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 03/30/2026

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Based on interview and record review the facility failed to ensure documentation was accurate and true for one of three sample residents (Resident #1). Findings include:Per record review, Resident #1 has diagnoses of COPD [Chronic Obstructive Pulmonary Disease, Type II Diabetes, Atrial fibrillation [a condition in which the heart beats irregularly] and Parkinson's disease. Resident #1 had a BIMS [Brief Interview of Mental Status] score of 3 as of 1/15/26 indicating cognitive impairment; was dependent on staff for ADLs [Activities of Daily Living] and hygiene; and was at risk for falls related to deconditioning, gait/balance problems, and Parkinson's.Per review of a nursing progress from 2/19/26, it states, Pt [Patient] was trying to transfer self from [his/her] wheelchair to without assistance. This writer was in the room with [his/her] roommate and witnessed this. Pt stood up and sat back down on the floor on [his/her] rear. Once on [his/her] rear [s/he] started turning towards the nurse and laid out. Stated I was going to bed, but the floor misses me laughing and cracking jokes. Immediately assessed, no complaints of pain or discomfort noted. Helped up and wheeled to the nurses cart till dinner. Emotional support give, [given] but resident continued making jokes and laughing. HHC [home health care] notified, on call service and [family representative]. Further record review showed that there was no documentation of Resident #1's vital signs or neurological checks until 2/20/26.A review of the facility's investigation on 2/23/26 revealed the following: Nurse #1 filed an incident report that showed Resident #1 had a fall on 2/19/26 that was witnessed and their representative was notified. A risk management report demonstrated that the incident note and nursing progress note did not match the resident's physical capabilities. The Director of Nursing reported to the State Agency that the resident is incapable to rolling on the floor or anywhere else by him/herself. During their investigation, the facility determined that the resident's fall was unwitnessed and the resident's representative was not notified of the fall. During interviews with LNA #1 (Licensed Nursing Assistant) and LNA #2 it was discovered that Nurse #1 had asked the LNAs to change their witness statements about the resident's fall. Based on the staff interviews and chart reviews, the facility concluded that the information in the medical record was falsified. An interview was conducted with the DON [Director of Nursing] on 3/30/26 at 10:45 AM. The DON stated Nurse #1 was put on unpaid leave and then resigned from the position following this investigation. The DON confirmed that through the facility's internal investigation they found that the documentation of the fall had been falsified. At 11:49 AM, she further confirmed the nurse did not implement fall protocols and assess the resident's vital signs or do neurological checks when the resident fell stating, It would have been in [Resident #1]'s progress notes.Per review of the facility's Charting and Documentation policy [revised July 2017] it states, 3. Documentation in the medical record will be objective (not opinionated or speculative), complete, and accurate.Per review of the facility's Falls-Clinical Protocol policy [last revised March 2018) it states, 2. In addition, the nurse shall assess and document/report the following: a. vital signs b. recent injury, especially fracture or head injury; c. Musculoskeletal function, observing for change in normal range of motion, weight bearing, etc.; D. change in cognition of level of consciousness; E. Neurological status; F. Pain; G. Frequency and number of falls since last physician visit; H. Precipitating factors, details on how fall occurred; I. All current medications, especially those associated with dizziness or lethargy; and J. All active diagnoses.

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