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	12/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Greensboro Nursing Home	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)
F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are fully informed and understand their health status, care and treatments. Based on interview and record review the facility failed to ensure three of three residents sampled (Resident#1, #2, and #3) were able to be informed to make treatment decisions by failing to have the resident or resident representative sign consent for prescribed psychotropic medication. Findings include:Per review of Resident #1's medical record, Resident #1 has a BIMS [Brief Interview of Mental Status] score of 3 as of 10/27/25 indicating they have cognitive impairment. Resident #1 is dependent on staff for ADLs [Activities of Daily Living] and hygiene. S/he has medical diagnoses of Alzheimer's Disease and peripheral vascular disease. On 12/11/25 Resident #1 was prescribed Quetiapine fumarate [an antipsychotic medication used to treat symptoms of psychosis] 25 mg [milligram] tablet: Give 25 mg by mouth one time a day related to Alzheimer's Disease with early onset.Per review of Resident #2's medical record, s/he has a BIMS of 0 as of 12/16/25, indicating severe cognitive impairment. They have medical diagnoses of Alzheimer's disease, epilepsy and depression. Resident #2 is dependent on staff for ADLs and hygiene. On 12/9/25 Resident #2 was prescribed Lorazepam [a medication used to treat anxiety] 0.5 [milligram][tablet: Give 0.5 mg buy mouth every four hours as needed for anxiety, nausea, SOB [shortness of breath] for 30 days.Per review of Resident #3's medical record they have medical diagnoses of dementia and depression. Resident#3 has a BIMS of 2 as of 12/2/25 indicating cognitive impairment. They are dependent on staff for ADLs and hygiene. Per record review on 12/8/25 Resident #3 was prescribed Lorazepam 1 mg [milligram] tablet one tablet by mouth every four hours as needed for anxiety, DOE [dyspnea on exertion], or nausea for 30 days po [by mouth] or sl [sublingual]. Per record review, there were no psychotropic medication consent forms in the three residents' records. Per record review there was no policy identifying psychotropic medication consents from residents or resident representatives.An interview was conducted with the Director of Nursing on 12/22/25 at 10:18 AM. She confirmed the facility does not have signed psychotropic medication consents for the three residents. At 11:15 AM she confirmed the facility does not have a policy related to psychotropic medication consent forms stating, We'll make a policy.

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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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to protect the residents' right to be free from verbal abuse by a visitor for 2 of 3 sampled residents (Resident #1 and Resident #3). Findings include:Per record review of Resident #1, a progress note written by the Social Worker on 12/17/25 states, The Central Supply Manager came to staff and reported that this resident's [spouse] was being verbally abusive to this resident. Another family member of a different resident came to staff and told our DON [Director of Nursing] that this residents [spouse] confronted another resident and was verbally abusive. The staff member, central supply manager has put in a report to APS [Adult Protective Services].Per record review of Resident #1, a progress note written by the DON on 12/17/25 states, Visitor came to this writer and ADON [Assistant Director of Nursing] at 1:25 PM to report that resident's [spouse] was in the hallway next resident's room [ROOM NUMBER] when [Resident #3] was walking by with [her/his] walker. [Resident #1's spouse] per visitor statement got into [Resident #3's] space and pointed [her/his] finger at [Resident #3] and stated '[He/she] is my [spouse] and you need to leave [him/her] alone. I do not want you around [him/her] at all.' Per visitor [Resident #3] started to tear up and visitor intervened and asked [Resident #3] to walk into the main dining area and have a seat. [Resident #1's spouse] then took [Resident #1] into his/her room and shut the door. The visitor then reported incident to this writer and ADON [Assistant Director of Nursing]. This writer reported incident with social work and administrator.The visitor who witnessed the incident on 12/17/25 was interviewed on 12/22/25 at 10:35 AM. Per this interview, the visitor stated that the spouse of Resident #1 came over to Resident #3 and pointed his/her finger at Resident #3, stating Resident #1 was their spouse, and to leave him/her alone. [He/she] is my goddamn [spouse]. Resident #3 was very upset and started to cry. The visitor stated it was horrible how he/she treated him/her. The visitor stated that the spouse of Resident #1 had acted this way before and that everyone must walk on eggshells when the spouse visits. The visitor stated that Resident #1's spouse then took him/her to their room and closed the door. After the spouse had left the facility, the visitor observed Resident #1 coming to his door and peeking out and stating I want to come out of my room. The visitor described Resident #1 as walking around like an abused puppy dog after he/she left his/her room. Per record review of Resident #1's care plan, there are no interventions found in place to protect the resident and address the behavior of Resident #1's spouse.Per record review of Resident #3, there is no documentation of the incident between her/him and Resident #1's spouse on 12/17/25, including no mention of the psychosocial outcome of being upset and crying. Per record review, there is no evidence of the facility investigating the incident between Resident #3 and Resident #1's spouse. Per record review, there are no interventions found in place to protect Resident #3 from the potential of further abuse by Resident #1's spouse.Per an interview with the Administrator and the DON on 12/22/25 at 9:48 AM, the DON confirmed that the spouse of Resident #1 had yelled at him/her inside his/her room and that Resident #1 was very scared afterward.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to report incidences of abuse for 2 of 3 sampled residents (Resident #1 and Resident #3). This is a repeat deficiency for this facility, with violations cited during the previous recertification surveys dated 6/11/25. Findings include:Per record review of Resident #1's chart, progress note written by the Social Worker on 12/17/25 states, The Central Supply Manager came to staff and reported that this resident's [spouse] was being verbally abusive to this resident. Another family member of a different resident came to staff and told our DON [Director of Nursing] that this residents [spouse] confronted another resident and was verbally abusive. The staff member, central supply manager has put in a report to APS [Adult Protective Services].Per record review of Resident #1's chart, progress note written by the DON on 12/17/25 states, Visitor came to this writer and ADON [Assistant Director of Nursing] at 1:25 PM to report that resident's [spouse] was in the hallway next resident's room [ROOM NUMBER] when [Resident #3] was walking by with [his/her] walker. [Resident #s'1 spouse] per visitor statement got into [Resident #3's] space and pointed [his/her] finger at [Resident #3] and stated [He/she] is my husband and you need to leave [him/her] alone. I do not want you around [him/her] at all. Per visitor [Resident #3] started to tear up and visitor intervened and asked [Resident #3] to walk into the main dining area and have a seat. [Resident #1's spouse] then took [Resident #1] into [his/her] room and shut the door. Visitor then reported incident to this writer and ADON. This writer reported incident with social work and administrator.The visitor who witnessed the incident on 12/17/25 was interviewed on 12/22/25 at 10:35 AM. Per this interview, the visitor stated that the spouse of Resident #1 came over to the table where they were sitting and pointed his/her finger at Resident #3, stating Resident #1 was their spouse, and to leave him/her alone. [He/she] is my goddamn [spouse]. Resident #3 was very upset and started to cry. The visitor stated it was horrible how he/she treated him/her. The visitor stated that the spouse of Resident #1 had acted this way before and that everyone must walk on eggshells when the spouse visits. The visitor stated that Resident #1's spouse then took him/her to their room and closed the door. After the spouse had left the facility, the visitor observed Resident #1 coming to his/her door and peeking out stating I want to come out of my room. The visitor described Resident #1 as walking around like an abused puppy dog after he/she left his/her room, subsequent to the spouse's visit. There is no evidence that the facility submitted incident reports to the State Licensing Agency related to the incident for either Resident #1 or Resident #3.Per an interview with the Administrator and the DON on 12/22/25 at 9:48 AM, the DON confirmed that the spouse of Resident #1 had yelled at him/her inside his/her room and the resident was very scared afterward. The DON confirmed that a report had been filed with APS about the incident between Resident #1 and his/her spouse but that no report had been filed with APS about the incident between Resident #1's spouse and Resident #3. The DON 's statement regarding the incident between Resident #1's spouse and Resident #3 was, it did not seem like a big deal. The DON confirmed that neither incident had been reported to State Licensing Agency. The DON and Administrator both stated they did not know that they had to report to both APS and the State Licensing Agency.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to thoroughly investigate an allegation of verbal abuse, send a summary of the investigation to the State Survey Agency, and take appropriate corrective action for 2 of 3 sampled residents (Resident #1 and Resident #3). Findings include:Per record review of Resident #1, a progress note written by the DON on 12/17/25 states, Visitor came to this writer and ADON [Assistant Director of Nursing] at 1:25 PM to report that resident's [spouse] was in the hallway next resident's room [ROOM NUMBER] when [Resident #3] was walking by with [her/his] walker. [Resident #1's spouse] per visitor statement got into [Resident #3's] space and pointed [her/his] finger at [Resident #3] and stated [He/she] is my [spouse] and you need to leave [him/her] alone. I do not want you around [him/her] at all. Per visitor [Resident #3] started to tear up and visitor intervened and asked [Resident #3] to walk into the main dining area and have a seat. [Resident #1's spouse] then took [Resident #1] into his/her room and shut the door. The visitor then reported incident to this writer and ADON [Assistant Director of Nursing]. This writer reported incident with social work and administrator.The visitor who witnessed the incident on 12/17/25 was interviewed on 12/22/25 at 10:35 AM. Per this interview, the visitor stated that the spouse of Resident #1 came over to Resident #3 and pointed his/her finger at Resident #3, stating Resident #1 was their spouse, and to leave him/her alone. [He/she] is my goddamn [spouse]. Resident #3 was very upset and started to cry. Visitor stated it was horrible how he/she treated him/her. The visitor stated that the spouse of Resident #1 had acted this way before and that everyone must walk on eggshells when the spouse visits. The visitor stated that Resident #1's spouse then took him/her to their room and closed the door. After the spouse had left the facility, the visitor observed Resident #1 coming to his door and peeking out and stating I want to come out of my room. The visitor described Resident #1 as walking around like an abused puppy dog after he/she left his/her room.Per record review of Resident #3, there was no notation in their medical record that s/he had been a part of an altercation with Resident #1's spouse. Upon further record review, there was no evidence that the altercation was thoroughly investigated, a summary of the investigation was sent to the State Licensing Agency, or that appropriate corrective action was taken to prevent further potential abuse. Per interview with the Administrator and the DON on 12/22/25 at 9:48 AM, the DON confirmed that the spouse of Resident #1 had yelled at him/her inside his/her room and that Resident #1 was very scared afterward. The DON confirmed that a report had been filed with APS (Adult Protective Services) about the incident between Resident #1 and his/her spouse but that no report had been filed with APS about the incident between Resident #1's spouse and Resident #3. The DON said regarding the incident between Resident #1's spouse and Resident #3 was that, it did not seem like a big deal. The DON confirmed that the incident involving Resident #3 had not been reported to the State Licensing Agency and had not been investigated as an allegation of abuse. The DON and the Administrator both stated they did not know that they had to report allegations of abuse to both APS as well as the State Licensing Agency.