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

June 2, 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 recertification survey conducted on **May 4, 2022.** 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 05/04/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREENSBORO NURSING HOME	47 MAGGIE'SPOND 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 A review of the facility's Emergency Preparedness Program was conducted in conjunction with the annual recertification survey on 5/2-5/4/22. There were no regulatory deficiencies as a result of the review.	E 000	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.	
F 000	INITIAL COMMENTS An unannounced onsite recertification survey and staff vaccination requirement review were conducted by the Division of Licensing and Protection at Greeensboro Nursing Home on 5/2-5/4/22. There were regulatory violations identified.	F 000	**F 656** Resident #9's care plan updated to reflect hospice care and services.	
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). (iii) Any specialized services or specialized	F 656	Residents receiving hospice services have the potential to be affected by the alleged deficient practice. Care plans for residents on hospice services have been reviewed and updated to reflect hospice care and services. Education to nurses on comprehensive person-centered care plans to include residents receiving hospice services. Director of Nursing or designee will conduct random audits to ensure hospice care and services are care planned 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: June 3, 2022	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Michelle Pierson — TITLE: Administrator — (X6) DATE: 5/30/2022

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 656	Continued From page 1 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 record review and interview, it was determined that the facility failed to develop a comprehensive care plan related to hospice for 1 of 14 resident's in a standard survey sample. (Resident identifier #9). Findings include: Review of Resident #9's medical record revealed a Significant Change MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 2/27/2022. Section J.1400 of this MDS is specific to the resident having a condition or chronic disease that may result in a life expectancy of less than 6 months - this section was coded a 1 which indicates the answer to this question is "yes". Section O0100 Special Treatment, Procedures, and Programs; K. Hospice was documented as "yes". The facility's Resident	F 656	**TAG F 656 POC Accepted on 6/02/22 by T. Dougherty/ P. Cota**	

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F 656	Continued From page 2 Roster Matrix, dated 5/2/22, listed Resident #9 as being a hospice resident. Review of Resident #9's current care plan did not include a care plan specific to hospice care and services. Interview on 5/4/22 at approximately 9:00 AM with the Administrator, confirmed that Resident #9 is receiving hospice services. Interview on 5/4/22 at approximately 9:25 AM with the DON (Director of Nurses), confirmed that Resident #9 has been receiving hospice services since February of 2022 and that a hospice care plan was not created for this resident by either the facility or the hospice provider. The DON stated that coordination of care is done verbally.	F 656	F'657 Resident # 11 does not currently have a pressure ulcer. Resident # 17 care plan has been updated to reflect current fall prevention interventions. Residents that have a pressure ulcer or fall have the potential to be affected by the alleged deficient practice. Care plans for residents that have pressure ulcers and falls have been reviewed and updated to reflect current wound with treatment and fall prevention interventions. Education to nurses on care plan revisions to include residents with pressure ulcers and fall prevention interventions. Director of Nursing or designee will conduct random audits to ensure pressure ulcers and fall prevention interventions are care planned weekly for 4 weeks, then monthly for 2 months or until substantial compliance has been met. Results will be reported to Q APL Date of Compliance: June 3, 2022 **TAG F 657 POC Accepted on 6/02/22 by T. Dougherty/P. Cota**	
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	F 657		

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F 657	Continued From page 3	F 657		

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:
Based on staff interview and record review, the facility failed to revise the care plan as needed for 2 applicable residents (Residents #17 & #11). Findings include:

1.) Per record review, staff did not revise Resident # 17's care plan to reflect an actual pressure ulcer. There is a physician order dated 2/7/22 to cleanse bilateral buttock with wound cleaner, gently pat dry, skin prep surrounding healthy skin, apply 4 x 4 border foam dressing to bilateral buttock and change every 3 days and as needed. This order was renewed on 4/19/22. There is a care plan in place to address potential for pressure ulcer development related to decreased mobility. There is no indication of the actual wound in the care plan.

On 05/03/22 at 2:00 PM, the Director Of Nurses (DON) confirmed that Resident # 17's care plan should have been and was not revised to reflect an actual pressure ulcer.

2.) Per record review, Res. #11 was admitted to the facility on 2/28/22 with diagnoses that include Functional quadriplegia, vascular dementia with behavioral disturbance, and attention and concentration deficit. The resident's Care Plan identified the resident as "at high risk for falls

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F 657	Continued From page 4 related to poor safety awareness and weakness". Review of Nurses Notes for Res. #11 for 4/1/22 record "[Res. #11] had unwitnessed fall while in TV/sunroom. [S/he] was not in chair. Found on floor a few feet away from the chair, on the floor, lying next to the wall next to the television. Assessed for injuries, found bruising on right forearm, with some swelling." Further review of Nurses Notes reveals on 4/22/22 "I heard a noise; [Res.#11] in entranceway to sun-room, face down. Noted 1.5 centimeter mild abrasion on upper part of left forehead, and slight bump under skin, 1.5 centimeters." Per review of Res. #11's Care Plan, there were no interventions added after either fall to prevent the resident from suffering further falls and injuries. Per interview with the Director of Nursing [DON] on 5/04/22 at 8:52 AM the DON confirmed Res. #11's Care Plan was not updated after falls on 4/1/22 and 4/22/22. The DON stated the resident's Care Plan "should have been updated" but was not.	F 657		