

Division of Licensing and Protection
103 South Main Street, Ladd Hall
Waterbury VT 05671-2306
<http://www.dail.vermont.gov>
Voice/TTY (802) 241-2345
To Report Adult Abuse: (800) 564-1612
Fax (802) 241-2358

June 3, 2011

Lance Comfort, Administrator
Greensboro Nursing Home
47 Maggie's Pond Road
Greensboro, VT 05841

Provider ID #:475043

Dear Mr. Comfort:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **May 11, 2011**.

Follow-up may occur to verify that substantial compliance has been achieved and maintained.

Sincerely,



Pamela M. Cota, RN
Licensing Chief

PC:jl

Enclosure



DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

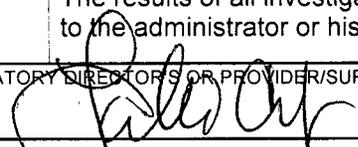
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Division of
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PRINTED: 05/23/2011
FORM APPROVED
OMB NO. 0938-0391

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 475043 | (X2) MULTIPLE CONSTRUCTION, Licensing and Protection A. BUILDING _____ B. WING _____ | (X3) DATE SURVEY COMPLETED C 05/11/2011 |
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| NAME OF PROVIDER OR SUPPLIER GREENSBORO NURSING HOME | STREET ADDRESS, CITY, STATE, ZIP CODE 47 MAGGIE'S POND ROAD GREENSBORO, VT 05841 |
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| (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 An unannounced onsite complaint investigation was conducted by the Division of Licensing and Protection on 05/11/2011. Based upon information gathered, there were regulatory findings. | F 000 | Staff will receive inservice and training regarding the State and Federal regulations regarding the responsibilities of reporting incidents and injuries including abuse to the appropriate authorities in a timely manner. | 6-22-11 |
| F 225 SS=D | 483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated | F 225 | DNS and Administrator will review each incident report to assure that reporting requirements are followed. Administrator and Director of Nurses will report to the Quality Assurance team, at each meeting, all such reportable incidents along with the action taken on them including reporting to appropriate agencies. Administrator and QA team will monitor and advise any modification to assure for continued compliance. <i>F225 PDC Accepted 5/31/11 J. Hosmer / Jmccotarn</i> | |

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| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  | TITLE ADMINISTRATOR | (X6) DATE 5-26-11 |
|--|-------------------------------|-----------------------------|

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 225 | <p>Continued From page 1</p> <p>representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interviews and record reviews, the facility failed to report (to the State survey and certification agency within 5 days of the incident) the results of an investigation into an alleged violation involving mistreatment of a resident (Resident #1) by a Licensed Nurse Assistant (LNA). Findings include:</p> <p>1. Per review of a written statement dated 03/16/11, Employee A witnessed around 7:30 AM that morning the LNA walking Resident #1 to the dining room for breakfast. Resident #1 was "half asleep so [s/he] was not walking very well" and the LNA "didn't stop, [s/he] was dragging [Resident #1] down the hallway". During an interview at 10:40 AM on 05/11/11, Employee A confirmed the observation of 3/16/11 and added that s/he "told the LNA not to do that" and "was going to report it after breakfast".</p> <p>Per review of a written statement dated 03/16/11, around 8:00 AM on that date, Employee B witnessed the LNA "dragging Resident #1 down the hallway from [his/her] room to the table". During an interview at 11:00 AM on 05/11/11, the Director of Dietary and Housekeeping confirmed his/her awareness of the above allegation on 03/16/11 after talking with Employee B. During an</p> | F 225 | | |

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| F 225 | Continued From page 2 interview at 11:35 AM on 05/11/11, Employee B confirmed seeing the LNA drag Resident #1, "limp and making no effort to walk", toward the dining hall. Employee B further confirmed telling the Director of Dietary and Housekeeping about the incident later that day, but did not report to the State Agency. Per review of a written Facility Incident Reporting Form dated 03/16/11, Employee C observed the LNA just before breakfast that day "kinda dragging a patient [Resident #1] down the hall". During an interview on 05/11/11 at 11:20 AM, the Social Worker stated that "the system worked", noting that after the investigation the facility took action (by dismissing the LNA) and "decided no report". Per review of the medical record of Resident #1, the Director of Nursing (DON) wrote on 03/18/11, "spoke to son about incident from other day. Told him that we were handling situation internally". During an interview at 3:30 PM on 05/11/11, the DON confirmed that s/he had not reported the incident to the State Agency at the conclusion of the internal investigation. | F 225 | | |
| F 241 SS=D | 483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on interviews, observation, and record | F 241 | The Dignity committee will inservice facility staff on matters of dignity and respect including matters regarding transporting and moving residents as well as dealing with residents when they are not ready to be moved or ones that are difficult in moving safely. | 6-22-11 |

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| F 241 | Continued From page 3 reviews, the facility failed to provide care which maintains or enhances the dignity and respect of one resident (Resident #1) in the sample. Findings include: 1. Per review of the facility's incident folder on 5/11/11, three eyewitnesses reported that an LNA dragged Resident #1 down the hall toward the dining hall on the morning of 03/16/11. Per review of the medical record and per observation at 2:30 PM on 05/11/11, Resident #1 has significant dementia and could not recall, nor be interviewed regarding, the incident of 03/16/11. a. Per review of a written statement dated 03/16/11, Employee A witnessed around 7:30 AM that morning the LNA walking Resident #1 to the dining room for breakfast. Resident #1 was "half asleep so [s/he] was not walking very well" and the LNA "didn't stop, [s/he] was dragging [Resident #1] down the hallway". During an interview at 10:40 AM on 05/11/11, Employee A confirmed the observation of 3/16/11. b. Per review of a written statement dated 03/16/11, around 8:00 AM on that date Employee B witnessed the LNA "dragging Resident #1 down the hallway from his/her room to the table". During an interview at 11:00 AM on 05/11/11, the Director of Dietary and Housekeeping confirmed his/her awareness of the above allegation on 03/16/11 after talking with Employee B. During an interview at 11:35 AM on 05/11/11, Employee B confirmed seeing the LNA drag Resident #1, "limp and making no effort to walk", toward the dining hall. c. Per review of a written Facility Incident | F 241 | Licensed staff are monitoring the movement and transporting of residents to assure that it is being accomplished in an appropriate manner while assuring the patients dignity. Administrator and Director of Nursing will spot check, monitor and report results to the QA team who review and advise of any other needed measure to assure continued compliance <i>F241 POC Accepted 5/31/11 J. Hasmer RN / J. M. Cotter RN</i> | | |

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| F 241 | Continued From page 4 Reporting Form dated 03/16/11, Employee C observed the LNA just before breakfast that day "kinda dragging a patient (Resident #1) down the hall". | F 241 | | | |