VERMONT

Department of Disabilities, Aging and Independent Living
Division of Licensing and Protection
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AGENCY OF HUMAN SERVICES

January 14, 2026

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 complaint investigation conducted on **December 22, 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 CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 475043	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 12/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Greensboro Nursing Home	**47 Maggie's Pond Road , Greensboro, Vermont, 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
F0000	INITIAL COMMENTS The Division of Licensing and Protection conducted an unannounced, onsite investigation of one complaint and one facility reported incident, including reports #2607690 and #2646315 on12/22/25 to determine compliance with 42 CFR Part 483 requirements for Long Term Care Facilities. The following regulatory deficiencies were identified:	F0000		
F0552 SS = E	Right to be Informed/Make Treatment Decisions CFR(s): 483.10(c)(1)(4)(5) §483.10(c) Planning and Implementing Care. The resident has the right to be informed of, and participate in, his or her treatment, including: §483.10(c)(1) The right to be fully informed in language that he or she can understand of his or her total health status, including but not limited to, his or her medical condition. §483.10(c)(4) The right to be informed, in advance, of the care to be furnished and the type of care giver or professional that will furnish care. §483.10(c)(5) The right to be informed in advance, by the physician or other practitioner or professional, of the risks and benefits of proposed care, of treatment and treatment alternatives or treatment options and to choose the alternative or option he or she prefers. This REQUIREMENT is NOT MET as evidenced by: 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	F0552		

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 reverse for further 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
Amy J Braun	Administrator	1/13/2026

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F0552 SS = E	Continued from page 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."	F0552	F0552 1. Resident 1, 2, and 3 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. Audits of residents' psychotropic medication consent forms were completed (12/23/2025). Audits will be conducted by DON or designee monthly x3 and brought to following QA meeting. 4. Staff were educated on the proper use of the medication consent forms. (12/23/2025) 5. The policy for psychotropic medication use was adjusted to discuss the consent form and usage. (12/23/2025) **Tag F 552 POC accepted on 1/14/26 by C. Howard/S. Stem**	
F0600 SS = D	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and	F0600		

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F0600 SS = D	Continued from page 2 exploitation as defined in 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)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is NOT MET as evidenced by: 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 #17 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	F0600	F0600 1. Resident #1 and Resident #3 were not negatively affected by the alleged deficiency practice 2. Residents in the facility could potentially be negatively affected the alleged deficiency practice. 3. Audits were performed and the care plan updated after exit review with state (12/22/2025) 4. Education has been done regarding documentation with charting. (12/23/2025) 5 Education provided to SS Director regarding performing psychosocial assessments (12/29/2025) 6.Audits were performed and interventions put into place to protect Resident 1 from Resident #3's spouse. 7. Results of above education, documentation, and interventions will be brought to upcoming QA meeting. **Tag F 600 POC accepted on 1/14/26 by C. Howard/S. Stem**	

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F0600 SS = D	Continued from page 3 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.	F0600		
F0609 SS = D	Reporting of Alleged Violations 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	F0609		

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F0609 SS = D	Continued from page 4 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 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 #17 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."	F0609	F0609 1. Resident 1 and 3 were not negatively affected by the alleged deficiency practice. 2. Resident 1 and 3 and any resident could potentially be affected negatively by the alleged deficiency practice. 3. Education/Training has been scheduled to educate management staff on abuse with an emphasis on verbal abuse x 3 months 4. Abuse education and results will be brought to upcoming QA meeting (Completion 1/31/2026) **Tag F 609 POC accepted on 1/14/26 by C. Howard/S. Stem**	

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F0609 SS = D	Continued from page 5 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.	F0609		
F0610 SS = D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated.	F0610		

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F0610 SS = D	Continued from page 6 §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §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 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 #17 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.	F0610	F0610 1. Resident 1 and 3 were not negatively affected by the alleged deficiency practice. 2. Resident 1 and 3 and any resident could potentially be negatively affected by the alleged deficiency practice. 3. Staff have been educated on documentation for charting. (12/23/2025) 4. Administrator and DON have been educated on the process of reporting to both APS and DAIL for any abuse, neglect, exploitation and investigative procedures. (12/23/2025) 5. Any reports of abuse, neglect, or exploitation will be brought upcoming QA to educate and reiterate the procedures of reporting and investigative obligations. **Tag F 610 POC accepted on 1/14/26 by C. Howard/S. Stem**	

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F0610 SS = D	Continued from page 7 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.	F0610		