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

August 21, 2024

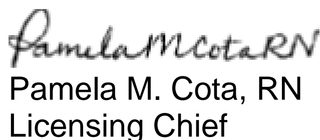
Ms. Michelle Pippa, Administrator
Greensboro Nursing Home
47 Maggie's Pond Road
Greensboro, VT 05841-8800

Dear Ms. Pippa:

Enclosed is a copy of your acceptable revised plans of correction for the recertification survey conducted on **July 10, 2024.** 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

Enclosure

PRINTED: 07/31/2024
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
	475043	A. BUILDING ______ B. WING ______	C 07/10/2024

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 An unannounced on-site re-certification survey was conducted by the Division of Licensing and Protection on 7/8/2024 - 7/10/2024 including Emergency Preparedness Requirements for 42 CFR Part 483 requirements for Long Term Care Facilities. The result of the Emergency Preparedness Survey identified the following regulatory violations:	E 000	E004 Root Cause Analysis was completed. It was determined that based on interview and record review, the facility failed to review and update their emergency preparedness plan (EPP) annually. This deficient practice could affect all residents and staff. Findings include Review of the facility emergency preparedness plan revealed there was no documented evidence that the plan had been reviewed or revised since 2019. The Administrator and Clinical Specialist determined that the GNH IDT will discuss and review the EPP on August 21st, 2024. The EPP will then be reviewed at the last QAPI of the year in December, annually. Facility will continue to follow state, federal, CDC and long-term guidance with developing an EP Plan, Reviewing and Updating Annually. Date of Compliance August 21st, 2024 Tag E004 POC accepted on 8/20/24 by K. Humphrey/P. Cota	
[redacted] SS=F	[redacted] CFR(s): 483.73(a) §403.748(a), §416.54(a), §418.113(a), §441.184(a), §460.84(a), §482.15(a), §483.73(a), §483.475(a), §484.102(a), §485.68(a), §485.542(a), §485.625(a), §485.727(a), §485.920(a), §486.360(a), §491.12(a), §494.62(a). The [facility] must comply with all applicable Federal, State and local emergency preparedness requirements. The [facility] must develop establish and maintain a comprehensive emergency preparedness program that meets the requirements of this section. The emergency preparedness program must include, but not be limited to, the following elements: (a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be [reviewed], and updated at least every 2 years. The plan must do all of the following: * [For hospitals at §482.15 and CAHs at §485.625(a):] Emergency Plan. The [hospital or CAH] must comply with all applicable Federal, State, and local emergency preparedness	E 004	E009 Root Cause Analysis was completed. It was determined that the facility failed to participate in an annual community collaborative disaster event. This deficient practice could affect all residents and staff.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [signature]
TITLE: Administrator
(X6) DATE: 8.12.24

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 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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E 004	Continued From page 1 requirements. The [hospital or CAH] must develop and maintain a comprehensive emergency preparedness program that meets the requirements of this section, utilizing an all-hazards approach. * [For LTC Facilities at §483.73(a):] Emergency Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. * [For ESRD Facilities at §494.62(a):] Emergency Plan. The ESRD facility must develop and maintain an emergency preparedness plan that must be [evaluated], and updated at least every 2 years. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to review and update their emergency preparedness plan annually. This deficient practice could affect all residents and staff. Findings include: Review of the facility emergency preparedness plan revealed there was no documented evidence that the plan had been reviewed or revised since 2019. During an interview on 07/10/2024 at 12:45 PM the facility Administrator confirmed that there was no documented evidence that the emergency preparedness plan had been reviewed annually.	E 004	GNH has collaborated with local, regional, State, and Federal to ensure a tabletop disaster event exercise is performed annually. We have established a tabletop date on August 28th, 2024, with Fire Chief Dave Brochu of Greensboro Fire Department for the disaster event of flooding in the building. At the last QAPI of the year, GNH will discuss the upcoming tabletop event that will be for the year 2025. Facility will continue to follow state, federal, CDC and long-term guidance with local, State, Tribal Collaboration Process. Date of Compliance August 24th, 2024. **Tag E009 POC accepted on 8/20/24 by K. Humphrey/P. Cota** **E025** Root Cause Analysis was completed. It was determined that the facility failed to provide evidence of arrangements and/or any agreements the facility with other facilities to receive patients in the event the facility is not able to care for them during an emergency. This deficient practice could affect all Residents and Staff. The Administrator and Clinical Specialist determined the following Transfer Agreements: The Transfer Agreement contract states that the agreement automatically renews for successive one-	
E 009 SS=F	[redacted] CFR(s): 483.73(a)(4)	E 009		

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E 009	Continued From page 2 §403.748(a)(4), §416.54(a)(4), §418.113(a)(4), §441.184(a)(4), §460.84(a)(4), §482.15(a)(4), §483.73(a)(4), §483.475(a)(4), §484.102(a)(4), §485.68(a)(4), §485.542(a)(4), §485.625(a)(4), §485.727(a)(5), §485.920(a)(4), §486.360(a)(4), §491.12(a)(4), §494.62(a)(4) [(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years [annually for LTC facilities]. The plan must do the following:] (4) Include a process for cooperation and collaboration with local, tribal, regional, State, and Federal emergency preparedness officials' efforts to maintain an integrated response during a disaster or emergency situation. * * [For ESRD facilities only at §494.62(a)(4)]: (4) Include a process for cooperation and collaboration with local, tribal, regional, State, and Federal emergency preparedness officials' efforts to maintain an integrated response during a disaster or emergency situation. The dialysis facility must contact the local emergency preparedness agency at least annually to confirm that the agency is aware of the dialysis facility's needs in the event of an emergency. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to participate in an annual community collaborative disaster event. This deficient practice could affect all residents and staff. Findings include: Per record review on 07/10/2024 of the facility emergency preparedness plan. The plan revealed	E 009	year terms unless either facility provides a written objection to a renewal no fewer than 30 days before the beginning of a new term between the facilities of Union House Nursing Home, Maple Lane Nursing Home, and St. Johnsbury Health & Rehab. The Union House, Maple Lane and St Johnsbury Health & Rehab have all signed and returned their contracts. The remaining facilities will be returned to GNH by September 3rd, 2024. Facility will continue to follow state, federal, CDC and long-term guidance with Arrangement with Other Facilities. Date of Compliance August 19th, 2024.	

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E 009	Continued From page 3 no documented evidence of collaboration or participation in community disaster events. During an interview on 07/10/2024 at 12:45 PM the facility Administrator confirmed that there was no documented evidence that the facility has been able to participate in collaborative disaster event since development of the Emergency Preparedness (EP) in 2019.	E 009		
E 025 SS=F	Arrangement with Other Facilities CFR(s): 483.73(b)(7) §403.748(b)(7), §418.113(b)(5), §441.184(b)(7), §460.84(b)(8), §482.15(b)(7), §483.73(b)(7), §483.475(b)(7), §485.625(b)(7), §485.920(b)(6), §494.62(b)(6). [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years [annually for LTC facilities]. At a minimum, the policies and procedures must address the following:] *[For Hospices at §418.113(b), PRFTs at §441.184.(b) Hospitals at §482.15(b), and LTC Facilities at §483.73(b):] Policies and procedures. (7) [or (5)] The development of arrangements with other [facilities] [and] other providers to receive patients in the event of limitations or cessation of operations to maintain the continuity of services to facility patients.	E 025	Tag E 025 POC accepted on 8/20/24 by K. Humphrey/P Cota	

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E 025	Continued From page 4 *[For PACE at §460.84(b), ICF/IIDs at §483.475(b), CAHs at §486.625(b), CMHCs at §485.920(b) and ESRD Facilities at §494.62(b):] Policies and procedures. (7) [or (6), (8)] The development of arrangements with other [facilities] [or] other providers to receive patients in the event of limitations or cessation of operations to maintain the continuity of services to facility patients. *[For RNHCIs at §403.748(b):] Policies and procedures. (7) The development of arrangements with other RNHCIs and other providers to receive patients in the event of limitations or cessation of operations to maintain the continuity of non-medical services to RNHCI patients. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to provide evidence of arrangements and/or any agreements the facility with other facilities to receive patients in the event the facility is not able to care for them during an emergency. This deficient practice could affect all Residents and Staff. Findings include: Review of the facility emergency preparedness plan revealed there was no documented evidence of agreements with other facilities to accept Residents in the event of an evacuation or relocation. During an interview on 07/10/2024 at 12:45 PM the facility Administrator confirmed that there was no documented evidence of agreements with the other facilities to receive residents in the eventof an emergency.	E 025		

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F 000 Continued From page 5

F 000 INITIAL COMMENTS

The Division of Licensing and Protection conducted an unannounced, onsite recertification survey from 07/08/2024 through 07/10/2024 to determine compliance with 42 CFR Part 483 requirements for Long Term Care Facilities. The following deficiencies were identified:

F 550 [redacted]
SS=E CFR(s): 483.10(a)(1)(2)(b)(1)(2)

§483.10(a) Resident Rights.
The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section.

§483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident.

§483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source.

§483.10(b) Exercise of Rights.
The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States.

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1. Root Cause Analysis was completed. It was determined that the facility failed to protect the resident's privacy and treat the resident with respect and dignity. This was determined through an observation of administration of a patch onto Resident #13 in a public area of the nursing home without consent or time being given to resident prior to application.

Director of Nursing (DON) reached out on 8/6/2024 to Randi Morse, long term care Ombudsman for Orleans County in request of providing education to the nursing staff at the facility on resident's rights. To be completed within the next three months as available by the Ombudsman's schedule.

The DON and Nurse educator to provide written education to all Nursing staff on resident's rights including a print off listing the rights for the employees to have on their personnel. Education to be provided through the date of September 11th, 2024. On this date the facility's annual education fair is being held and all remaining nursing staff will complete their education.

The DON and administrator determined that to follow and implement resident rights; that all medications will be given in the privacy of their room. Unless requested personally by resident and/or resident representative to be given

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F 550	Continued From page 6 §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, for 1 applicable resident (Resident #13), the facility failed to protect the resident's privacy and treat the resident with respect and dignity. The facility also failed to ensure each resident has a right to self-determination and access to persons and services outside of the facility, by locking all doors to the facility 24 hours a day, 7 days a week. By creating a locked facility, there is a failure to ensure the right of each resident to exercise their rights as a citizen (or resident) of the United States or make personal choices about going outside without interference. This can potentially affect all residents of the facility and all visitors, including family, legal representatives, and advocates. Findings Include: 1. Per record review, Resident #13 has resided at this facility since 08/15/2023. S/he has a BIMS (Brief Interview for Mental Status) score of 3, which is indicative of severe cognitive impairment. Her/his diagnoses include dementia (a loss of cognitive function) and parkinsonism (a chronic progressive movement disorder); per the	F 550	elsewhere. This will be implemented through a change of medication times to earlier/more appropriate timing when residents will be in their rooms to benefit the resident by decreasing change in day-to-day routine. Nurses will also be encouraged to utilize the medication cart in the hallways, to provide easier and faster access to medications. Medication changes to be consulted and approved by physician and nursing to change over to giving medications in room by August 12th, 2024. DON will perform audits on medications being given in rooms daily on two random days a week for 30 days. 2. Root Cause Analysis was completed. It was determined that the facility failed to protect the resident's privacy and treat the resident with respect and dignity. The Administrator, Director of Nursing (DON), Social Services and Director of therapy determined that the appropriate steps were to conduct an assessment for residents to determine ability and safety of access to door codes. As well as a form to be provided at time of admission for residents and/or family/caregiver that provides the door codes to the facility. The Director of Therapy created an Instrumental ASL assessment: Community Accessibility form that was reviewed by the Administrator and DON. This form will be used to determine if the	

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F 550

Continued From page 7

care plan, s/he has speech, language, and memory deficits and requires maximum assistance for all activities of daily living and includes an intervention of "Allow adequate time to respond, repeat as necessary, do not rush, make eye contact, and request clarification from the resident to ensure understanding."

On 07/10/24 at 8:30 AM, this surveyor observed an LPN (Licensed Practical Nurse) approach Resident #13, who was seated in a common area, eating breakfast with several other residents and visitors. The LPN approached Resident #13, stating, "I'm going to apply your patch to your belly," while lifting the shirt of Resident#13 to just below breast level, exposing her/his abdomen and undergarments, including an incontinence brief. S/he removed the expired medication patch and applied a new one while holding Resident 13's shirt up, leaving her/his abdomen exposed.

Per record review, a document titled "Resident Rights Guidelines for all Nursing Procedures, on page 4, under the General Guidelines heading, F) "close the entrance door and provide for the resident's privacy."
Per interview with the LPN on 7/10/24 at approximately 9:30 AM, s/he stated, "We give medications in the dining room here; it is such a small place." s/he confirmed that s/he had exposed Resident #13 to other residents and should have taken the resident to a private space.

Per interview with the Director of Nursing (DON) and the Administrator on 7/10/24 at approximately 9:45 AM, the DON agreed that the LPN should not administer medications in a common area. Additionally, she/he confirmed that the resident

F 550

resident has the cognitive ability and/or safety awareness to be able to appropriately have access to the door codes. Occupational Therapy will be responsible for completing this assessment. All residents currently admitted to the facility will have this assessment completed with the goal date of September 20th, 2024. If a resident is deemed capable of having the facility door codes, they will be provided with a laminated card with the door codes, they will be asked to sign a sign out sheet and will be placed on Q15 minute checks during their time outside. If a resident is deemed uncapable of having the facility door codes, they will be accompanied by a staff member or family/caregiver when they would like to go outside. Going forward, this assessment is to be— completed during the admission process and can be re-evaluated if resident conditions improves or worsens.

Social Services created an acknowledgement form for Facility Door Codes that was reviewed by the Administrator and DON. This form provides the entry and exit door codes to the main doors. Within the form the resident and/or caregiver/family is agreeing they are taking responsibility for having the codes and keeping the codes private; or share with designated others they feel comfortable with having the codes. This form has been added to the facility's admission packet. The form is

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F 550	Continued From page 8 was not treated with respect and dignity, and his/her privacy was not observed per their policy and the resident's rights. 2) During an observation on 7/8/24 at 10:10 AM, this surveyor encountered a barrier to entry to the facility. The entry door was locked. The only way to gain access was to press a doorbell, which alerted the staff. A staff member then had to come and physically open the door; once inside, there was a second locked door with a keypad to the right of it. The staff member explained that an additional code, different from the first, was needed to open the second door. Per record review, Resident #11 has resided at the facility since 6/19/23; S/he has diagnoses of depression and anxiety. S/he has a BIMS of 15. Per interview with Resident # 11 on 7/8/2024 at 11:56 AM, s/he stated that the facility had a rule that residents could only go outside with a staff member. The staff member has a code for both doors and remains outside with the resident, using the keypads to allow the resident to re-enter the building. Resident #11 expressed frustration that s/he could not go outside when s/he wanted to and had to wait for the availability of staff to accompany him/her. S/he stated that residents were not allowed to have the door codes and had to ask staff members to open the doors. "We can only go out when it is pre-scheduled in a group or convenient for staff." Per interview with an Occupational Therapy Assistant (OTA) on 7/8/24 at 12:10 PM, s/he stated, "The doors are always locked, and residents are not allowed to go outside the building to use the grounds without a staff	F 550	signed upon admission and a copy is provided so they can have a written record of the facility door codes. All current family members have been notified via email or mail as of 8/7/2024. Facility will continue to follow state, federal, CDC and long-term guidance with Resident Rights/Exercise of Rights Date of Compliance August 12th, 2024. **Tag F 550 POC accepted on 8/20/24 by K. Humphrey/P. Cota**	

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F 550	Continued From page 9 member to "supervise." Per interview on 7/8/24 at approximately 1:20 PM, a family member indicated the locked facility door presented a challenge. S/he visited her/his spouse during odd hours when a ride was available, often during early evening hours. S/he had to wait for staff to open the door and then had to find busy staff members to open the door to let him/her leave. S/he states the door code was not offered to her/him. During an interview on 7/9/2024 at 1:50 PM a Resident's family member expressed that they do not like that s/he has to bother staff to enter or exit the facility. The family member stated that some visitors do have the code that is used to enter and exit the facility, but s/he does not. S/he also stated that sometimes staff are busy and s/he needs to wait until they come to get in. Per interview on 7/8/24 at 11:17 AM the facility Administrator confirmed that the facility doors are locked at all times. The Administrator stated that the doors are locked to ensure safety for the Residents and staff. The Administrator also confirmed that there is not a process in place to assess residents for the ability to go outside alone and residents and/or representatives have not given consent to reside in a locked facility. Per further interview the Administrator stated that s/he could not locate a policy or procedure for the doors being locked or a policy for operating a completely locked facility.	F 550		
F 726 SS=F	Competent Nursing Staff CFR(s): 483.35(a)(3)(4)(c)	F 726		

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	475043	A. BUILDING ________ B. WING ________	C 07/10/2024

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F 726	Continued From page 10 §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. §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 interview, staff education record review, and the facility assessment, the facility failed to ensure that licensed nurses and licensed nursing assistants were assessed for competency and skill sets to provide care and respond to each resident's individualized needs. This has the potential to affect all residents.	F 726	F726 Root Cause Analysis was completed. It was determined that all nursing staff including Licensed Nursing Assistant's (LNA's), Licensed Practical Nurses (LPN's), and Registered Nurses (RN's) who have been employed for over a year lacked evidence of any competency evaluation required to demonstrate that they had the necessary skills to provide care. Due to this, Greensboro Nursing Home was in non-compliance with maintaining Competent Nursing Staff requirements. DON and Nursing Educator reviewed and updated the competency list for Nursing and LNA's to reflect 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. DON preformed an audit and made a list of all Nursing staff employees. The DON then determined which of these staff members lacked annual competency completion. DON, Nursing Educator and LNA lead to review and ensure all full-time and part-time nursing staff are up to date with their annual competencies by	

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F 726	Continued From page 11 Findings include: Per review of 3 sampled Licensed Nursing Assistant's (LNA's) employee training files revealed 1 LNA file that lacked evidence of any competency evaluation required to demonstrate that they had the necessary skills to provide care needed. Review of the education and competency file for 3 Licensed Nursing Assistants (LNAs) revealed 1 LNA had no evidence that they were assessed for competency in the skills needed to care for the residents. 3. Review of the education and competency file for 3 Licensed Practical Nurse (LPN) revealed that 2 of the 3 had no evidence of annual competency evaluation of the skills needed to care for the residents. Per interview on 7/10/24 at 1:21 PM, the Administrator confirmed that there was no evidence of competency evaluation for the 3 staff members.	F 726	August 12th, 2024. All Per-diem Nursing staff will have their annual competencies completed by September 28th, 2024. DON and Nursing Educator added the updated competency lists to the annual education packet to ensure all future competencies will be completed with all nursing staff annually. DON and Nursing Educator created a chart on August 1st, 2024, that has all Nursing Staff listed and includes dates of completed competencies. This chart will be updated monthly by DON and Nursing Educator, with a new chart annually. DON and Nursing Educator created a chart on August 1st, 2024, that has all Nursing Staff listed and includes dates of completed competencies. This chart will be updated monthly by DON and Nursing Educator, with a new chart annually. Facility will continue to follow state, federal, CDC and long-term guidance with our annual nursing staff competency's. Date of Compliance August 24th, 2024. Tag F 726 POC accepted on 8/20/24 by K. Humphrey/P Cota	
F 801 SS=F	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)	F 801		

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F 801	Continued From page 12 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. (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. (i) The director of food and nutrition services	F 801	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 if the facility's continued compliance with applicable law. **F801** Root Cause Analysis was completed. It was determined that the facility had neither a full-time and/or part-time dietician, nor a certified Director of Nutrition Services. The administrator reviewed and accepted the application of Brittany Clark who accepted a full-time position as the facility's full-time dietician on 7/10/2024. Brittany currently holds the licensure for certified Director of Nutrition Services. The Dietician will be precepting current kitchen manager Aliana Cate until she becomes certified through the University of Florida and is able to hold the certified dietary manager. The Dietician will remain full-time until this outcome has been obtained. The end-date goal is for one year from the date of State Survey that was conducted on 7/10/2024. Facility will continue to follow state, federal, CDC and long-term guidance with Qualified Dietary Staff Date of Compliance August 12th, 2024.	

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F 801	Continued From page 13 must at a minimum meet one of the following qualifications- (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 higher learning; or (E) Has 2 or more years of experience in the position of director of food and nutrition services in a nursing facility setting and has completed a course of study in food safety and management, by no later than October 1, 2023, that includes topics integral to managing dietary operations including, but not limited to, foodborne illness, sanitation procedures, and food purchasing/receiving; 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 on staff interviews and record review, the facility failed to employ either a full-time dietitian and/or a part-time dietitian; and a certified Director of Nutrition Services. Findings include: Per review of the Dietary Manager's employee file there was no documented evidence of the certification required for Dietary Managers.	F 801	Tag F 801 POC accepted on 8/20/24 by K. Humphrey/P. Cota	

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F 801	Continued From page 14 An interview was conducted with the facility's administrator on 7/9/24 at approximately 4:10 PM. The administrator stated that the facility does not have a full-time dietitian. S/he also confirmed that the facility does not have a certified Director of Nutrition Services.	F 801		
F 880 SS=F	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other	F 880	**F880** Root Cause Analysis was completed. It was determined that facility failed to establish and maintain a water management program to minimize the risk of Legionella (a bacteria that causes inflammatory conditions of the lungs) and other opportunistic pathogens in building water systems that would include an assessment to identify where Legionella and other opportunistic waterborne pathogens (e.g., Pseudomonas Acinetobacter) could grow and spread; and measures to prevent the growth of opportunistic waterborne pathogens (also known as control measures), and how to monitor them. The Administrator, Infection Preventionist, and Clinical Specialist reviewed GNH's Legionella Water Management Program Policy. This Policy is to be reviewed annually during the Last QAPI of the year in December. The Legionella Surveillance and Detection Policy was also reviewed.	

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F 880	Continued From page 15 persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on interview, the facility failed to establish and maintain a water management program to minimize the risk of Legionella (a bacteria that	F 880	The Administrator and Infection prevention purchased "Managing the risk of legionellosis associated with building water-systems" through ASHRAE (The American Society of Heating, Refrigerating, and Air-conditioning Engineers). This policy was reviewed by DON, Administrator, and Infection Preventionist. It will continue to be reviewed annually on the last QAPI of the year in December. Within the next 60 days the facility's interdisciplinary team will review the Legionella Environmental Assessment Form provided by CDC. The DON and Administrator reached out to Legionella Control Systems who provides Legionella testing and emergency services regarding any Legionella outbreaks. It was also determined that Northeastern Vermont Regional Hospital tests for Legionella via urine if a suspected outbreak occurs. Facility will continue to follow state, federal, CDC and long-term guidance with Infection Prevention & Control. Date of Compliance August 24th, 2024. **Tag F 880 POC accepted on 8/20/24 by K. Humphrey/P. Cota**	

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F 880	Continued From page 16 causes inflammatory conditions of the lungs) and other opportunistic pathogens in building water systems that would include an assessment to identify where Legionella and other opportunistic waterborne pathogens (e.g., Pseudomonas Acinetobacter) could grow and spread; and measures to prevent the growth of opportunistic waterborne pathogens (also known as control measures), and how to monitor them. Findings include: Per Interview on 7/10/24 at approximately 11:00 AM, the Director of Nursing (DON), who is the Certified Infection Preventionist, indicated s/he did not have knowledge of a water management program specific to this facility. The maintenance director and the administrator were also asked for evidence of the program. Both confirmed they had no knowledge of the existence of such a program and confirmed that an assessment of the building had not been performed and a program to minimize the risk of Legionella and other opportunistic pathogens in the water system had not been developed.	F 880		