VERMONT

Department of Disabilities, Aging and Independent Living
Division of Licensing and Protection
280 State Drive/HC 2 South
Waterbury, VT 05671-2060
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AGENCY OF HUMAN SERVICES

July 14, 2025

Ms. Amy Braun, Administrator
Greensboro Nursing Home
47 Maggie's Pond Road
Greensboro, VT 05841

Provider ID #: 475043

Dear Ms. Braun:

Enclosed is a copy of your acceptable plans of correction for the recertification survey conducted on **June 11, 2025.** Please post this document in a prominent place in your facility.

We may follow up to verify that substantial compliance has been achieved and maintained. If we find that your facility has failed to achieve or maintain substantial compliance, remedies may be imposed.

Sincerely,

Pamela M. Cota, RN, BS
Assistant Division Director
State Survey Agency Director

Enclosure

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 _____	C 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

(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
E 000	Initial Comments The Division of Licensing and Protection conducted an onsite, unannounced survey of the facility's emergency preparedness program on 6/11/2025 during an annual re-certification survey. There were no regulatory violations related to emergency preparedness as a result of this survey.	E 000		
F 000	INITIAL COMMENTS The Division of Licensing and Protection conducted an unannounced, onsite re-certification survey and investigation of one facility reported incident #23420, and one complaint #24069 from 6/9/2025 through 6/11/2025 to determine compliance with 42 CFR Part 483 requirements for Long Term Care Facilities. Deficiencies were cited as a result of this survey.	F 000		
F 605 SS=D	Right to be Free from Chemical Restraints CFR(s): 483.10(e)(1), 483.12(a)(2), 483.45(c)(3)(d)(e) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(1) The right to be free from any . . . chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2). §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in	F 605		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: Administrator | (X6) DATE: 7/11/2025

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 605	Continued From page 1 this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must-. . . §483.12(a)(2) Ensure that the resident is free from . . . chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. . . . . §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic. §483.45(d) Unnecessary drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- (1) In excessive dose (including duplicate drug therapy); or (2) For excessive duration; or (3) Without adequate monitoring; or (4) Without adequate indications for its use; or (5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or (6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section.	F 605	1. Resident #4 or other residents were not negatively affected by the alleged practice. 2. Residents in the facility have the potential to be negatively affected by the alleged deficiency practice. 3. The DON and Nurse Manager have reviewed and corrected the end date of Lorazepam order for Resident #4. 4. All residents with psychotropic drugs orders have been reviewed, end dates audited. Completed on 7/10/2025 5. Ongoing audits for psychotropic end dates will be audited X12 weeks and presented as a QAPI to QA Meeting. Audits will be completed by the DON and/or RN Nurse Manager **Tag F 605 POC accepted on 7/14/25 by S. Freeman/S. Stem**	

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§483.45(e) Psychotropic Drugs. Based on a comprehensive assessment of a resident, the facility must ensure that--

§483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record;

§483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs;

§483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and

§483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order.

§483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication.
This REQUIREMENT is not met as evidenced by:
Based on interview and record review, the facility

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F 605	Continued From page 3	F 605		

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

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F 605	Continued From page 4 [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." 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."	F 605		
F 609 SS=D	Reporting of Alleged Violations	F 609		

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F 609	Continued From page 5 CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: 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: Per record review Resident #77 was admitted in	F 609	1. Resident #77 or other residents were not negatively affected by the alleged deficiency practice. 2. Residents in the facility have the potential to be negatively affected by the alleged deficiency practice. 3. Re-education of Abuse Neglect and Exploitation and reporting was completed facility wide on June 6, 2025 4. Monthly education for Abuse, Neglect and Exploitations and reporting will be conducted monthly for 6 months. 5. Education audits will be performed monthly x6 months and presented as a QAPI to the QA meeting. **Tag F 609 POC accepted on 7/14/25 by S. Freeman/S. Stem**	

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F 609	Continued From page 6 May of 2025 and began exhibiting aggressive behaviors requiring staff intervention and emergent transfer to the hospital. 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. 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.	F 609		
F 628 SS=D	Discharge Process CFR(s): 483.15(c)(2)(iii)(3)-(6)(8)(d)(1)(2); 483.21(c)(2)(i)-(iii) §483.15(c)(2) Documentation. When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider. (iii) Information provided to the receiving provider must include a minimum of the following: (A) Contact information of the practitioner responsible for the care of the resident. (B) Resident representative information including contact information	F 628		

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(C) Advance Directive information
(D) All special instructions or precautions for ongoing care, as appropriate.
(E) Comprehensive care plan goals;
(F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care.

§483.15(c)(3) Notice before transfer.
Before a facility transfers or discharges a resident, the facility must-
(i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman.
(ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and
(iii) Include in the notice the items described in paragraph (c)(5) of this section.

§483.15(c)(4) Timing of the notice.
(i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged.
(ii) Notice must be made as soon as practicable before transfer or discharge when-
(A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section;

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F 628	Continued From page 8 (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402,	F 628	1. Resident #77 was not negatively affected by the alleged deficiency practice. 2. Residents in the facility could potentially be negatively affected by the alleged deficiency practice. 3. Bed Hold notifications were provided and made accessible to all management and clinical team. Completed 6/20/2025 4. Audits of all residents who leave the facility or transfer to a hospital will have a bedhold agreement signed and uploaded. Completed 7/8/2025 5. Audits of bed hold agreements will be conducted biweekly x3 months. 6. Audits will be conducted by Social Services and presented as a QAPI for QA Meeting. **Tag F 628 POC accepted on 7/14/25 by S. Freeman/S. Stem**	

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codified at 42 U.S.C. 15001 et seq.); and
(vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act.

§483.15(c)(6) Changes to the notice.
If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available.

§483.15(c)(8) Notice in advance of facility closure
In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l).

§483.15(d) Notice of bed-hold policy and return-

§483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies-
(i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing

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facility;
(ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any;
(iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and
(iv) The information specified in paragraph (e)(1) of this section.

§483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section.

§483.21(c)(2) Discharge Summary
When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following:
(i) A recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results.
(ii) A final summary of the resident's status to include items in paragraph (b)(1) of §483.20, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or resident's representative.
(iii) Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over-the-counter).
This REQUIREMENT is not met as evidenced by:
Based on interview and record review, the facility

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F 628	Continued From page 11 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 5/8/2025 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."	F 628		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii)	F 657		

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GREENSBORO NURSING HOME	47 MAGGIE'S POND ROAD GREENSBORO, VT 05841

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F 657	Continued From page 12 §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: 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	F 657	1. Resident #4 was not negatively affected by the alleged deficiency practice 2. Residents in the facility have the potential to be negatively affected by the alleged deficiency practice. 3. Fall incident Resident #4 dated 9/5/2024 was screened and uploaded in MISC section of resident's documents. Resident #4 was receiving skilled services at time of fall. 4. Documentation related to 11/5/2024 date was uploaed in MISC section of resident's documents and linked to the OT note indicating no rehab interventions indicated at this time. 5. Documentation related to 2/24/2025. Screen was completed 2/25/25 and located in MISC section of resident's documents indicating resident is on hospice services and nursing to assess footwear use. 6. Documentation related to 5/8/2025 were uploaded in MISC section of resident's documents indicating the need to assess the environment. This resulted in OT treatment and evaluation. Environmental assessment was in order. 7. All documents were already completed on dates provided (continued)	

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F 657	Continued From page 13	F 657		

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.

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F 657	Continued From page 14 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.	F 657	1. Resident #4 was not negatively affected by the alleged deficiency practice. 2. Residents in the facility have the potential to be negatively affected by the alleged deficiency practice 3. Correction was completed for resident #4 after discussion on 6/11/2025 4. Audits of all care plans audited. Completed 7/10/2025. 5. Audits will be completed weekly x12 weeks and presented as a QAPI at QA meeting by DON and/or RN Manager. **Tag F 657 POC accepted on 7/14/25 by S. Freeman/S. Stem**	
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: 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:	F 684		

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F 684	Continued From page 15 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	F 684	1. Resident #20 were not negatively affected by the alleged deficiency practice. 2. Residents in the facility have the potential to be negatively affected by the alleged deficiency practice. 3. Hospice Enrollment notifications was completed on 7/10/2025 by noting on the patient's dashboard if patient is on hospice services. 4. Communications meeting with Hospice will be conducted by DON/RN Manager and Social Services by 7/20/2025 5. Audits for hospice residents will be conducted weekly x12 weeks by the DON/RN Manager or designee and presented as a QAPI to QA Meeting **Tag F 684 POC accepted on 7/14/25 by S. Freeman/S. Stem**	

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F 684	Continued From page 16 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.	F 684		
F 756 SS=D	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record.	F 756		

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F 756	Continued From page 17 §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: 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	F 756	1. Residents were not negatively affected by the alleged deficiency practice. 2. Residents in the facility have the potential to be negatively affected by the alleged deficiency practice. 3. Monthly Medication reviews have been completed. Completed 7/10/2025 4. Audits of monthly medication reviews will be done weekly and presented as a QAPI **Tag F 756 POC accepted on 7/14/25 by S. Freeman/S. Stem**	

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F 756	Continued From page 18	F 756		

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 761 SS=F	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: 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 6/10/25 at 1:18 PM of the medication cart, an 8 oz [ounce] Spectrum Hand Sanitizer was found with an expiration date of 5/24/25. A package of (3) Sani-cloth germicidal disposable wipes were found in the medication	F 761	1. Residents were not negatively affected by the alleged deficiency practice. 2. Residents in the facility have the potential to be negatively affected by the alleged deficiency practice. 3. Completion of removing the expired items were completed immediately. 4. Audits of stock and expiration dates will be completed by 7/20/2025 5. First In First Out system and audits have been developed and audits x12 weeks and presented as a QAPI to QA Meeting. **Tag F 761 POC accepted on 7/14/25 by S. Freeman/S. Stem**	

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F 761	Continued From page 20 cart with an expiration date of 1/25. On 6/10/25 at 1:20 PM LPN#1(Licensed Practical Nurse) confirmed that these medications/biologicals were expired and stated, "I'll get rid of these."	F 761		
F 773 SS=D	Lab Srvcs Physician Order/Notify of Results CFR(s): 483.50(a)(2)(i)(ii) §483.50(a)(2) The facility must- (i) Provide or obtain laboratory services only when ordered by a physician; physician assistant; nurse practitioner or clinical nurse specialist in accordance with State law, including scope of practice laws. (ii) Promptly notify the ordering physician, physician assistant, nurse practitioner, or clinical nurse specialist of laboratory results that fall outside of clinical reference ranges in accordance with facility policies and procedures for notification of a practitioner or per the ordering physician's orders. This REQUIREMENT is not met as evidenced by: 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	F 773	1. Residents were not negatively affected by the alleged deficiency practice. 2. Residents in the facility have the potential to be negatively affected by the alleged deficiency practice. 3. Charts have been reviewed for lab audits and MMR. Completed 7/8/2025 4. Audits will be performed weekly by DON or RN Manager x 12 weeks and presented as a QAPI to QA Meeting. **Tag F 773 POC accepted on 7/14/25 by S. Freeman/S. Stem**	

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F 773	Continued From page 21	F 773		

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

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F 773	Continued From page 22 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.	F 773		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility	F 812		

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F 812	Continued From page 23 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."	F 812	1. Residents were not negatively affected by alleged deficiency practice. 2. Residents in the facility have the potential to be negatively affected by the alleged deficiency practice 3. FIFO system has been developed and completion will be by 7/20/2025. Expired items were immediately thrown out. 4. Melted plastic area is scheduled to be replaced on 7/18/2025 5. Freezer room will be cleaned out by 7/18/2025 6. Mop bucket was immediately removed and completion of education to put it back in closet when not in use was completed 7/10/2025 7. Weekly audits x12 by the Dietary Manager and monitored by the CDM will be done and presented as a QAPI to QA meeting. **Tag F 812 POC accepted on 7/14/25 by S. Freeman/S. Stem**	
F 880 SS=F	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable	F 880		

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 _____	C 06/11/2025

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F 880	Continued From page 24 diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility	F 880	1. Residents were not negatively affected by the alleged deficiency practice. 2. Residents in the facility have the potential to be negatively affected by the alleged deficiency practice. 3.Risk assessment has been created. Completion will be done 7/18/2025 4. Monthly assessments will be done. 5. Audits x3 months will be presented as a QAPI to QA meeting. **Tag F 880 POC accepted on 7/14/25 by S. Freeman/S. Stem**	

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F 880	Continued From page 25	F 880		

must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and
(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.

§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.

§483.80(e) Linens.
Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.

§483.80(f) Annual review.
The facility will conduct an annual review of its IPCP and update their program, as necessary.
This REQUIREMENT is not met as evidenced by:
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

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F 880	Continued From page 26	F 880		

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."