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

January 8, 2020

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

Dear Mr. Labelle:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **December 11, 2019.** 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

Pamela M. Cota, RN
Licensing Chief

JAN 7 2020

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	475043	A. BUILDING _____ B. WING _____	12/11/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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
E 000	Initial Comments During an unannounced on-site re-certification survey, 12/9/19 through 12/11/19, the Division of Licensing and Protection conducted a review of the facility's Emergency Preparedness Program. The facility was found to be in substantial compliance with Emergency Preparedness planning.	E 000		
F 000	INITIAL COMMENTS An unannounced on-site re-certification survey was conducted by the Division of Licensing and Protection on 12/9/2019 through 12/11/2019. The following regulatory violations were identified as a result:	F 000		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6).	F 656		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

ADMINISTRATOR 01/03/2020

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	475043	A. BUILDING _____ B. WING _____	12/11/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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
F 656	Continued From page 1 (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review the facility failed to implement care plan interventions for 1 of 15 sampled residents (Resident #22). Findings include: Per record review Resident #22's care plan that was created on 9/11/19 and revised on 11/18/19 states that the "resident has the potential for nutrition risk". The care plan also states "weigh at same time of day and record as ordered". The Physician's order dated 8/16/19 states "Weigh resident monthly". There is no evidence in the record that a weight was obtained in November. The last weight documented was taken on 10/31/2019.	F 656	Preparation and/or execution of this plan of corrections does not constitute the providers admission of/or agreement with the alleged violations or conclusions set forth in this statement of deficiencies. The plan of correction is prepared and/or executed as required by state and federal law. F 656 1. Resident #22 had no negative effects as a result of the alleged deficient practice. 2. All Resident's with care planned scheduled weight have the potential to be affected by the alleged deficient practice. 3. All residents with scheduled weights have been reviewed. 4. A process for monitoring scheduled weights and obtaining scheduled weights per resident care plan has been developed. 5. Education will be provided to all nursing staff regarding the requirement to ensure care planned weights are obtained. 6. Audits of scheduled weights will be completed weekly by the Director of Nursing or designee. 7. Results of the audit will be report to the QAA committee for 4 months at will time the committee will determine future frequency of the audits. 8. Corrective action plan to be completed 1/11/20.	

F656 POC accepted 1/7/20 SFreemanRN/pmc

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	475043	A. BUILDING _____ B. WING _____	12/11/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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
F 656	Continued From page 2 On 12/11/2019 at 12:10 PM during an interview with the Director of Nursing and Assistant Director of Nursing confirmation was made that resident #22 had a Physician's order to weight resident monthly and that there was no evidence that the resident had been weighed since 10/31/19.	F 656	F 657	
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to– (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by:	F 657	1. Residents # 3, 17, 23, 25 and 27 had no negative effects as a result of the alleged deficient practice. 2. All residents have the potential to be affect by the alleged deficient practice. 3. And internal audit of all care plans was completed for input by the interdisciplinary team (IDT). 4. The process for care plans has been reviewed and revised to ensure all necessary departments have input into the care plan. 5. Education will be provided to all members of the IDT regarding the requirement for input into the care plan of each resident. 6. Audits of care plan be completed weekly by the Director of Nursing or designee. 7. Results of the audit will be reported to the QAA committee for 6 months at which time the committee will determine future frequency of the audits. 8. Corrective action plan to be completed 1/11/20.	

F657 POC accepted 1/7/20 sFreemanRN/PMC

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	475043	A. BUILDING _____ B. WING _____	12/11/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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
F 657	Continued From page 3 Based on record review and staff interview, the facility failed to ensure that all the required members of the interdisciplinary team (IDT) were involved in prepared the comprehensive care plan for 5 of 15 residents sampled (Residents #3, 17, 23, 25, 27). Findings include: 1. Resident #3 had a care plan meeting held on 9/27/19. Documentation in the Electronic Health Record lists the disciplines attending, however there was no indication that a Licensed Nursing Assistant (LNA) or Physician were present at the meeting. There was also no documentation to indicate that the absent members of the team provided input into the care plan meeting. 2. Resident #17's care plan meeting was held on 11/14/2019. The signature sheet used to document attendance at the meeting does not include the Physician or LNA's signature. There was no evidence in the medical record that the Physician or LNA provided input into the care plan. 3. Resident #23's care plan meeting was held on 9/19/2019. The signature sheet used to document attendance at the meeting does not include the Physician or LNA's signature. There was no evidence in the medical record that the Physician or LNA provided input into the care plan. 4. Resident #25 had a care plan meeting held on 12/5/19. In the paper record the Care Conference paperwork lists the disciplines attending, and there was no indication that a Physician was present at the meeting. There was also no documentation to indicate that the Physician provided input into the care plan	F 657		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	475043	A. BUILDING _____ B. WING _____	12/11/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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
F 657	Continued From page 4 meeting. 5. Resident #27's care plan meeting was held on 10/17/2019. The signature sheet used to document attendance at the meeting does not include the Physician or LNA's signature. There was no evidence in the medical record that the Physician or LNA provided input into the care plan. On 12/11/2019 at 11:15 AM, during an interview with the Director of Nursing and Staff Educator confirmation was made that there was no evidence in the record that the Physician and an LNA provide input into the care plans listed above.	F 657		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(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: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record;	F 758		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	475043	A. BUILDING _____ B. WING _____	12/11/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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
F 758	Continued From page 5 §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based upon interview and record review, the facility failed to ensure that the medication regimen was free of unnecessary medications regarding a 'stop date' for 'as needed' [PRN] Psychotropic medications for 2 residents [Res. #26 & #19] of 5 sampled residents. Findings include: Per review of Physician Orders for Res. #26, an order with a start date of 11/23/19 was entered	F 758		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	475043	A. BUILDING _____ B. WING _____	12/11/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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
F 758	Continued From page 6 for the Psychotropic medication 'Buspirone- give 5 milligrams [mg] by mouth every 8 hours as needed [PRN] for anxiety.' There was no stop date for the medication. A review was conducted of Res. #26's Medication Administration Record [MAR] for November and December 2019. The MAR listed the Psychotropic medication as still active, greater than 14 days after the start date. There was no stop date for the medication. Per review of Physician Orders for Res. #19, an order with a start date of 11/8/19 was entered for the Psychotropic medication 'Lorazepam 0.5 milligrams [mg]- give one tablet by mouth every 8 hours as needed [PRN] for anxiety.' There was no stop date for the medication. The medical record revealed a Pharmacy Medication Regimen Review had identified the PRN Psychotropic medication for Res. #19 as requiring an end date or be stopped after 14 days. The physician's response to the pharmacy recommendation was to discontinue the medication if it had not been used for 30 days. A review was conducted of Res. #19's Medication Administration Record [MAR] on 12/10/19 for November and December 2019. The MAR recorded that the PRN medication had been ordered with a start date of 11/8/19, and had not been used by the resident. The MAR listed the Psychotropic medication as still active, greater than 30 days after the start date. Per interview on 12/11/19 at 1:34 PM with the facility's Assistant Director of Nursing [ADON], the ADON confirmed that both Res. #19 and Res. #26 had active 'As Needed' [PRN] orders for Psychotropic medications. The ADON confirmed that the PRN Psychotropic medications for both residents were ordered greater than 14 days ago.	F 758	F 758 1. Resident # 26 and 19 had no negative effects from this alleged deficit practice. 2. Resident's with prn psychotropic medication have the potential to be affected by the alleged deficient practice. 3. All residents receiving prn psychotropic medications have been reviewed and Resident # 26 and # 19 had the prn medications discontinued. 4. A process for monitoring prn psychotropic medication has been developed. 5. Education will be provided to all nurses receiving orders for prn psychotropic medication. 6. Audits of prn psychotropic medications will be completed weekly by the Director of Nursing or designee. 7. Results of the audit will be reported to the QAA committee for 4 months at which time the committee will determine future frequency of the audits. 8. Corrective action plan to be completed 1/11/20. F758 POC accepted 1/7/20 SFreemanRN/PMC	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	475043	A. BUILDING _____ B. WING _____	12/11/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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
F 758	Continued From page 7 The ADON also confirmed that a Pharmacy Medication Regimen Review had identified the PRN Psychotropic medication for Res. #19 as requiring an end date or be stopped after 14 days. The ADON confirmed the physician's response to the pharmacy recommendation was to discontinue the medication if it had not been used for 30 days. Per record review and confirmed by the ADON, the PRN Psychotropic medication had not been used for 30 days, and was past the 30 day mark and the PRN order had not been discontinued.	F 758		
F 801 SS=D	Qualified Dietary Staff CFR(s): 483.60(a)(1)(2) §483.60(a) Staffing The facility must employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, taking into consideration resident assessments, individual plans of care and the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e) This includes: §483.60(a)(1) A qualified dietitian or other clinically qualified nutrition professional either full-time, part-time, or on a consultant basis. A qualified dietitian or other clinically qualified nutrition professional is one who- (i) Holds a bachelor's or higher degree granted by a regionally accredited college or university in the United States (or an equivalent foreign degree) with completion of the academic requirements of a program in nutrition or dietetics accredited by an appropriate national accreditation organization recognized for this purpose.	F 801	F 801 1. No residents were negatively affected by the alleged deficient practice. 2. Residents receiving meals in the facility have the potential to be affected by the alleged deficient practice. 3. The current dietary manager in the building now has initiated approved education to become a Certified Dietary Manager. 4. The facility contracts with a Registered Dietician, who has agreed to increase to 34 hours per week (Full Time) effective immediately. F801 POC accepted 1/7/20 SFramanRN/PMC	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	475043	A. BUILDING _____ B. WING _____	12/11/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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
F 801	Continued From page 8 (ii) Has completed at least 900 hours of supervised dietetics practice under the supervision of a registered dietitian or nutrition professional. (iii) Is licensed or certified as a dietitian or nutrition professional by the State in which the services are performed. In a State that does not provide for licensure or certification, the individual will be deemed to have met this requirement if he or she is recognized as a "registered dietitian" by the Commission on Dietetic Registration or its successor organization, or meets the requirements of paragraphs (a)(1)(i) and (ii) of this section. (iv) For dietitians hired or contracted with prior to November 28, 2016, meets these requirements no later than 5 years after November 28, 2016 or as required by state law. §483.60(a)(2) If a qualified dietitian or other clinically qualified nutrition professional is not employed full-time, the facility must designate a person to serve as the director of food and nutrition services who- (i) For designations prior to November 28, 2016, meets the following requirements no later than 5 years after November 28, 2016, or no later than 1 year after November 28, 2016 for designations after November 28, 2016, is: (A) A certified dietary manager; or (B) A certified food service manager; or (C) Has similar national certification for food service management and safety from a national certifying body; or D) Has an associate's or higher degree in food service management or in hospitality, if the course study includes food service or restaurant management, from an accredited institution of	F 801		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	475043	A. BUILDING _____ B. WING _____	12/11/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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
F 801	Continued From page 9	F 801		

higher learning; and
(ii) In States that have established standards for food service managers or dietary managers, meets State requirements for food service managers or dietary managers, and
(iii) Receives frequently scheduled consultations from a qualified dietitian or other clinically qualified nutrition professional.
This REQUIREMENT is not met as evidenced by:
Based upon interview and record review, the facility failed to ensure a qualified dietitian or other clinically qualified nutrition professional is employed full-time, or if not, designate a person to serve as the director of food and nutrition services who meets national accreditation requirements. Findings include:

Per interview with the facility's designated Dietary Manager [DM] on 12/10/19 at 03:00 PM, the DM stated that s/he had been employed at the facility as dietary staff for approximately 1 year. The DM stated the previous DM had left without notice 5 days earlier, [12/5/19] and s/he was subsequently promoted to Dietary Manager and was serving in the capacity. The DM denied any special training, and reported that the facility did have a Qualified Dietician but she was not present and was not employed full time.

An interview was conducted with the facility's Administrator [ADM] on 12/10/19 at 03:10 PM. The ADM stated that the facility did employ a Qualified Dietician but the Dietician was not employed full time [34+ hours]. The ADM stated that the previous DM had left the position abruptly, and that the current Dietary Manager was appointed by the facility. The ADM confirmed that the DM was not certified by a national

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	475043	A. BUILDING _____ B. WING _____	12/11/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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
F 801	Continued From page 10 certifying body as a Certified Dietary Manager, and that the facility planned to have her/him trained to become certified, but had not done so yet.	F 801		