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 21, 2022

Ms. Michelle Pippa, Administrator
Greensboro Nursing Home
47 Maggie's Pond Road
Greensboro, VT 05841-8800

Dear Ms. Pippa:

Enclosed is a copy of your acceptable plans of correction for the complaint investigation conducted on **December 28, 2021.** 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

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 _____	C 12/28/2021

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 000	INITIAL COMMENTS The Division of Licensing and Protection conducted an onsite, unannounced investigation of one complaint and two facility reported events from 12/27/21 to 12/28/21. The following regulatory deficiencies were identified:	F 000		
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	**See attached Plan of Correction**	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature]	CED	01/11/2022

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 657	Continued From page 1	F 657	**See attached Plan of Correction**	

Based on staff interview and record review, the facility failed to review and revise the care plan for one of three sampled residents (Resident #1). Findings include:

1. Per record review, Resident #1 was admitted to the facility on 8/10/21 with a BIMS (Brief Interview for Mental Status) score of 05 (severe impairment) and diagnoses of paranoid schizophrenia and dementia. Per progress notes, Resident #1 was quickly identified as a frequent wanderer, as evidenced by exit seeking and wandering into other resident rooms, and a care plan focus of "[Resident #1] is a moderate wandering risk" was initiated on 6/11/21. On the same day that the care plan focus was initiated, three interventions were started for wandering risk under the care plan. These care plan interventions included "Distract resident from wandering by offering pleasant diversions, structured activities, food, conversation, television, book. Resident prefers coffee and snacks, sports, TV shows", "Identify pattern of wandering", and "Provide structured activities: toileting, walking inside and outside, reorientation strategies including signs, pictures and memory boxes."

Per progress notes, Resident #1 had multiple incidences of wandering into other resident rooms, opening exit doors, and getting outside the facility following the creation of the wandering care plan. A progress note from 6/19/21 at 10:40 PM states, "found in 14 A bed at approximately 2100." A progress note from 6/23/21 at 23:32 states, "The resident wandered throughout the evening shift, and was found in the rooms of other residents. [Resident #1] 'borrowed" clothing from a female resident and wore them over [their]

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F 657	Continued From page 2	F 657	**See attached Plan of Correction**	

own." A progress note on 6/28/21 at 9:52 PM states, "Resident exit seeking prior to supper, x3, setting off alarms. Resident teamed up with another exit seeking resident and they tried every door. Resident [#1] got outside on patio at one point, and 3 staff attempted to redirect [them] in." There were no updates made to the care plan following these incidents.

Per the record, Resident #1 successfully eloped from the building on 7/5/21, was located walking along the street, and was brought back to the facility unharmed. The care plan was updated to include a new care plan focus of "elopement from building on 7/5/21" which was initiated on 7/6/21. The care plan focus included the following interventions placed on 7/6/21: "Encourage all meals in dining area as accepted. Encourage attendance at activities as accepted. Offer card games, likes poker", "Follow previous plan of care for wandering risk", "Occasional staff 1-1 van rides from facility", "Occasional times outside with 1-1 staff".

Following the elopement on 7/5/21, the record shows that Resident #1 continued to make elopement attempts and enter other residents' rooms. Per a progress note on 7/26/21 at 4:48 AM, "Up wandering ... into other residents' rooms. A female resident stated that [Resident #1] entered her room and, when she told [them] to leave, [they] yelled at her." Per a progress note on 8/10/21 at 4:12 PM, "Resident arrived at 1140 via [family member's] car. Staff stated that resident wandered onto the lawn away from the [family member's]." Per a progress note on 8/11/21 at 9:27 PM, "resident found in empty room across the hall naked." Per a progress note on 8/12/21 at 8:49 PM, "One exit attempt

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F 657	Continued From page 3 alarming door." Per a progress note on 8/15/21 at 3:44 PM, "Noted to be sleeping on an empty bed across the hall from [their] room." There were no changes to either the wandering care plan or the elopement care plan following these incidents, including no additional interventions related to entering resident rooms. Per a progress note on 8/21/21 at 7:07 AM, "At 0010 resident followed LNA (licensed nursing assistant) into another resident's room and took hold of said resident's R (right) forearm and refused to let go when requested to do so. According to LNA, [Resident #1] did let go on [their] own after several seconds. Afterwards, while LNA was consoling offended peer, [Resident #1] entered the room of a female next door and laid down upon an unoccupied bed." The female resident was unharmed. Per interview on 12/27/21 at approximately 3:30 PM, the Administrator confirmed that Resident #1's care plan had not been reviewed or revised following instances of attempted elopements or wandering into other resident rooms prior to the 7/5/21 elopement or the 8/21/21 resident-to-resident incident.	F 657	**See attached Plan of Correction**	
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents.	F 689		

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F 689	Continued From page 4 This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility failed to ensure each resident receives adequate supervision to prevent accidents for one of three sampled residents (Resident #1) as evidenced by a lack of adequate supervision for wandering. Findings include: 1. Per record review, Resident #1 was admitted to the facility on 8/10/21 with a BIMS (Brief Interview for Mental Status) score of 05 (severe impairment) and diagnoses of paranoid schizophrenia and dementia. Per progress notes, Resident #1 was quickly identified as a frequent wanderer, as evidenced by exit seeking and wandering into other resident rooms. A care plan focus of "[Resident #1] is a moderate wandering risk" was initiated on 6/11/21 with several interventions in place. Per the record, after several attempts by Resident #1 to elope from the facility through exit seeking, Resident #1 successfully eloped from the facility on 7/5/21 and was found walking along the road. Resident #1 sustained no harm from this elopement. As a result, Resident #1 was placed on 15-minute checks by facility staff. Per the record, Resident #1 had not been placed on any increased supervision prior to the elopement despite exit seeking behaviors. Per the record, Resident #1 remained on 15-minute checks until 7/23/21 and was changed to 30-minute checks after having no significant elopement attempts or incidences of wandering into other resident rooms since the 7/5/21 elopement. Per a progress note on 7/26/21 at 4:48 AM, "Up wandering ... into other residents' rooms. A female resident stated that [they]	F 689	**See attached Plan of Correction**	

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F 689	Continued From page 5	F 689	**See attached Plan of Correction**	

entered her room and, when she told [them] to leave, [they] yelled at her." Per a progress note on 8/10/21 at 4:12 PM, "Resident arrived at 1140 via [family member's] car. Staff stated that resident wandered onto the lawn away from the [family member]." Per a progress note on 8/11/21 at 9:27 PM, "resident found in empty room across the hall naked." Per a progress note on 8/12/21 at 8:49 PM, "One exit attempt alarming door." Per a progress note on 8/15/21 at 3:44 PM, "Noted to be sleeping on an empty bed across the hall from [their] room." Per the facility's checks documentation, Resident #1 remained on 30-minute checks throughout this time period and following these incidences of wandering/exit seeking.

Per a progress note on 8/21/21 at 7:07 AM, "At 0010 resident followed LNA (licensed nursing assistant) into another resident's room and took hold of said resident's R (right) forearm and refused to let go when requested to do so. According to LNA, [Resident #1] did let go on [their] own after several seconds. Afterwards, while LNA was consoling offended peer, [Resident #1] entered the room of a female next door and laid down upon an unoccupied bed." Per the record, Resident #1 remained on 30-minute checks throughout and following this incident.

Per a progress note on 8/27/21 at 9:18 PM, "Continues on 30min checks, resident walked out main door into lobby, sitting on couch, redirected back inside. Later resident eloped from building out of south right door." The facility's checks documentation confirms that Resident #1 was on 30-minute checks following this elopement attempt until their discharge on 9/2/21.

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F 689	Continued From page 6 Per interview on 12/27/21 at approximately 3:30 PM, the Administrator confirmed that the frequency with which checks are performed is up to nursing. The Administrator also confirmed that Resident #1's frequency of supervision was not adjusted or reevaluated following the many attempts by Resident #1 to wander into other resident rooms and to elope after checks were decreased on 7/23/21 from 15 minutes to 30 minutes.	F 689	**See attached Plan of Correction**	
F 726 SS=D	Competent Nursing Staff CFR(s): 483.35(a)(3)(4)(c) §483.35 Nursing Services The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. §483.35(a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs.	F 726		

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F 726	Continued From page 7 §483.35(c) Proficiency of nurse aides. The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility failed to ensure that all licensed nurses have the specific competencies and skill sets necessary to care for residents' needs. Findings include: 1. Per record review, LPN (licensed practical nurse) 1 was hired by the facility as an LPN on 9/2/2021 after receiving their temporary LPN license on 8/31/21. LPN 1 was working as an LNA (licensed nursing assistant) at the facility prior to being transferred to an LPN position. Per review of the facility's training and competency documents, there is no documentation of LPN 1 receiving any training or competencies specific to the role of an LPN upon hire as an LPN or at any time thereafter prior to LPN 1's last day on 6/25/21. Per interview on 12/27/21 at approximately 1:00 PM, the Director of Nursing confirmed that newly hired LPNs receive an orientation checklist, trainings, and must demonstrate competency in several aspects of the LPN role, such as medication administration and dressing changes. The DON also confirmed that documented evidence of these trainings/competencies could not be located for LPN 1 and that they may not have been conducted due to time constraints related to the public health emergency.	F 726	**See attached Plan of Correction**	

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER #	MULTIPLE CONSTRUCTION	DATE SURVEY COMPLETE:
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F 641	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to ensure that the Resident Assessment accurately reflects the residents' status for one of three sampled residents (Resident #1). Findings include: 1. Per review of the MDS (minimum data set) assessments for Resident #1 during their admission, an MDS assessment was documented on 8/6/21 for a discharge with anticipated return and on 8/16/21 for a 5-day assessment. In both of these assessments, under the "behaviors" section, the section for "presence of wandering" is marked as "behavior not observed" since the last performed MDS assessment. Per Resident #1's record, there is ample evidence of wandering behaviors between Resident #1's admission to the facility and their discharge MDS assessment on 8/6/21, as well as between the 8/6/21 discharge MDS assessment and their 5-day MDS assessment on 8/16/21. During the time period that both assessments were being conducted, Resident #1 had care plan focuses for both wandering (initiated on 6/11/21) and elopement (initiated on 7/6/21). Progress notes on 6/19/21, 6/23/21, 6/28/21, 7/5/21, 7/26/21, 8/10/21, 8/11/21, 8/12/21, and 8/15/21 detail significant incidences of wandering by Resident #1. Per interview on 12/27/21 at approximately 3:30 PM, the Administrator confirmed that the MDS Coordinator who was employed by the facility at the time inaccurately coded the MDS assessments on 8/6/21 and 8/16/21 in regard to Resident #1's wandering behaviors.
F 839	Staff Qualifications CFR(s): 483.70(f)(1)(2) §483.70(f) Staff qualifications. §483.70(f)(1) The facility must employ on a full-time, part-time or consultant basis those professionals necessary to carry out the provisions of these requirements. §483.70(f)(2) Professional staff must be licensed, certified, or registered in accordance with applicable State laws. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility failed to ensure that all professional staff are licensed, certified, or registered in accordance with applicable State laws. Findings include: 1. Per record review, LPN (licensed practical nurse) 1 was hired by the facility as an LPN on 9/2/2021 after receiving their temporary LPN license on 8/31/21. LPN 1 was working as an LNA (licensed nursing assistant) at the facility prior to being transferred to an LPN position. Per review of LPN 1's LPN license on the

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F 839	Continued From Page 1

Vermont Office of Professional Regulations register, LPN 1's license expired on 6/15/21. Per the facility's records, LPN 1 worked shifts on 6/15/21, 6/16/21, 6/18/21, 6/21/21, 6/22/21, 6/23/21, and 6/24/21.

Per Act 6 of the Vermont Legislature (an act relating to extending health care regulatory flexibility during and after the COVID-19 pandemic), LPN students enrolled in an accredited program who met certain requirements but had not taken their nursing boards could receive a temporary LPN license that would allow them to work as an LPN during Vermont's State of Emergency. The Vermont State of Emergency expired at midnight on 6/14/21 and all temporary licenses for LPNs who had not previously had an LPN license expired on 6/15/21.

Per interview on 12/27/21 at approximately 1:00 PM, the Administrator confirmed that LPN 1 had worked from 6/15/21 through 6/25/21 as an LPN without an active LPN license until LPN 1's resignation on 6/25/21 due to facility oversight.

See attached Plan of Correction

Tags F 657, F 689, F 726, F 641, F 839
POC Accepted on 01/20/22 by K. Ruffe/ P. Cota

Greensboro Nursing Home

Plan Of Correction

Tags F 657, F 689, F 726, F 641, F 839
POC Accepted on 01/20/22 by K. Ruffe/P. Cota

POC

The filing of this plan of correction does not constitute an admission of the allegations set forth in the statement of deficiencies. The plan of correction is prepared and executed as evidence of the facility's continued compliance with applicable law.

F641

Resident #1 no longer resides at the facility.
All residents at the facility have the potential to be affected by the alleged deficient practice.

The Director of Nursing or designee will provide weekly updates to the MDS coordinator on resident behaviors. Director of Nursing or designee will conduct random audit of 2 resident MDS's weekly to review accuracy of MDS assessments for behaviors. Audits will continue weekly for 4 weeks then monthly times 2 or until substantial compliance has been achieved.
Results will be reported to QAPI

Date of Compliance: 01/17/2022

F839

LPN 1 is no longer employed at the facility. Facility no longer uses LPN'S with temporary licenses.
All residents at the facility have the potential to be affected by the alleged deficient practice.

Facility conducted an audit for current licensures of nurses to ensure compliance.

Education was provided to Human Resources regarding checking for proper and current licensure within the requirements of the State of Vermont.

Human Resources or designee will conduct audits of 2 nurse licenses weekly for 4 weeks then monthly for 2 months or until substantial compliance is achieved.

Results will be reported to QAPI

Date of Compliance: 01/17/2022

Tags F 657, F 689, F 726, F 641, F 839 POC
Accepted on 01/20/22 by K. Ruffe/P. Cota

The filing of this plan of correction does not constitute an admission of the allegations set forth in the statement of deficiencies. The plan of correction is prepared and executed as evidence of the facility's continued compliance with applicable law.

F657
Resident #1 no longer resides at the facility.

Residents who wander or are at risk for elopement have the potential to be affected by the alleged deficient practice.

Wandering/Elopement evaluations completed for 100% of the residents. Care plans for residents that wander and are an elopement risk have been reviewed and updated to reflect the wandering behavior and elopement risk with current interventions.

Education to nurses on wandering and elopement risk management to include care plan reviews and revisions as changes in resident behaviors are identified.

DNS or designee will review resident behavior flowsheets and nurses' notes weekly. DNS or designee will conduct random care plan audits to ensure wandering and elopement risk care plans have been updated weekly for 4 weeks, then monthly for 2 months or until substantial compliance has been met.
Results will be reported to QAPI

Date of Compliance: 1/24/2022

F689
Resident #1 no longer resides at the facility.

Residents who wander or are at risk for elopement have the potential to be affected by the alleged deficient practice.

Wandering/Elopement evaluations completed for 100% of the residents. Supervision requirements reviewed and care plans updated for residents with wandering and exit seeking behaviors.

Education to nurses on wandering and elopement risk management to include evaluation of supervision and identifying need to increase supervision when wandering and exit seeking behaviors are seen.

DNS or designee will review resident behavior flowsheets and nurses' notes weekly for wandering and exit seeking behaviors. DNS or designee will conduct audits to ensure supervision needs are reevaluated and adjusted weekly when wandering or exit seeking behaviors are seen for 4 weeks, then monthly for 2 months or until substantial compliance has been met.
Results will be reported to QAPI

Date of Compliance: 1/24/2022

F 726
LPN 1 is no longer employed at the facility.

All residents at the facility have the potential to be affected by the alleged deficient practice.

DNS or designee to audit all nurse's training/education files for required training and competencies. Nurses with incomplete files, will receive the required training and complete their competencies.

Education provided to the Staff Development Coordinator regarding training, competency requirements, and documentation for nursing staff.

Director of Nursing or designee will conduct random audits of nurse's education files to ensure they have received the required training and competencies weekly for 4 weeks then monthly for 2 months or until substantial compliance is achieved.
Results will be reported to QAPI

Date of Compliance: 1/24/2022

Tags F 657, F 689, F 726, F 641, F 839 POC
Accepted on 01/20/22 by K. Ruffe/P. Cota