aware of the failure to monitor and was working on a process to update the electronic medical record to include side effect monitoring. | F 282 | | |
| F 323 SS=D | 483.25(d)(1)(2)(n)(1)-(3) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES<br><br>(d) Accidents.<br>The facility must ensure that -<br><br>(1) The resident environment remains as free from accident hazards as is possible; and<br><br>(2) Each resident receives adequate supervision | F 323 | | |

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| F 323 | Continued From page 10<br>and assistance devices to prevent accidents.<br><br>(n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements.<br><br>(1) Assess the resident for risk of entrapment from bed rails prior to installation.<br><br>(2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation.<br><br>(3) Ensure that the bed's dimensions are appropriate for the resident's size and weight.<br>This REQUIREMENT is not met as evidenced by:<br>Based on staff interview and record review, the facility failed to ensure that the resident environment remains as free as possible from accident hazards (Resident # 33, #11 and #2). Findings include:<br><br>1. Per record review, Resident #11 had a history of falls. A 12/7/16 Morse fall risk scale rated him/her as being at high risk for falling with a score of 80. For scores greater than or equal to 51, the scale suggests to implement high risk fall prevention interventions.<br><br>Per review of the medical record, the resident had 4 falls between 12/23/16- 1/25/17. Per the nursing progress notes, on 1/16/17 the resident fell after tripping over a bucket in the hallway which was being used by construction contractors who were doing renovations in the facility. The | F 323 | *This Plan of Correction is the center's credible allegation of compliance.*<br><br>*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.*<br><br>F323<br><br>For resident #11 and for all residents of the facility, the facility will inservice staff on the necessity of maintaining an obstacle free environment in the facility to assure resident safety.<br><br>The Administrator or designee will conduct three random audits per week of the identified areas to verify that a safe environment is being provided.<br><br>For resident #2, resident #3 and for all residents of the building, Nursing and maintenance staff will be inserviced on the facility policy and procedure on siderail use and fitment.<br><br>The Director of Nursing or designee will conduct three random audits per week of residents utilizing siderails to verify facility policy is being followed.<br><br>The Administrator is responsible for this plan of correction.<br><br>F323 POC accepted 2/22/17 GColemanRN/PMC | 2/25/17 |

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| GREENSBORO NURSING HOME | 47 MAGGIE'S POND ROAD GREENSBORO, VT 05841 |

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| F 323 | Continued From page 11<br>construction contractors had moved the patient prior to nursing doing an assessment. Following the incident, the facility Nurse Managers' (NM) progress note detailed that s/he provided education to the contractor staff re not moving patients. The note adds that "Resident's room in process of being re-modeled, contractor staff working on renovations, buckets were cluttering the hallway." Per interviews on the afternoon of 1/25/17, the interim Director of Nursing (DNS) confirmed the above circumstances of the fall and the environmental hazard information. Additionally, following the unwitnessed fall, the DNS stated that it would be her/his expectation that neural vital signs (NVS) would be completed; by the end of the survey, the DNS was not able to provide evidence that NVS were completed following the 1/16/17 fall (until documented as discontinued by the resident's physician on 1/18/17).<br><br>2. Per record review, Resident #2 has diagnoses of altered mental status, Asthma, Reflux and other chronic medical problems. On 1/23/17 at approximately 3:06 PM, the resident was observed in bed with side rails up; there was a gap between the mattress and side rails presenting a potential entrapment risk. At approximately 3:26 PM, the facility administrator and Director of Maintenance (DM) measured a 4" gap between the mattress and bed rails and changed the resident's bed to one with a tighter fit between the mattress and rails.<br><br>Per interview with the facility's DM on 1/25/17 beginning at 11:26 AM, s/he reported that s/he checks resident rooms for safety issues each month which includes beds/rails; however, s/he | F 323 | | |

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| F 323 | Continued From page 12<br>does not keep a record of the safety checks.<br><br>Per review of the resident's medical record, there was a doctor's order for bilateral ½ side rails for positioning. The facility policy for Siderail Use was reviewed and states that the "1. Siderail assessment will be completed on admission. 2. Siderail assessment will be reviewed at least quarterly and prn. 3. Upon quarterly or prn review of the siderails, a progress note will be documented, dated and signed on the back of the Siderail Assessment Form. 4. Use, type and number of siderails will be addressed in the resident's Total Care plan. 5. Maintenance will be notified in writing to remove, apply or change types of siderails needed."<br><br>Per 1/25/17 at 12:58 PM interview with the facility's Interim DNS (Director of Nursing), s/he confirmed that there was no evidence that a siderail assessment or quarterly assessment for side rails was completed for Resident #2. There was also no evidence that the risk and benefits of bed rails was reviewed with the resident or his/her representative per regulations.<br><br>3. Per observation on 1/23/2017 with the facility Administrative staff, Resident # 33 had a bed with side rails used for positioning because of a diagnosis of Parkinson's disease. S/he is noted to be up in his/her wheelchair during the day. There was a measured gap of 4 inches between the mattress and the side rails. This was confirmed during observation with the Administrator and the Director of Maintenance on 1/25/2017 and the mattress was replaced providing a tighter fit. There is no evidence to support that the facility does routine assessments for the need for side rails, their correct placement | F 323 | | |

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| F 323 | Continued From page 13<br>and proper maintenance. This is confirmed during interview with the interim DNS during interview on 1/25/2017. | F 323 | | |
| F 329 SS=D | 483.45(d) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS<br><br>(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used--<br><br>(1) In excessive dose (including duplicate drug therapy); or<br><br>(2) For excessive duration; or<br><br>(3) Without adequate monitoring; or<br><br>(4) Without adequate indications for its use; or<br><br>(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or<br><br>(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section.<br>This REQUIREMENT is not met as evidenced by:<br>Based on medical record review, the facility failed to monitor adequately for potential side effects for psychoactive medications for 2 of 15 residents (Resident # 4 and # 33). The details are listed below:<br><br>1. Per record review for Resident #4 showed that s/he was started on olanzapine (an anti-psychotic medication) on 11/30/16. A screening of the resident for potential involuntary movement side | F 329 | *This Plan of Correction is the center's credible allegation of compliance.*<br><br>*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.*<br><br>F329<br><br>For resident #33, resident #4 and all residents of the facility, to assure that proper monitoring for the side effects of psychoactive medications has occurred, licensed nursing staff will be in-serviced on the facility policy and procedure.<br><br>The Director of Nursing or designee will conduct three random audits per week of residents receiving psychoactive medications to verify facility policy is being followed.<br><br>The Director of Nursing is responsible for this plan of correction<br><br>F329 POC accepted 2/22/17 Coleman RN Prne | 2/25/17 |

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| F 329 | Continued From page 14<br>effects was not conducted by nursing staff until 1/5/17. This screening is required as a baseline measurement when the medication is started, and subsequently every 6 months while on the medication. On 1/25/17 at noon, the Director of Nursing confirmed that the facility did not conduct the side effect screening until 1/5/17.<br><br>2. Record review for Resident #33 showed that s/he was routinely administered quetiapine (an antipsychotic medication) per physician orders during 2016. A screening for involuntary movement side effects is required at least every 6 months while taking this medication. The facility provided evidence of such screening dated 6/7/16 and 1/5/17. The screening of 1/5/17 was a full month beyond the 6 month required interval. The Director of Nursing confirmed on 1/25/17 at 3:20 PM that the 1/5/17 side effect screening was not timely. | F 329 | *This Plan of Correction is the center's credible allegation of compliance.*<br><br>*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* | |
| F 371 SS=F | 483.60(i)(1)-(3) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY<br><br>(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities.<br><br>(i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations.<br><br>(ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices.<br><br>(iii) This provision does not preclude residents from consuming foods not procured by the facility. | F 371 | F371<br><br>For all residents of this facility and to assure the storing, preparing, distributing, and serving of food under sanitary conditions, all dietary staff have been in-serviced on kitchen sanitary procedures and expectations.<br><br>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.<br><br>The Administrator will be responsible for this plan of correction. | 2/25/17 |



F371 POC accepted 2/22/17 GColemanRN/PME

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| F 371 | Continued From page 15<br><br>(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety.<br><br>(i)(3) Have a policy regarding use and storage of foods brought to residents by family and other visitors to ensure safe and sanitary storage, handling, and consumption.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation and staff interview, the facility failed to store, prepare and distribute food under sanitary conditions. Findings include:<br><br>Per observation during the initial kitchen tour on 1/23/17 beginning at 9:16 AM, the following unsanitary conditions were observed:<br><br>1. In the walk in refrigerator, a container of leftover beef and vegetable soup was not dated. An approximate 2 gallon container of pickle slices was not dated when opened; there were dried dark colored drip stains and grit on the containers' cover. There were open bottles of olives and salad dressing and 5 bottles of mustard that were all open but not dated when put in use.<br><br>2. The Hobart mixer in the main kitchen had dried white spatter on the mixer shield and bowl holder arms. A flat beater with dried brown matter on the blade was hanging with clean utensils.<br><br>3. The Air-conditioner grill was heavily soiled with dust. The unit extended over a prep table and over an open box of gloves, box of cereal and bagged marshmallows. | F 371 | | |

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| F 371 | Continued From page 16<br>4. The paint on the window sills over the 3 bay pot sink was peeling and the area heavily soiled with black debris.<br><br>5. The shelf unit (adjacent to the stove) was soiled with grit and dried spatter; clean cooking trays and pans were stored on the soiled shelf. The storage shelves under the prep table were soiled with dried spatter and food particles; Large containers of soy sauce, cooking oils and vinegar and trays were stored on the soiled surface.<br><br>6. The 4 fire sprinkler heads in the main kitchen were heavily soiled with dust. A pipe (at the front of the stove) to the fire suppression system was heavily soiled with grease and dust.<br><br>7. The facility was only able to show 3 months of temperature logs for the refrigerator and freezer and cooked food temperatures. Temperature logs for the rest of the year were missing since the last dietary manager left.<br><br>The above observations were confirmed by the Dietary Manager at the time of the observations. S/he reported that the kitchen did not have a written cleaning schedule or process to ensure that all areas of the kitchen were cleaned on a regular basis. | F 371 | | |
| F 428 SS=D | 483.45(c)(1)(3)-(5) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON<br><br>c) Drug Regimen Review<br><br>(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. | F 428 | | |

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| F 428 | Continued From page 17<br>(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories:<br><br>(i) Anti-psychotic;<br>(ii) Anti-depressant;<br>(iii) Anti-anxiety; and<br>(iv) Hypnotic.<br><br>(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon.<br><br>(i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug.<br><br>(ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified.<br><br>(iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record.<br><br>(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time | F 428 | *This Plan of Correction is the center's credible allegation of compliance.*<br><br>*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.*<br><br>F428<br><br>For resident #33, resident #4 and for all residents of the facility, licensed nursing staff have been inserviced on facility policy regarding medication reviews and required communication thereafter.<br><br>The Director of Nursing or designee will conduct three random audits per week of resident records to assure pharmacist recommendations have been reviewed and any recommendations have been communicated to the attending physician.<br><br>The Director of Nursing is responsible for this plan of correction.<br><br>F428 POC accepted 2/22/17 GColemanRN/PMC | 2/25/17 |

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| F 428 | Continued From page 18<br>frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident.<br>This REQUIREMENT is not met as evidenced by:<br>Based on staff interview and record review, the facility failed to act in a timely manner when the pharmacist noted medication regimen irregularities for 2 of 15 residents in the applicable sample (Residents #4 and #33). Findings include:<br><br>1. Record review of Resident #4 showed that the pharmacist notified the facility on 12/6/16 that Resident #4 needed to have a screening for involuntary movement side effects related to use of olanzapine (an antipsychotic medication). During the pharmacist's next monthly review on 1/2/17, s/he again notified the facility that the screening was necessary. Nursing staff performed and documented the side effect screening on 1/5/17. On 1/25/17 at noon, the Director of Nursing confirmed that the facility did not respond in a timely manner to the two notifications by the pharmacist on 12/6/16 and 1/2/17.<br><br>2. Record review of Resident #33 showed that the pharmacist notified the facility on 12/6/16 that Resident #33 needed to have a screening for involuntary movement side effects related to the use of quetiapine (an anti psychotic medication). During the pharmacist's next monthly medication review on 1/2/17, s/he again notified the facility that screening was necessary. Nursing staff performed and documented the screening on 1/5/17. On 1/25/17 at 3:20 PM, the Director of Nursing confirmed that the facility did not respond in a timely manner to the two notifications by the | F 428 | | |

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| F 428 | Continued From page 19<br>pharmacist on 12/6/16 and 1/2/17. | F 428 | | |
| F 461 SS=D | Various sections in 483.10,483.25,483.90 BEDROOMS - WINDOW/FLOOR, BED/FURNITURE/CLOSET<br><br>483.10<br>(i)(4) Private closet space in each resident room, as specified in §483.90(d)(2)(iv);<br><br>483.25<br>(n)(4) Follow the manufacturers' recommendations and specifications for installing and maintaining bed rails.<br><br>483.90<br>(c)(3) Conduct Regular inspection of all bed frames, mattresses, and bed rails, if any, as part of a regular maintenance program to identify areas of possible entrapment. When bed rails and mattresses are used and purchased separately from the bed frame, the facility must ensure that the bed rails, mattress, and bed frame are compatible.<br><br>(d)(1)(vi) - Resident Rooms<br><br>Bedrooms must –<br>(vi) - Have at least one window to the outside; and<br><br>(vii) Have a floor at or above grade level.<br><br>(d)(2) -The facility must provide each resident with–<br><br>(i) A separate bed of proper size and height for the safety and convenience of the resident; | F 461 | *This Plan of Correction is the center's credible allegation of compliance.*<br><br>*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*<br><br>F461<br><br>For resident #33 and for all residents of the building, nursing and maintenance staff will be inserviced on the facility policy and procedure on siderail use and fitment.<br><br>The Director of Nursing or designee will conduct three random audits per week of residents utilizing siderails to verify facility policy is being followed.<br><br>The Administrator is responsible for this plan of correction.<br><br>F461 POC accepted 2/22/17 GCrisman RN/PMC. | 2/25/17 |

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| GREENSBORO NURSING HOME | 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 |
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| F 461 | Continued From page 20<br>(ii) A clean, comfortable mattress;<br><br>(iii) Bedding, appropriate to the weather and climate; and<br><br>(iv) Functional furniture appropriate to the resident's needs, and individual closet space in the resident's bedroom with clothes racks and shelves accessible to the resident.<br><br>(h)(4) Private closet space in each resident room, as specified in §483.90<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation and staff interviews, the facility failed to have a system in place to regularly assess and monitor proper use of side rails for 1 of 15 residents (# 33). The specifics are detailed below:<br><br>1. Per observation on 1/23/2017 with the facility Administrative staff, Resident # 33 had a bed with side rails used for positioning because of a diagnosis of Parkinson's disease. S/he is noted to be up in his/ her wheelchair during the day. There was a measured gap of 4 inches between the mattress and the side rails. This was confirmed during observation with the Administrator and the Director of Maintenance on 1/25/2017 and the mattress was replaced providing a tighter fit. There is no evidence to support that the facility does routine assessments for the need for side rails, their correct placement and proper maintenance. This is confirmed during interview with the interim DNS during interview on 1/25/2017. | F 461 | | |