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

July 25, 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 revisit survey conducted on **July 22, 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 _____	R 07/05/2022

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 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 revisit to the 05/04/2022 survey was completed by the Division of Licensing and Protection on 07/05/2022. The facility was not found to be in substantial compliance with the following regulatory violation that was identified on the 05/04/2022 survey.	{F 000}	**F 656** Resident #11's care plan updated to reflect risk for further resident to resident abuse.	
{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 at risk for resident-to-resident abuse have the potential to be affected by the alleged deficient practice. Care plans for residents at risk for resident-to-resident abuse have been reviewed and updated. Education to nurses on comprehensive person-centered care plans to include residents at risk for resident-to-resident abuse. Director of Nursing or designee will conduct random care plan audits 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: August 3, 2022	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: CEO | (X6) DATE: 7/21/22

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 observation, staff interviews and record review, the facility failed to completely implement their plan of correction with a June 3, 2022, date of compliance by implementing a person-centered comprehensive care plan for 1 of 3 residents in the applicable sample (Resident #11). Findings include: A review of Resident #11's medical record revealed that on 7/2/22 at the start of the shift, Resident #11 was "yelling out and hitting out at staff" he/she was left in his/her wheelchair in his/her room to "calm down". When he/she got to the hallway another resident "walked by him/her and stepped on his/her foot on purpose". Resident #11's care plan was reviewed and did not contain reference to risk for further resident to resident abuse and associated interventions. The	{F 656}	**TAG F 656 POC Accepted on 7/24/22 by H. Fox/P. Cota**	

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{F 656}	Continued From page 2 absence of this care plan entry was confirmed by the Director of Nursing at 1000 on July 5, 2022.	{F 656}		