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	06/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Greensboro Nursing Home	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)
F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. Based on interview and record review, the facility failed to ensure that residents are free from chemical restraints for one of three sampled residents (Resident #4) as evidenced by administration of medications without proper indication for use and no discontinued date. Findings include: Per record review, Resident #4 has diagnoses that include: Alzheimer's dementia, major depressive disorder, and anxiety disorder. The MDS [Minimum Data Set, a comprehensive assessment of each resident's functional capabilities] record review assesses the resident is dependent on staff for activities of daily living, hygiene, and needs assistance with food and fluid intake. Per record review of a physician order on 4/10/25, it states please continue Ativan (generic name is lorazepam used to treat anxiety) in setting of hospice and comfort directed care to reduce anxiety/agitation. Risks of mood exacerbation if discontinued. Per record review there is no end date for the Lorazepam. The Director of Nursing (DON) entered the order for the Lorazepam on 4/16/25 into the electronic health record (EMR) as Lorazepam Oral Tablet 1 MG (milligram) Give 1 tablet by mouth every 4 hours as needed for anxiety, dyspnea on excretion, nausea until 7/10/25. The Psychotropic Medication Use policy (Revised 2025) states, 12a(1) For psychotropic medications that are NOT antipsychotics: if the prescriber or attending physician believes it is appropriate to extend the PRN (as needed) order beyond 14 days, he or she will document the rationale for extending the use and include the duration for the PRN order. An interview was conducted with the DON [Director of Nursing] on 6/11/25 at 10:06 AM. The DON stated the handwritten Physician's Orders are the justification for the medication, and the pharmacist recommendations are the physician orders that the MD documents. Per record review, there are no notes documented on the April 2025 MRR [Medication Regimen Review] in reply to the pharmacist recommendations and there are no recommendations about the Lorazepam. The DON was asked regarding the discrepancy between the physician order and the EMR. She stated the sheet labeled Physician's Orders isn't the order and the pharmacist monthly review is the order used. The DON was asked to provide the documentation with the order she entered into the EMR, and the document provided on 6/11/25 at approximately 10:30 AM was the April pharmacist review that doesn't address the Lorazepam. (continued on next page)

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 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The DON stated the medication didn't need to have an end date since it had a justification for use per the pharmacist. DON was asked to provide documentation regarding this. The document was provided on 6/11/25 at approximately 10:30 AM. Per record review the document originated from the pharmacist titled Brief Summary of the Mega Rule - for reference for Skilled Facilities (Revised 11/1/2024) which states PRN Psychotropic orders are limited to 14 days, unless the prescriber believes it is appropriate to extend the order beyond 14 days & documents the reason & specific number of days (ie x 30, x 60 or x 90 days) to continue the order in the clinical record. The document also states, There is NOT an exception for comfort care / hospice / end of life orders.

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide one of two residents sampled (Resident #77) or the resident's representative with a bed-hold notice after discharge to the hospital. Findings include: Per record review Resident #77 was admitted on [DATE] and was transferred to the hospital on 5/9/2025. Per review of the Bed Policy [No date of revision] states, It is the policy of [the facility] to offer all residents who leave the facility for transfer to a hospital the right to return as soon as a bed is available, providing the nursing home is able to meet the medical needs of the resident and that the welfare of other residents will not be adversely affected .A copy of this policy would be sent to all residents or responsible party) at the time of transfer or leave, and documentation of such notification will be satisfied by any entry in the medical record indicating notification of the bed hold policy has been made. Further record review revealed that there was no documented evidence that a bed hold notice was provided to the Resident or their responsible party. An interview was conducted with the DON [Director of Nursing] on 6/11/25 at 10:00 AM. The DON confirmed the facility did not have a bed hold in place for Resident #77. When asked for documentation the DON confirmed that she could not find the bed hold document for Resident #77 stating, We are struggling to find it.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. Based on interviews, observations, and record review, the facility failed to review, revise, and implement resident care plans for 1 of 5 residents in the applicable sample related to falls (Residents #4). Findings include: Per record review, Resident #4 has diagnoses that include: Alzheimer's dementia, major depressive disorder, and anxiety disorder. Review of the Resident's last MDS [Minimum Data Set, a comprehensive assessment resident's functional capabilities] dated 6/8/2025 reveals that the resident is dependent on staff for activities of daily living, hygiene, and needs assistance with food and fluid intake. Nursing Progress notes dated 9/4/24, 11/1/24, 1/13/25, 2/26/25, and 5/8/25 document that the Resident had falls on each of the dates. Per policy review of Falls and Fall Risk, Managing, under section Resident-Centered Approaches to Managing Falls and Fall Risk (Last revised 2018) it states The staff, with the input of the attending physician, will implement a resident-centered fall prevention plan to reduce the specific risk factor(s) of falls for each resident at risk or with a history of falls. The policy also includes Monitoring Subsequent Falls and Fall Risk which states, The staff will monitor and document each resident's response to interventions intended to reduce falling or the risk of falling. Included in the Fall Risk Assessment policy, item 4. includes if an individual continues to fall the staff and physician will reevaluate and reconsider the current interventions. Falls - Clinical Protocol policy under Treatment/ Management identification of pertinent interventions to prevent further falls and if a underlying cause of falls isn't identifiable various relevant interventions will be implemented to reduce or stop further falling. With continued record review, after the 9/5/24, 11/5/24, 2/24/25, and 5/8/25 falls, the screening, review, evaluation, and OT (Occupational Therapy) referral interventions have no documentation of being completed or further recommendations to assist residents in reducing falls. Per record review of Resident #4's care plan, an intervention of Non-skid strips placed by floor when in bed was documented on 12/27/24. On 1/4/25 an intervention was added that states, Fall mat placed on right side of bed. Per observation of the Resident's room on 6/9/25, 6/10/25 and 6/11/25 there were no non-skid strips on the floor by the bed or a fall mat on the right side of the bed. An interview was conducted with the DON [Director of Nursing] on 6/11/25 at 10:06 AM. The DON confirmed when the resident is in bed there should be a fall mat. On 6/11/25 at approximately 10:30 AM the DON provided a printed copy of the referral to OT and no further documentation was provided regarding the results of the assessments or referrals.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident’s preferences and goals. Based on interview and record review, the facility failed to coordinate and implement hospice care measures for 1 of 1 sampled resident (Resident #20). Findings include: Per record review, a Phycisian's order dated 6/10/2025 states Caledonia Home Health and Hospice services phone# . There were no other orders for hospice care, no progress notes from hospice, no updates to his/her care plan mentioning hospice care or interventions, and no way to identify when hospice provided care located in the Resident's medical record. Per review of the facility's Hospice Policy it states, .it is the responsibility of the facility to meet the resident's personal care and nursing needs in coordination with the hospice representative, and ensure that the level of care provided is appropriately based on the individual resident's needs .communicating with the hospice provider (and documenting such communication) to ensure that the needs of the resident are addressed and met 24 hours per day .Coordinated care plans for residents receiving hospice services will include the most recent hospice plan of care as well as the care and services provided by our facility . in order to maintain the resident's highest practicable physical, mental, and psychosocial well-being. Per interview with the Director of Nursing (DON) on 6/10/2025 at 3:57 PM she reported that Resident #20 has been on hospice services since 6/3/2025, and that the hospice provider, Caledonia Home Health and Hospice, provides the facility with their documentation when they get to it. The Director of Nursing stated that they didn'tt have any medical records from the hospice agency for Resident #20. When asked again on 6/11/2025 at 11:28 AM if she had received any records from Caledonia Home Health and Hospice, she said she hadn't and that it takes a while to get information from hospice. When asked how they know what hospice interventions to put in place for Resident #20 since receiving hospice services she stated that it's just through verbal communication.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. Based on interview and record review, the facility failed to act on a pharmacist's Medication Regimen Review (MMR) that was then ordered by a physician for 1 of 5 Residents in the sample (Resident #20). The facility also failed to ensure that monthly MMRs were completed for 1 of 5 Residents in the sample (Resident #9). 1. Per record review there was no evidence that Monthly Medication Regimen Reviews were completed for Resident #9 for the month of March of 2025. Per interview on 6/11/2025 at 10:30 AM the Director of Nursing (DON) stated that the pharmacist sends the MMRs to her and she reviews them then follows up with the physician. The DON confirmed that there was no documented evidence in the record and that she could not produce the MMRs for March of 2025. 2. Per record review, on 11/11/2024, Resident #20 had a Medication Regimen Review (MMR) completed where the pharmacist identified the need for a one time digoxin level test. The physician reviewed and signed the document stating Ok to order x1 now and again yearly with their signature dated 11/14/2024. Per record review, on 12/6/2024, the pharmacist performed another Medication Regimen Review (MMR) where they stated Attn nursing: As a result of my consult last month, Dr. [facility doctor] ordered a one time Digoxin level on 11/14. As of 12/6/24, I do not see this scanned into PCC. Please obtain & scan in, so I can review next month. Per record review, on 1/14/2025, the pharmacist performed the monthly Medication Regimen Review (MMR) where they again stated Attn nursing: This is repeated from last month, as I do not see a Digoxin level scanned into PCC. The facility's Medication Regimen Reviews (MMR) policy states The MMR involves a thorough review of the resident ' s medical record to prevent, identify, report, and resolve medication related problems, medication errors and other irregularities, for example . inadequate monitoring for adverse consequences. Per interview with the Director of Nursing (DON) she reports the only digoxin level testing she has is from 1/28/2025. The Director of Nursing (DON) was unable to provide evidence that the facility acted on the pharmacists consult from the Medication Regimen Review, and the providers order for the 11/14/2024 digoxin testing. The facility failed to act upon the physician ' s order based on the Medication Regimen Review to monitor Resident #20 ' s digoxin levels to ensure they were in a therapeutic range.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations and interview, the facility failed to ensure medications were removed from the medication storage room when expiration dates were reached. Findings include: Per observation on [DATE] at 1:18 PM of the medication cart, an 8 oz [ounce] Spectrum Hand Sanitizer was found with an expiration date of [DATE]. A package of (3) Sani-cloth germicidal disposable wipes were found in the medication cart with an expiration date of 1/25. On [DATE] at 1:20 PM LPN#1(Licensed Practical Nurse) confirmed that these medications/biologicals were expired and stated, I'll get rid of these.

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F 0773 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain laboratory tests/services when ordered and promptly tell the ordering practitioner of the results. Based on interview and record review, the facility failed to obtain laboratory services when ordered by a physician for 1 of 5 residents in the sample (Resident #20). The facility also failed to obtain laboratory results and promptly notify the ordering physician of laboratory results for 1 of 5 residents in the sample (Resident #9). Findings include: 1. Per record review the consulting pharmacist performed a Medication Regimen Review for Resident #9 dated 5/19/2025 states Resident has the following labs drawn on 5/12/2025 - BMP (basic metabolic panel) I do not see the results in Resident's chart yet. Please obtain & scan them into [Point Click Care, PCC is an electronic Health Record] for me to review next month. Further record review revealed that there was no evidence that the Resident's BMP results were obtained, reviewed, or acted on. Per interview on 6/11/2025 at 10:30 AM the Director of Nursing (DON) stated that the pharmacist sends the MMRs to her, she reviews them then follows up with the physician. The DON stated that she was unable to locate lab results for the 5/12/2025 lab draw in the record or through the laboratory's record system. The DON confirmed that there was no evidence in the record that the BMP results were obtained, reviewed, or acted on. 2. Per record review, on 11/11/2024, Resident #20 had a Medication Regimen Review (MMR) completed where the pharmacist identified the need for a one time digoxin level test. The physician reviewed and signed the document on 11/14/2024 stating Ok to order x1 now and again yearly. Per record review, on 12/6/2024, the pharmacist performed another MMR where they stated Attn nursing: As a result of my consult last month, Dr. [facility doctor] ordered a one time Digoxin level on 11/14. As of 12/6/24, I do not see this scanned into PCC. Please obtain & scan in, so I can review next month. Per record review, on 1/14/2025, the pharmacist performed the monthly MMR where they again stated Attn nursing: This is repeated from last month, as I do not see a Digoxin level scanned into PCC. Per interview with the Director of Nursing (DON) she reports the only digoxin level results that she can produce are from 1/28/2025. The DON was unable to provide evidence that the facility followed the Pharmasist recommendations made on 11/11/2024, 12/6/2024, and 1/14/2025, or implemented providers orders by obtaining laboratory services to determine Resident #20's digoxin levels on 11/14/2024.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation and interview, the facility failed to store food in accordance with professional standards for food service safety and failed to maintain a sanitary kitchen. Findings include: Per observation on 6/11/25 at 9:08 AM, (4) 1 pound 12 ounce packages of cream of wheat were found in the dry storage with an expiration date of 4/1/25. On 6/11/25 at approximately 9:10 AM the food service staff member confirmed these were expired stating, Sorry, I'll get rid of these. Per observation of the kitchen on 6/11/25 at approximately 9:08 AM, there was melted plastic on the wall behind the toaster. The food service worker confirmed the condition of the wall 6/11/25 at approximately 9:10 AM, stating, It's been here for about a year .It's from the toaster. Per observation on 6/11/25 at approximately 9:12 AM a room with two large freezers had hats hanging from pipes on the ceiling. Per observation there were also coats hung up on the wall, and a dirty mop bucket with mop water in it on the floor. The food service staff member confirmed the condition of the freezer room on 6/11/25 at approximately 9:13 AM stating, Yeah, we usually just put everything in here.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. Based on interview and record review, the facility failed to implement an infection prevention and control program designed to help prevent the development and transmission of communicable diseases and infections related to Legionella prevention. Findings include: Per record review of the facility's water management program, there was no risk assessment to identify areas in the building that could grow and spread Legionella in the facility water system. Per the facility's Legionella Water Management Program policy [Revised 7/2017] states, 3. The purposes of the water management program are to identify areas in the water system where Legionella bacteria can grow and spread, and to reduce the risk of Legionnaire's disease .The identification of areas in the water system that could encourage the growth and spread of Legionella or other waterborne bacteria, including: (1) Storage tanks; (2) Water heaters (3) Filters; 4) Aerators; (5) Showerheads and hoses; (6) Misters, atomizers, air washers and humidifiers ; (7) Hot tubs; (8) Fountains; and (9) Medical devices such as CPAP [Continuous Positive Airway Pressure] machines, hydrotherapy equipment, etc .E. Specific measures used to control the introduction and/or spread of legionella (e.g., temperature, disinfectants); f. The control limits or parameters that are acceptable and that are monitored, g. A diagram of where control measures are applied, h. A system to monitor control limits and the effectiveness of control measures; i. A plan for when the control limits are not met/and or control measures are not effective; and j. Documentation of the program. An interview was conducted with the Administrator and Director of Maintenance on 6/11/25 at 1:16 PM. They confirmed that the facility did not complete a risk assessment, including identifying areas in the building where Legionella could grow or reside. The Director of Maintenance stated, We don't have any areas where Legionella could grow.