

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 475043	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/11/2025
NAME OF PROVIDER OR SUPPLIER Greensboro Nursing Home		STREET ADDRESS, CITY, STATE, ZIP CODE 47 Maggie's Pond Road Greensboro, VT 05841	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>Based on interview and record review the facility failed to ensure that an allegation of abuse was reported to facility administration, Adult Protective Services, and the State Licensing Agency. Findings include:</p> <p>Per record review Resident #77 was admitted in May of 2025 and began exhibiting aggressive behaviors requiring staff intervention and emergent transfer to the hospital.</p> <p>Review of the Accident/Incident witness interview tool dated 5/22/2025 that was completed by a Licensed Nursing Assistant (LNA) revealed that on 5/8/2025 she saw another LNA hit Resident #7 with a package of wipes. The interview tool states that the Resident was hitting the LNA and that the Resident stopped for a moment and lunged at the LNA.</p> <p>On 6/10/2025 at 2:15 PM the facility Administrator confirmed that the LNA who reported witnessing the other LNA hit Resident #77 with the package of wipes on 5/8/2025 failed to report it until 5/22/2025 and that she should have reported it at the time it occurred.</p>

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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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