VERMONT

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

May 7, 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 **March 30, 2026.** 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

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES			FORM APPROVED OMB NO. 0938-0391
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 **03/30/2026**

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 FRI [Facility Reported Incident] including reports #2785790 and #2702007 on 3/30/26 to determine compliance with 42 CFR Part 483 requirements for Long Term Care Facilities. The following regulatory deficiency was identified:	F0000		
F0842 SS = D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5),483.70(h)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(h) Medical records. §483.70(h)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(h)(2) The facility must keep confidential all information contained in the resident's records,	F0842	F0842 1. Resident #1 was not negatively affected by the alleged deficiency practice. 2. Residents in the facility could have had the potential to be negatively affected by the alleged deficiency practice. 3. The facility followed policy and protocol on the incident reporting procedures regarding this alleged event. 4. Education for all LNA's on Falls and Your Role As an LNA and documentation was completed on March 31, 2026 5. Education for Nurses on Fall Prevention & Documentation in Skilled Nursing Facilities was completed on April 7, 2026 6. The DON or designee will complete audits on charting and documentation on Falls monthly for 3 months. This will be presented to QA on scheduled QA on 4/29 and in July QA. Completion date 4/7/2026	

regardless of the form or storage method of the records, except when release is-

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 Administrator (X6) DATE 4/23/26

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F0842 SS = D	Continued from page 1 (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(h)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(h)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(h)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50.	F0842	**Tag F0842 POC accepted on 5/7/26 by C. Howard/S. Stem**	

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F0842 SS = D	Continued from page 2 This REQUIREMENT is NOT MET as evidenced by: Based on interview and record review the facility failed to ensure documentation was accurate and true for one of three sample residents (Resident #1). Findings include: Per record review, Resident #1 has diagnoses of COPD [Chronic Obstructive Pulmonary Disease, Type II Diabetes, Atrial fibrillation [a condition in which the heart beats irregularly] and Parkinson's disease. Resident #1 had a BIMS [Brief Interview of Mental Status] score of 3 as of 1/15/26 indicating cognitive impairment; was dependent on staff for ADLs [Activities of Daily Living] and hygiene; and was at risk for falls related to deconditioning, gait/balance problems, and Parkinson's. Per review of a nursing progress from 2/19/26, it states, "Pt [Patient] was trying to transfer self from [his/her] wheelchair to without assistance. This writer was in the room with [his/her] roommate and witnessed this. Pt stood up and sat back down on the floor on [his/her] rear. Once on [his/her] rear [s/he] started turning towards the nurse and laid out. Stated "I was going to bed, but the floor misses me" laughing and cracking jokes. Immediately assessed, no complaints of pain or discomfort noted. Helped up and wheeled to the nurses cart till dinner. Emotional support give, [given] but resident continued making jokes and laughing. HHC [home health care] notified, on call service and [family representative]." Further record review showed that there was no documentation of Resident #1's vital signs or neurological checks until 2/20/26. A review of the facility's investigation on 2/23/26 revealed the following: Nurse #1 filed an incident report that showed Resident #1 had a fall on 2/19/26 that was witnessed and their representative was notified. A risk management report demonstrated that the incident note and nursing progress note did not match the resident's physical capabilities. The Director of Nursing reported to the State Agency that the resident "is incapable to rolling on the floor or anywhere else by him/herself." During their investigation, the facility determined that the resident's fall was unwitnessed and the resident's representative was not notified of the fall. During interviews with LNA #1 (Licensed Nursing Assistant) and LNA #2 it was discovered that Nurse #1 had asked the LNAs to change their witness statements about the resident's fall. Based on the staff interviews and chart reviews, the facility concluded that the	F0842		

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F0842 SS = D	Continued from page 3 information in the medical record was falsified. An interview was conducted with the DON [Director of Nursing] on 3/30/26 at 10:45 AM. The DON stated Nurse #1 was put on unpaid leave and then resigned from the position following this investigation. The DON confirmed that through the facility's internal investigation they found that the documentation of the fall had been falsified. At 11:49 AM, she further confirmed the nurse did not implement fall protocols and assess the resident's vital signs or do neurological checks when the resident fell stating, "It would have been in [Resident #1]'s progress notes." Per review of the facility's "Charting and Documentation" policy [revised July 2017] it states, "3. Documentation in the medical record will be objective (not opinionated or speculative), complete, and accurate." Per review of the facility's "Falls-Clinical Protocol" policy [last revised March 2018) it states, "2. In addition, the nurse shall assess and document/report the following: a. vital signs b. recent injury, especially fracture or head injury; c. Musculoskeletal function, observing for change in normal range of motion, weight bearing, etc.; D. change in cognition of level of consciousness; E. Neurological status; F. Pain; G. Frequency and number of falls since last physician visit; H. Precipitating factors, details on how fall occurred; I. All current medications, especially those associated with dizziness or lethargy; and J. All active diagnoses."	F0842		