VERMONT

Department of Disabilities, Aging and Independent Living
Division of Licensing and Protection
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Waterbury, VT 05671-2060
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AGENCY OF HUMAN SERVICES

April 8, 2026

Mr. Bradford Ellis, Administrator
Vernon Green Nursing Home
61 Greenway Drive
Vernon, VT 05354

Provider ID #: 475008

Dear Mr. Ellis:

Enclosed is a copy of your acceptable plans of correction for the recertification survey conducted on **January 14, 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
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: 475008	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 01/14/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Vernon Green Nursing Home	**61 Greenway Drive , Vernon, Vermont, 05354**

(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
E0000	Initial Comments The Division of Licensing and Protection conducted an emergency preparedness review during the annual recertification survey on 1/14/2026. There were no regulatory violations identified.	E0000		
F0000	INITIAL COMMENTS The Division of Licensing and Protection conducted an unannounced, onsite recertification survey and investigation of two FRI's # 2716564 and # 2668623 from 1/12/2026 through 1/14/2026 to determine compliance with 42 CFR Part 483 requirements for Long Term Care Facilities. Deficiencies were cited as a result of this survey.	F0000	F000 Allegation of Substantial Compliance: Vernon Green Nursing Home, herein after sometimes “facility”, has and continues to be in substantial compliance with 42 CFR Part 483 subpart B. Vernon Green Nursing Home has or will have substantially corrected the alleged deficiencies and achieved substantial compliance by the date specified herein. This Plan of Correction constitutes Vernon Green Nursing Home’s allegation of substantial compliance such that the alleged deficiencies cited have been or will be substantially corrected on or before February 28, 2026. The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies herein. To continue to remain in substantial compliance with state and federal regulations, Vernon Green Nursing Home has taken or will take the actions set forth in this plan of correction.	
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 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 observation, interview, and record review the facility failed to ensure residents were free from abuse for one of three sampled residents (Res #54). This is a repeat deficiency for this facility, with violations cited during the previous two recertification surveys, dated 10/30/24 and 12/4/23.	F0600	**F 0600 Vernon Green has and will continue to comply with CFR(s): 483.12 (a)(1), free from Abuse and Neglect.** **What corrective action will be accomplished for those residents found to have been affected by the deficient practice;** Resident #54’s mood and behavior remain at baseline.	02/10/2026

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
M.Bradford Ellis	Executive Director	03.04.2026

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F0600 SS = D	Continued from page 1 Findings include: Per review of the facility's "Resident Abuse, Neglect, Exploitation, and Misappropriation of resident property" policy [last revised 9/23/24] it states, "Policy: It is the established priority of [facility] to provide its residents with a living environment free from any instance of abuse, neglect, exploitation and misappropriation of resident property…To that end, a policy has been established to deter the prospect of resident [abuse, neglect, exploitation and misappropriation] that governs staff screening and training, preventative and protective measure, and procedures for identification, investigation and reporting [abuse, neglect, exploitation, misappropriation]…[Facility] will maintain a living and work environment that minimizes the likelihood of resident [abuse, neglect, exploitation, misappropriation]." Per record review, Resident #54 has a BIMS [Brief Interview of Mental Status] score of 1 as of 1/8/26 indicating the resident is cognitively impaired. Resident #54 has medical diagnoses of dementia, Alzheimer's Disease, and depression. The resident is dependent on staff for ADLs [Activities of Daily Living] and hygiene. Per review of the facility's internal investigation it states, "Two staff members [LNA [Licensed Nursing Assistant]#3 and LNA#4], LNAs reported that "night shift LNA staff received in report that [Resident #54] had required 2 showers due to bowel movements and became aggressive with the second shower and the [LNA#1][had "sprayed [him/her] in the face with cold water." [LNA #2] had assisted [LNA #1] with the shower as [Resident #54] became aggressive. Both staff were "laughing" about the incident. The incident occurred on 11/13/25 during the evening shift. Per review of a witness statement from LNA#3 it states, "[LNA#3] when she arrived at work [LNA#1] and [LNA#2] were behind the desk laughing about something. [LNA#1] was giving her report and said that [Resident #54] ad two blowouts and needed two showers. During the second shower [Resident #54] was agitated and pulling on the hose and pipes and [LNA#1] said she was so frustrated she just sprayed [Resident #54] with freezing water. [LNA#2] had to help because [Resident #54] was trying to rip the hose out of [LNA#1]'s hands and started pulling on the pipes. Both [LNA#12 and LNA#2] were laughing about this. [Resident #54] wanted to apologize to someone, [s/he] did not know who."	F0600	**How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;** An audit was completed to ensure nursing staff have had the required screening and training. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur;** Education provided to nursing staff regarding Abuse Prevention and Reporting. Audits will be completed monthly for 3 months to ensure that staff screening and training are complete and current. **How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** Results of the audits will be discussed at monthly QAPI meetings for further recommendations. The Director of Nursing or designee will oversee compliance of the plan of correction. **Tag F0600 POC accepted on 4/8/26 by S. Stem**	2/25/2026 2/25/2026 2/25/2026

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F0600 SS = D	Continued from page 2 Per review of the follow-up investigation it states, "The allegation was reported to APS [Adult Protective Services], the Vermont Board of Nursing and the Windham County Sheriff's Department. As of this date there are no outcomes....[Resident #54] was assessed by the DON [Director of Nursing] and the social services director at different times throughout the day. [S/he has no recollection of the incident and his mood and behavior is at baseline.....4. Corrective Action(s) Taken: [Resident #54] was assessed and has no recollection of the incident. [His/Her] mood and behavior are at baseline. Behavior is being monitored by staff and emotional support provided to both [Resident #54] and [his/her] [family representative]. [LNA#1] was suspended immediately pending investigation, and subsequently terminated from employment. [LNA#2] was suspended immediately pending investigation, and subsequently terminated from employment. MD [Medical Director] has been notified. Education regarding abuse and neglect is being done with staff. Social services and behavioral services will remain involved for ongoing support and management…3. Conclusion There is enough evidence to support that this allegation is substantiated." Per review of an addendum to final the report dated 11/19/25 it states, "[Resident #54] was noted to have 5 bruises on [his/her] left forearm in healing stages. These are likely related to staff's attempt to prevent [him/her] from grabbing the water hose in the shower by holding onto [his/her] arm during the previously reported incident. [Resident #54] has no pain and is in good spirits at this time. [S/he] does not recall how the bruising occurred. Appropriate notifications have been made, will monitor bruising." On 1/13/26 at 1:30 PM an interview was conducted with the DON. She confirmed the abuse occurred, stating, "Yes, I substantiated it." She confirmed that the abuse should not have occurred.	F0600		
F0628 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	F0628	//	

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F0628 SS = D	Continued from page 3 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 (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	F0628		

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F0628 SS = D	Continued from page 4 transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (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, codified at 42 U.S.C. 15001 et seq.); and	F0628		

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F0628 SS = D	Continued from page 5 (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 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.	F0628		

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F0628 SS = D	Continued from page 6 §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 failed to ensure discharge notices were sent to the Long-Term Care Ombudsman for one of two sampled residents (Resident #58). Findings include: Per review of Resident #58's medical record, Resident #58 has a BIMS [Brief Interview of Mental Status] score of 15 as of 12/29/25, indicating they did not have any cognitive impairment. Resident #58 has medical diagnoses of non-ST elevated myocardial infarction (a heart attack that partially obstructs the coronary artery) and unspecified dementia. Resident #58 was independent with ADLs [Activities of Daily Living] and hygiene. Per review of a social services progress note dated 12/17/25 at 12:46 PM states, "…[Resident #58] who will be returning home on Saturday, 12-20-25 with services. [S/he] also has a friend who will help [him/her] and a place called [facility] that assists [him/her] with transportation needs. Both [Resident #58 and family representative] are aware that they should schedule a	F0628	**F 628 Vernon Green has and will continue to comply with CFR(s): 483.15(c)(2)(iii)(3)-(6)(8)(d)(1)(2); 483.21(c)(2), Discharge Process.** **What corrective action will be accomplished for those residents found to have been affected by the deficient practice;** The ombudsman was notified of Resident #58's discharge on 1/13/26. **How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;** An audit was completed of all discharges for the prior 3 months to ensure the ombudsman has been notified. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur;** Education provided to staff involved in discharge planning regarding ombudsman notification. Audits will be completed monthly for 3 months of all discharges to ensure ombudsman notification is complete.	**1/13/2026** **2/25/2026** **2/25/2026**

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F0628 SS = D	Continued from page 7 follow-up appointment with [his/her] PCP [primary care provider].” An administration note on 12/20/25 at 5:52 PM states, “PT [Patient] discharged.” Per review of the facility’s “Documentation of Transfers and Discharges” policy [last revised 12/23/16] states, “1.All documentation concerning the transfer or discharge of a resident must be recorded in the resident’s medical record.” There is no mention of sending any transfer or discharge notices to the Long-Term Care ombudsman. An interview was conducted with social services on 1/13/26 at 1:42 PM. Social services confirmed she did not inform the ombudsman of the resident’s discharge, stating, “I didn’t know I had to do that.”	F0628	**How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** Results of the audits will be discussed at monthly QAPI meetings for further recommendations. Administrator or designee will oversee compliance of the plan of correction. **Tag F0628 POC accepted on 4/8/26 by S. Stem**	02/25/2026
F0645 SS = D	PASARR Screening for MD & ID CFR(s): 483.20(k)(1)-(3) §483.20(k) Preadmission Screening for individuals with a mental disorder and individuals with intellectual disability. §483.20(k)(1) A nursing facility must not admit, on or after January 1, 1989, any new residents with: (i) Mental disorder as defined in paragraph (k)(3)(i) of this section, unless the State mental health authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission, (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services; or (ii) Intellectual disability, as defined in paragraph (k)(3)(ii) of this section, unless the State intellectual disability or developmental disability authority has determined prior to admission- (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services,	F0645		

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F0645 SS = D	Continued from page 8 whether the individual requires specialized services for intellectual disability. §483.20(k)(2) Exceptions. For purposes of this section- (i)The preadmission screening program under paragraph(k)(1) of this section need not provide for determinations in the case of the readmission to a nursing facility of an individual who, after being admitted to the nursing facility, was transferred for care in a hospital. (ii) The State may choose not to apply the preadmission screening program under paragraph (k)(1) of this section to the admission to a nursing facility of an individual- (A) Who is admitted to the facility directly from a hospital after receiving acute inpatient care at the hospital, (B) Who requires nursing facility services for the condition for which the individual received care in the hospital, and (C) Whose attending physician has certified, before admission to the facility that the individual is likely to require less than 30 days of nursing facility services. §483.20(k)(3) Definition. For purposes of this section- (i) An individual is considered to have a mental disorder if the individual has a serious mental disorder defined in 483.102(b)(1). (ii) An individual is considered to have an intellectual disability if the individual has an intellectual disability as defined in §483.102(b)(3) or is a person with a related condition as described in 435.1010 of this chapter. This REQUIREMENT is NOT MET as evidenced by: Based on interview and record review the facility failed to ensure PASARR screenings were completed for two of five sampled residents (Residents #5 and #48). Findings include: Per review of the medical records for Resident # 5 and Resident # 48, the records did not contain a PASARR (a Preadmission Screening and Resident Review). This is a	F0645	**F0645 Vernon Green has and will continue to comply CFR(s): 483.20(k)(1)-(3) PASARR Screening for MD & ID.** **What corrective action will be accomplished for those residents found to have been affected by the deficient practice;** PASARR Screening was completed for Resident #5 and #48 on 1/16/26.	**1/16/2026**

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F0645 SS = D	Continued from page 9 federal requirement ensuring people with serious mental illness or intellectual/developmental disabilities are not wrongly placed in Medicaid-certified nursing facilities, instead directing them to the most appropriate, least restrictive setting with needed specialized services. A level 1 screening is conducted to identify conditions that require specialized services. Per interview with the Director of Social Services at 11:16 AM on 1/14/2026, she confirmed that all residents should have a Level 1 PASARR screening completed before they are admitted to the facility. She also stated that for a new admission to the facility, from the community, she will conduct the PASARR interview which starts with a Level 1 interview. She confirmed that PASARR documents are not in Resident #5 and Resident #109s' charts.	F0645	**F0645 Continued** **How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;** An audit was completed for all residents to ensure PASARR Screening was completed. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur;** Education provided to staff involved in PASARR Screening. Audits will be completed monthly for 3 months of all admissions to ensure PASARR Screening is completed. **How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** Results of the audits will be discussed at monthly QAPI meetings for further recommendations. Administrator or designee will oversee compliance of the plan of correction. **Tag F0645 POC accepted on 4/8/26 by S. Stem**	02/25/2026 02/25/2026
F0657 SS = E	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §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	F0657		02/25/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 475008	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 01/14/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Vernon Green Nursing Home	**61 Greenway Drive , Vernon, Vermont, 05354**

(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
F0657 SS = E	Continued from page 10 after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is NOT MET as evidenced by: Based on interview and record review the facility failed to ensure care plans were revised timely for four residents (Residents #6, #14, #37, and #57) of 16 sampled residents. This is a repeat deficiency for this facility, with violations cited during the previous two recertification surveys, dated 10/30/24 and 12/4/23. Findings include: 1.Per a record review, Resident #6 has diagnoses that include anemia, GERD (gastro esophageal reflux disease), non-pressure chronic ulcer of the left foot, and other malaise, all indications that present a risk for weight loss. Per a record review, Resident #6 weighed 123.6 pounds on 12/7/25. Resident #6's next recorded weight of 114.4 pounds was taken on 12/22/25. The weight loss of 9.2 pounds or 7.4% in a 15-day period between 12/7/25 and 12/22/25 is a significant weight loss, per MDS (Minimum Data Set) guidelines. According to CMS (Centers for Medicare & Medicaid Services) for long-term care residents, a significant weight loss is defined as a loss of 5% or more of body weight in the last 30 days or 10% or more of body weight in the last 180 days (6 months). Per a record review, Resident #6 has a care plan approach dated 10/30/24 which states, "I am at risk for weight changes and altered fluid status D/T [due to] my variable meal intake r/t [related to] my physical limitations, as well as my cognitive/mood state." Resident #6 has a care plan approach dated 10/30/24, which states that she/he should be monitored for sudden weight loss. Per a record review, the facility dietician noted the weight loss in a progress note dated 12/29/25 at 3:15pm, "WEIGHT WARNING: Value: 114.4 [pounds] Vital Date: 2025-12-22 11:01:00. -3.0% change from last weight [7.4%, 9.2] -7.5% change [8.5%, 10.6]." Resident #6's care plan was not updated to reflect any interventions for the weight loss. Per an interview with the DON (Director of Nursing) on 1/13/26 at 1 pm, the DON stated that there should have been a progress note from the dietitian during the month of 12/25 addressing Resident #6's significant weight loss.	F0657	**F0657 Vernon Green has and will continue to comply with CFR(s): 483.21(b)(2)(i)-(iii), Care Plan Timing and Revision.** **What corrective action will be accomplished for those residents found to have been affected by the deficient practice;** Resident #6 Care plan updated to reflect current interventions for weight management. Resident #37 Care plan updated to reflect current fall risk interventions. Resident #14 Care plan updated to reflect current fall risk interventions. Resident #57 is deceased. **How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;** An audit was completed of care plans to ensure falls risk interventions, weight loss interventions and comfort care interventions are current. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur;** Education provided to staff responsible for care plan revision regarding revising the care plan as necessary when the residents plans of care change related to falls, weight and comfort measures. Audits will be completed weekly x 4 weeks then monthly for 3 months for all falls, weight changes and comfort care to ensure interventions are in place. **How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** Results of the audits will be discussed at monthly QAPI meetings for further recommendations. The Director of Nursing or designee will oversee compliance of the plan of correction. **Tag F0657 POC accepted on 4/8/26 by S. Stem**	**2/25/2026** **2/25/2026** **2/10/2026** **2/25/2026**

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F0657 SS = E	Continued from page 11 Per an interview with the dietician on 1/14/26 at 11:59 am, the dietician stated that she/he was aware of the weight loss incurred by Resident #6. The dietitian stated that in a discussion s/he had with Resident #6 about the current weight loss, the resident stated to the dietitian that s/he did not want an additional intervention and would like to wait and see if their weight increased. During the interview on 1/14/26 at 11:59 am, the dietitian stated, “I should have written a note about that, shouldn’t I.” 2.Per a record review, Resident #37 has diagnoses that include unspecified dementia of unspecified severity with other behavioral disturbance, repeated falls, history of falling, weakness, and unsteadiness on feet. Per a record review, Resident #37 has a care plan problem dated 3/31/25 that states, “I am at risk for falling R/T [related to] my decreased safety awareness.” Per a record review, Resident #37 sustained 8 documented falls between 9/29/25 and 12/27/25. Per a record review, Resident #37 sustained a fall on 9/29/25. A nursing progress note dated 9/29/25 at 8:31 pm states, “Resident sitting on floor next to wc [wheelchair] in former single room across the hall from current trip [triple] occupancy room. Appears to have lowered [him/her-self] to the ground.” Resident #37 sustained a fall on 10/17/25. A nursing progress note dated 10/17 pm at 5:47 pm states, “Unwitnessed, found on floor in bathroom of old room across hallway from current room; Unwitnessed fall.” Resident #37 sustained a fall on 11/8/25. A nursing progress note dated 11/8/25 at 11:52 pm states, “Resident found on floor next to bed. Unwitnessed fall; holding head with "goose egg"/presumed hematoma to left of apex of head; "I hit my head. I was trying to get into bed. I have a headache.” Resident #37 sustained a fall on 11/22/25. Per a nursing progress note dated 11/22/25 at 11:30 pm, “At 6:15p Lna [licensed nursing assistant] reported that [Resident #37] was on the floor on his head. Upon getting to hallway [s/he] was in front of [his/her] w/c on knees and forehead resting on [his/her] hat.” Resident #37 sustained a fall on 12/7/25. Per a nursing progress note dated 12/7/25 at 4:35 pm, “[Resident #37 fell forward out of w/c, redness to right knee. Denies pain. Witness and [s/he] did not hit [his/her] head. Staff assisted up to w/c and then [s/he] went to bed.” Resident #37 sustained a fall on 12/26/25. Per a nursing progress note dated 12/26/25 at 2:53 am states, “Resident seen sitting on the floor just outside of room - resident is naked with [his/her] brief to [his/her] thigh - resident assessed - incontinent of	F0657		

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F0657 SS = E	Continued from page 12 bowel and bladder - denies hitting head - " just my pride" very apologetic." Resident #37 sustained two falls on 12/27/25. A nursing progress note dated 12/27/25 at 1:01 pm states, "Observed by staff walking out of another patients room when [s/he] lost [his/her] balance and fell. Patient did not hit [his/her] head, no injuries noted." A nursing progress note dated 12/27/25 at 8:38 pm states, "PT attempting to get OOB [out of bed] at approx. [approximately] 2020 [8:20 pm] and rolled out of bed and onto floor before staff could assist. Did not hit head and no injuries noted." There were no new interventions documented in Resident 37's care plan subsequent to any of the above-mentioned falls. Per an interview with the DON (Director of Nursing) on 1/14/26 at 9:06 am, s/he confirmed that Resident #37's care plan should have been updated subsequent to each fall. 3.Per record review, Resident #14 has a Care Plan which identifies the resident as "at risk for falls related to decreased cognition, poor safety awareness, requiring encouragement to sit or rest." The four interventions listed in Resident #14's Care Plan to prevent future falls are all dated 12/5/2025. Review of Progress Notes for Resident #14 dated 1/4/26 reveal at 9:20 AM the resident was "Sleeping in chair, leaning forward and fell to the floor hitting their right frontal head on floor." The resident sustained a "quarter sized bump on right lateral forehead - ice applied." Further review of Resident #14's Care Plan revealed no updates to prevent future falls for the resident. Further review of Progress Notes for Resident #14 reveals 2 days later the resident fell again. Progress Notes record on 1/6/26 "At 4:30 this morning [Resident #14's] bed alarm could be heard. When staff went to check, [Resident #14] was sitting on the floor next to [h/her] bed… A quarter size abrasion is noted to the left side of [h/her] forehead." Further review of Resident #14's Care Plan again revealed no updates added to prevent future falls for the resident. An interview was conducted with the DON [Director of Nursing] on 1/14/26 at 9:06 AM.	F0657		

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F0657 SS = E	Continued from page 13 The DON confirmed Resident #14's care plan was not updated to prevent future falls after falls on 1/4/26 and 1/6/26. 4.Per review of Resident #57's medical record, they have a BIMS [Brief Interview of Mental Status] score of 99 as of 11/25/25 which indicates severe cognitive impairment. The resident was dependent on staff for ADLs [Activities of Daily Living] and hygiene. Resident #57 had medical diagnoses of dementia, history of TIA [Transient Ischemic Attack] and cerebral infarction, and MDD [Major Depressive Disorder]. Per review of a progress note dated 11/16/25 at 5:54 AM it states, "Called to [Resident]'s room, observed eyes closed skin warm and dry to touch, right side of [his/her] face drooping, nonresponsive, 107/88 99.8 92 18 o2 oxygen saturation] sat 95%. no mottling or edema, observed, [s/he] is moving around, picking [his/her] legs up, picking [his/her] nose." Per review of a progress note dated 11/16/25 it states, "[Resident #57] noted with facial droop. Resident is nonverbal but nurse suspects resident might have had a stroke. POA [Power of Attorney] was notified, does not wish to have resident transferred to hospital. Request to have comfort measures in place." Per review of a physician progress note dated 11/26/25 at 6:30 PM (occurred on 11/17/25 this is LATE entry) it states, "[Resident #57] was noted by staff yesterday to have left-sided facial droop and to be nonverbal. They had high suspicion of a cerebrovascular infarction at that time. They reach out to [his/her family representative] who is her DPOA and [s/he] did not want [him/her] transferred to the hospital at that time and preferred that [s/he] be started on comfort measures and to remain here at [facility]. Due to advanced dementia [Resident #57]'s quality of life had been declining over recent years and [his/her family representative] felt that any transfer to the hospital would be more traumatic than beneficial and would not have wanted any major interventions done if a condition was found." Per review of the facility's "Care Planning-Interdisciplinary Team" policy [last revised 11/28/23] it states, "Policy: Our facility's Care Planning/Interdisciplinary Team is responsible for the development of an individualized comprehensive care plan for each resident…3.The care plan is based on the resident's comprehensive assessment and is developed by a [sic] interdisciplinary team which includes, but is	F0657		

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F0657 SS = E	Continued from page 14 not necessarily limited to the following personnel: a. attending physician; registered Nurse who has a responsibility for the resident; c. Dietary Manager/Dietician d. Social Services Worker responsible for resident; e. Activity Director/Coordinator; f. Therapists (speech, occupational . recreational, etc.), as applicable; consultants (as appropriate); h. Director of Nursing (as applicable);i. Charge Nurse responsible for resident care; j. Nursing Assistants responsible for the resident's care; and k. others as appropriate or necessary to meet the needs of the resident." Per review of Resident #57's care plan, there is no information regarding the resident being placed on comfort care. An interview was conducted with the DON [Director of Nursing] on 01/13/26 at 3:59 PM. The DON confirmed that care plan was not updated to reflect comfort care stating, "I don't see it there."	F0657		
F0658 SS = D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is NOT MET as evidenced by: Based on observation interview and record review the facility failed to ensure professional standards were maintained regarding delegation of nursing duties for one of four sampled residents (Resident #5). This is a repeat deficiency for this facility, with violations cited during the previous two recertification surveys, dated 10/30/24 and 12/4/23.Findings include: Review of Prescribed Orders for Resident #5 include "Lidocaine External Patch 4 % (Lidocaine patch is a topical anesthetic used to stop pain,) Apply to left and right hip topically at bedtime on 12 hours. off 12 hours. and remove per schedule." Review of the Medication Administration Record [MAR] for Resident #5 for Jan. 12, 2026, reveals licensed nursing staff initialing as completed the application of Lidocaine patches to the left and right hip of Resident #5 at 8:00 PM on Jan. 12, 2026.	F0658	**F0658 Vernon Green has and will continue to comply with CFR(s): 483.21(b) (3)(i) Services Provided Meet Professional Standards.** **What corrective action will be accomplished for those residents found to have been affected by the deficient practice;** It was confirmed by the Director of Nursing with the Licensed Nurse that the patches were removed for Resident #5 on 1/13/26. **How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;** Education was provided to the Licensed Nurse regarding LNA Scope of Practice and Delegation of duties on 2/6/26. Medication Administration Competencies completed for Licensed Nurses responsible for medication administration. //	01/13/2026 02/06/2026 02/20/2026

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F0658 SS = D	Continued from page 15 An interview was conducted with the Staff Nurse for Resident #5 on Jan. 13 at 9:11 AM. The Staff Nurse stated ""the LNAs [Licensed Nursing Assistants] take off the lidocaine patches. I have no concern signing off [on the MAR regarding removing the Lidocaine patches] before I check [to see if LNAs removed the two patches.]" The Staff Nurse stated that no LNA had reported removing the lidocaine patches to h/her. The Staff Nurse then marked the electronic MAR order for the removal of the two lidocaine patches as completed at 7:59 AM on Jan. 13, 2026. Per observation on 1/13/26 at 9:14 AM the Staff Nurse then entered Resident #5's room to administer the resident their oral medications and did not check Resident #5 to remove the left and right Lidocaine patches before or after administering the medications and leaving the room. Per review of the National Guidelines for Nursing Delegation [Effective Date: 04/01/2019 Written by: American Nurses Association – National Council State Boards of Nursing -Jointly Adopted by: ANA Board of Directors / NCSBN Board of Directors], delegation "rights" include:The activity falls within the delegate's job description or is included as part of the established written policies and procedures of the nursing practice setting.The licensed nurse along with the employer and the delegate is responsible for ensuring that the delegate possesses the appropriate skills and knowledge to perform the activity.The licensed nurse is responsible for monitoring the delegated activity, following up with the delegate at the completion of the activity,The licensed nurse should ensure appropriate documentation of the activity is completed. Per record review, review of the facility's "Job description: Licensed Nurse Assistant" reveals no mention of assisting with medication administration.Review of 5 sampled LNA's training and competencies revealed no training regarding medication administration or assisting with medication administration for any of the 5 LNAs. An interview was conducted with the facility's Administrator on 1/13/26 at 12:24 PM. The facility's Administrator reported there are no Licensed Nursing Assistants in the facility that are certified/trained to assist with medication administration, including removal of lidocaine patches. Review of the "Vermont State Board of Nursing LNA [Licensed Nursing Assistant] Scope of Practice Statement" includes "An LNA may not perform activities	F0658	**F0658 Continued** **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur;** Education provided to Licensed Nurses and LNA's regarding LNA Scope of Practice and Delegation of duties. Random Medication Administration audits will be performed weekly x 4 weeks then monthly for 3 months. **How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** Results of the audits will be discussed at monthly QAPI meetings for further recommendations. The Director of Nursing or designee will oversee compliance of the plan of correction **Tag F0658 POC accepted on 4/8/26 by S. Stem**	**2/25/2026** **2/25/2026**

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F0658 SS = D	Continued from page 16 which exceed the scope defined by the level of licensure. This means that LNAs may not perform, even if directed to do so, an activity not appropriate to their level of licensure or otherwise prohibited by law." [References/Citations: 26 V.S.A. § 1592. Definitions: Administrative Rules 2.8 (c) Vermont Board of Nursing Position Statement: The Role of the Nurse in Delegating Nursing Interventions-Date of Initial acceptance: January 2011, Revised (Date) _ January 12, 2015, July 9, 2018]. An interview was conducted with the facility's Director of Nursing [DON] on 1/13/26 at 1:30 PM. The DON confirmed that there are no Licensed Nursing Assistants in the facility that are certified/trained to assist with medication administration. The DON further confirmed it is out of the scope of practice for the Staff Nurse to delegate a task to staff member unqualified and lacking the certification to perform the task, and out of the scope of practice for an LNA who is not certified as required to perform the delegated task. The DON confirmed that participating in medication administration, as in removal of a prescribed medication patch, was both out of an LNA's scope of practice and the LNA's job description. The DON further confirmed that the facility's "Medication Administration/Medication Errors" Policy and Procedure [Document ID: VACH-PP-1-6-623, Reissued 11/29/23] includes "Medications shall be administered in a safe and timely manner and as prescribed, in accordance with good nursing principles and practices and only by persons legally authorized to do so." The DON confirmed that the Staff Nurse delegating the medication patch removal to an LNA and then signing off on the Medication Administration Record that a Physician's Order was completed without verification was a violation of facility policy and not according to accepted professional standards.	F0658		
F0689 SS = D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and	F0689		

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F0689 SS = D	Continued from page 17 §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is NOT MET as evidenced by: Based on interview and record review the facility failed to ensure residents were free from accidents and hazards for two of 11 sampled residents (Residents #14 and #37). This is a repeat deficiency for this facility, with violations cited during the previous two recertification surveys, dated 10/30/24 and 12/4/23. Findings include: 1.Per record review, Resident #14 has a Care Plan which identifies the resident as “at risk for falls related to decreased cognition, poor safety awareness, requiring encouragement to sit or rest.” The four interventions listed in Resident #14’s Care Plan to prevent future falls are all dated 12/5/2025. Review of Progress Notes for Resident #14 dated 1/4/26 reveal at 9:20 AM the resident was “Sleeping in chair, leaning forward and fell to the floor hitting their right frontal head on floor.” The resident sustained a “quarter sized bump on right lateral forehead - ice applied.” Further review of Resident #14’s Care Plan revealed no new intervention added to prevent future falls for the resident. Further review of Progress Notes for Resident #14 reveals 2 days later the resident fell again. Progress Notes record on 1/6/26 “At 4:30 this morning [Resident #14’s] bed alarm could be heard. When staff went to check, [Resident #14] was sitting on the floor next to [h/her] bed… A quarter size abrasion is noted to the left side of [h/her] forehead.” Further review of Resident #14’s Care Plan again revealed no new intervention added to prevent future falls for the resident. An interview was conducted with the DON [Director of Nursing] on 1/14/26 at 9:06 AM. The DON confirmed there were no new interventions implemented to prevent future falls for Resident #14 after falls on 1/4/26 and 1/6/26. 2.Per a record review, Resident #37 has diagnoses that include unspecified dementia of unspecified severity with other behavioral disturbance, repeated falls,	F0689	**F0689 Vernon Green has and will continue to comply with CFR(s): 483.25(d)(1)(2) Free of Accident Hazards/ Supervision/Devices.** **What corrective action will be accomplished for those residents found to have been affected by the deficient practice;** Residents #14 and #37 care plan updated to include implementation of individualized, resident-centered interventions. **How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;** An audit was completed to ensure residents at risk of falls have appropriate individualized, resident-centered interventions in place. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur;** Education provided to Licensed Nurses regarding implementation of appropriate individualized, resident-centered interventions related to fall risk. Audits will be conducted weekly x4 weeks then monthly x3 months of residents with falls to ensure individualized, resident-centered interventions are in place. **How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** Results of the audits will be discussed at monthly QAPI meetings for further recommendations. The Director of Nursing or designee will oversee compliance of the plan of correction. **Tag F0689 POC accepted on 4/8/26 by S. Stem**	2/25/2026 2/25/2026 2/25/2026 2/25/2026

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Vernon Green Nursing Home	**61 Greenway Drive , Vernon, Vermont, 05354**

(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
F0689 SS = D	Continued from page 18 history of falling, weakness, and unsteadiness on feet. Per a record review, Resident #37 has a care plan problem dated 3/31/25 that states, “I am at risk for falling R/T my decreased safety awareness.” Per a record review, Resident #37 sustained 8 documented falls between 9/29/25 and 12/27/25. Per a record review, Resident #37 sustained a fall on 9/29/25. A nursing progress note dated 9/29/25 at 8:31 pm states, “resident sitting on floor next to wc [wheelchair] in former single room across the hall from current trip [triple] occupancy room. Appears to have lowered [him/her-self] to the ground.” Resident #37 sustained a fall on 10/17/25. A nursing progress note dated 10/17 pm at 5:47 pm states, “unwitnessed, found on floor in bathroom of old room across hallway from current room; Unwitnessed fall.” Resident #37 sustained a fall on 11/8/25. A nursing progress note dated 11/8/25 at 11:52 pm states, “Resident found on floor next to bed. Unwitnessed fall; holding head with "goose egg"/presumed hematoma to left of apex of head; "I hit my head. I was trying to get into bed. I have a headache.” Resident #37 sustained a fall on 11/22/25. Per a nursing progress note dated 11/22/25 at 11:30 pm, “At 6:15p Lna [licensed nursing assistant] reported that [Resident #37] was on the floor on his head. Upon getting to hallway [s/he] was in front of [his/her] w/c on knees and forehead resting on [his/her] hat.” Resident #37 sustained a fall on 12/7/25. Per a nursing progress note dated 12/7/25 at 4:35 pm, “[Resident #37 fell forward out of w/c, redness to right knee. Denies pain. Witness and [s/he] did not hit [his/her] head. Staff assisted up to w/c and then [s/he] went to bed.” Resident #37 sustained a fall on 12/26/25. Per a nursing progress note dated 12/26/25 at 2:53 am states, “resident seen sitting on the floor just outside of room - resident is naked with [his/her] brief to [his/her] thigh - resident assessed - incontinent of bowel and bladder - denies hitting head - " just my pride" very apologetic.” Resident #37 sustained two falls on 12/27/25. A nursing progress note dated 12/27/25 at 1:01 pm states, “Observed by staff walking out of another patients room when [he/she] lost [his/her] balance and fell. Patient did not hit [his/her] head, no injuries noted.” A nursing progress note dated 12/27/25 at 8:38 pm states, “PT attempting to get OOB at approx [approximately] 2020 [8:20 pm] and rolled out of bed and onto floor before staff could assist. Did not hit head and no injuries noted.” Per a record review, there were no documented interventions implemented in Resident #37’s care plan subsequent to any of the above listed falls.	F0689		

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F0689 SS = D	Continued from page 19 Per an interview with the DON (Director of Nursing) on 1/14/26 at 9:06 am, s/he confirmed that there should have been new interventions attempted after each fall.	F0689		
F0692 SS = D	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is NOT MET as evidenced by: Based on interview and record review the facility failed to ensure interventions were implemented after a significant weight loss for one of two sampled residents (Res #6).This is a repeat deficiency for this facility, with the violation cited during the previous recertification survey, dated 10/30/24. Findings include: Per a record review, Resident #6 has diagnoses that include anemia, GERD (gastro esophageal reflux disease), non-pressure chronic ulcer of the left foot, and other malaise, all indications that present a risk for weight loss. Per a record review, Resident #6 weighed 123.6 pounds on 12/7/25. Resident #6's next recorded weight of 114.4 pounds. was taken on 12/22/25. The weight loss of 9.2 pounds. or 7.4% in a 15-day period between 12/7/25 and	F0692	**F0692 Vernon Green has and will continue to comply with CFR(s): 483.25(g)(1)-(3) Nutrition/Hydration Status Maintenance.** **What corrective action will be accomplished for those residents found to have been affected by the deficient practice;** Resident #6 care plan updated to reflect current interventions regarding weight loss. **How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;** An audit was completed of care plans to ensure weight loss interventions are current.	02/25/2026 2/25/2026 2/25/2026

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F0692 SS = D	Continued from page 20 12/22/25 is a significant weight loss, per MDS (Minimum Data Set) guidelines. According to CMS (Centers for Medicare & Medicaid Services) for long-term care residents, a significant weight loss is defined as a loss of 5% or more of body weight in the last 30 days or 10% or more of body weight in the last 180 days (6 months). Per a record review, Resident #6 has a care plan approach dated 10/30/24 which states, “I am at risk for weight changes and altered fluid status D/T my variable meal intake r/t my physical limitations, as well as my cognitive/mood state.” Resident #6 has a care plan approach dated 10/30/24, which states that s/he should be monitored for sudden weight loss. Resident #6 has a care plan approach dated 10/30/24 that states “Weigh me per my physician's orders and chart. Report any significant weight changes to my MD/Family.” Per a record review, the facility dietician noted the weight loss in a progress note dated 12/29/25 at 3:15pm, “WEIGHT WARNING: Value: 114.4 [pounds] Vital Date: 2025-12-22 11:01:00. -3.0% change from last weight [7.4%, 9.2] -7.5% change [8.5%, 10.6].” Resident #6’s care plan was not updated to reflect any interventions for the weight loss. Resident’s #6’s record does not reflect notification of the MD or family with regard to the significant weight loss. Per an interview with the DON (Director of Nursing) on 1/13/26 at 1pm, the DON stated that there should have been a progress note from the dietitian during the month of 12/25 addressing Resident #6’s significant weight loss. Per an interview with the dietician on 1/14/26 at 11:59am, the dietician stated that s/he was aware of the weight loss incurred by Resident #6. In a discussion with Resident #6 about the current weight loss, the resident stated to the dietitian that s/he did not want an additional intervention and would like to wait and see if their weight increased. During the interview on 1/14/26 at 11:59am, the dietitian stated, “I should have written a note about that, shouldn’t I.”	F0692	**F692 Continued** **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur;** Education provided to staff responsible for care plan revision regarding revising the care plan as necessary when the residents plans of care change related to weight. Audits will be completed weekly x 4 weeks then monthly for 3 months for all weight changes to ensure interventions are in place. **How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** Results of the audits will be discussed at monthly QAPI meetings for further recommendations. The Director of Nursing or designee will oversee compliance of the plan of correction. **Tag F0692 POC accepted on 4/8/26 by S. Stem**	**2/25/2026** **2/25/2026**
F0726 SS = F	Competent Nursing Staff CFR(s): 483.35(a)(3)(4)(d) §483.35 Nursing Services The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide	F0726		02/25/2026

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F0726 SS = F	Continued from page 21 nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.71. §483.35(a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. §483.35(a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs. §483.35(d) Proficiency of nurse aides. The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. This REQUIREMENT is NOT MET as evidenced by: Based on interview and record review the facility failed to ensure there were competent nursing staff for one of five nurses and five of five Licensed Nursing Assistants in the sample. Findings include: 1.Review of the State of Vermont's "Title 26 : Professions and Occupations- Chapter 028 : Nursing Subchapter 004 : NURSING ASSISTANTS"," A person shall not practice nursing or nursing-related functions as defined in section 1641 of this subchapter without being licensed by the Board." The State of Vermont definitions include ""Nursing assistant" means an individual who performs nursing or nursing-related functions under the supervision of a licensed nurse" and "Nursing or nursing-related functions" means nursing-related activities as defined by rule, which include basic nursing and restorative duties for which a nursing assistant is prepared by education and supervised practice."	F0726	**F0726 Vernon Green has and will continue to comply with CFR(s): 483.35(a)(3)(4)(d) Competent Nursing Staff.** **What corrective action will be accomplished for those residents found to have been affected by the deficient practice;** The orientation checklist was obtained for the nurse and was dated 1/23/26 as completed. The facility does not employ medication administration LNAs, therefore no training medication administration is necessary. **How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;** An audit was completed to ensure all nursing staff have current completed competencies.	1/23/2026 **2/25/2026**

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F0726 SS = F	Continued from page 22 Per the State of Vermont statutes, in order for a Licensed Nursing Assistant to handle and administer medications to a nursing home resident, the Assistant must have “completed a Board-approved medication administration education program and an examination as set forth by rules adopted by the Board; and (C) is endorsed by the Board and authorized to administer medication in a nursing home.” The statutes further state a “Medication nursing assistant” means a licensed nursing assistant who is under the supervision of a nurse holding a currently valid endorsement authorizing the delegation to the nursing assistant of tasks of medication administration performed in a nursing home.” [Title 26: Professions and Occupations, Chapter 028: Nursing, Subchapter 004: NURSING ASSISTANTS, (Cite as: 26 V.S.A. § 1641) § 1641. Definitions, § 1644. Prohibitions; offenses.] Review of Prescribed Orders for Resident #5 include “Lidocaine External Patch 4 % (Lidocaine patch is a topical anesthetic used to stop pain,) Apply to left and right hip topically at bedtime on 12 hours. off 12 hours. and remove per schedule.” An interview was conducted with the Staff Nurse for Resident #5 on Jan. 13 at 9:11 AM. The Staff Nurse stated “"the LNAs [Licensed Nursing Assistants] take off the lidocaine patches.” The Staff Nurse stated that no LNA had reported removing the lidocaine patches to her. Per observation on 1/13/26 at 9:14 AM the Staff Nurse then entered Resident #5’s room to administer the resident their oral medications and did not check Resident #5 to remove the left and right Lidocaine patches before or after administering the medications and leaving the room. Per record review, review of the facility’s “Job description: Licensed Nurse Assistant” reveals no mention of assisting with medication administration. Review of 5 sampled LNA’s training and competencies revealed no training regarding medication administration or assisting with medication administration for any of the 5 LNAs. An interview was conducted with the facility’s	F0726	**F0726 Continued** **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur;** Education provided to nursing staff regarding having current competency evaluations. Audits will be completed for all new hires, and annually for all staff to ensure competencies are completed. **How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** Results of the audits will be discussed at monthly QAPI meetings for further recommendations. The Director of Nursing or designee will oversee compliance of the plan of correction. **Tag F0726 POC accepted on 4/8/26 by S. Stem**	**2/25/2026** **2/25/2026**

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F0726 SS = F	Continued from page 23 Administrator on 1/13/26 at 12:24 PM. The facility's Administrator reported there are no Licensed Nursing Assistants in the facility that are certified/trained to assist with medication administration, including removal of lidocaine patches. 2.Per review of employee training and competency files it was noted that a Registered Nurse who was hired on12/16/2025 had no proof that the facility had assessed her for skills competency. One of five Licensed Nursing Assistant's flies reviewed revealed no proof of competency assessment for 2024 and 2025. Per interview with the Director of Nursing on 1/14/2026 at 1:17 PM, S/He stated the RN is very new; and new staff are given a packet of competencies to go through with their preceptor and then they return them when they are done. The DON confirmed that the RN was working shifts and had not handed in her competencies yet. The DON also confirmed that the LNA did not have proof of competency for 2024 and 2025 competency packet and there was no evidence of training.	F0726		
F0759 SS = D	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is NOT MET as evidenced by: Based on observation and interview the facility failed to ensure the facility was free from medication errors greater than 5% with 2 errors in 32 opportunities [6.25%]. Findings include: Review of the facility's "Medication Administration/Medication Errors" Policy and Procedure [Document ID: VACH-PP-1-6-623, Reissued 11/29/23] reveals "Medications shall be administered in a safe and timely manner and as prescribed, in accordance with good nursing principles and practices..." 1). Review of Prescribed Orders for Resident #5 include "Lidocaine External Patch 4 % (Lidocaine patch is a	F0759	**F0759 Vernon Green has and will continue to comply with CFR(s): 483.45(f)(1) 483.45(f) Medication Errors.** **What corrective action will be accomplished for those residents found to have been affected by the deficient practice;** It was confirmed by the Director of Nursing with the Licensed Nurse that the patches were removed for Resident #5 and #44 on 1/13/26. Education was provided to the Licensed Nurse regarding LNA Scope of Practice and Delegation of duties.	1/13/2026

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F0759 SS = D	Continued from page 24 topical anesthetic used to stop pain,) Apply to left and right hip topically at bedtime- on 12 hours, off 12 hours and remove per schedule." Review of the Medication Administration Record [MAR] for Resident #5 for Jan. 12, 2026, reveals licensed nursing staff initialed as completed the application of Lidocaine patches to the left and right hip of Resident #5 at 8:00 PM on Jan. 12, 2026. Per interview with the Staff Nurse for Resident #5 on Jan. 13 at 9:11 AM, the Staff Nurse stated "I have no concern signing off [on removing the Lidocaine patches] before I check [to see if the two patches are present.]" The Staff Nurse stated that no LNA had reported removing the lidocaine patches to her. The Staff Nurse then marked the electronic MAR order for the removal of the two lidocaine patches as completed at 7:59 AM on Jan. 13, 2026. Per observation on 1/13/26 at 9:14 AM the Staff Nurse then entered Resident #5's room to administer the resident their oral medications and did not check Resident #5 to remove the left and right Lidocaine patches before or after administering the medications and leaving the room. 2). Review of Physician Orders for Resident #44 include "Lidocaine External Patch 4 % Apply to midback topically at bedtime for pain." Further orders include "Remove Lidocaine patch every AM (mid back)." Review of the Medication Administration Record [MAR] for Resident #44 for Jan. 12, 2026, reveals licensed nursing staff initialed as completed the application of Lidocaine patches to the mid back of Resident #44 at 8:00 PM on Jan. 12, 2026. Per observation on 1/13/26 at 9:24 AM the Staff Nurse then entered Resident #44's room to administer the resident their oral medications. During the medication administration, the Staff Nurse attempted to remove the lidocaine patch but was unable to locate it. The Staff Nurse was then observed initialing Resident #44's MAR as having completed the order to remove the lidocaine patch, without actually confirming the patch was ever present. An interview was conducted with the facility's Director of Nursing [DON] on 1/13/26 at 1:30 PM. The DON confirmed that neither order for Resident #5 or Resident #44's lidocaine patches were completed as ordered. The DON further confirmed the Staff RN was in error when documenting on the MAR that the removal of the patches were completed as ordered.	F0759	**F0759 Continued** **How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;** Medication Administration Competencies completed for Licensed Nurses responsible for medication administration completed. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur;** Education provided to Licensed Nurses and LNA's regarding LNA Scope of Practice and Delegation of duties. Random Medication Administration audits will be performed weekly x 4 weeks then monthly for 3 months. **How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** Results of the audits will be discussed at monthly QAPI meetings for further recommendations. The Director of Nursing or designee will oversee compliance of the plan of correction. **Tag F0759 POC accepted on 4/8/26 by S. Stem**	**2/25/2026** **2/25/2026** **2/25/2026**
F0812	Food Procurement,Store/Prepare/Serve-Sanitary	F0812		

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F0812 SS = F	Continued from page 25 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 failed to ensure cleanliness of the kitchen, the food prep area, and the dish storage area. Contamination from biological, chemical and/or physical means can have an adverse effect on all residents. Findings include: Per observation, during the initial tour of the kitchen on 1/12/2026 at approximately 11:10 AM, there was a large metal box style vent above and to the right of a rack of clean plate covers. Vent grates were covered in dust and several pieces of a white flaky substance. Per interview with a member of the kitchen staff on 1/12/2026 at 11:12 AM, s/he confirmed that the dust and/or pieces of flaky substance from the vent could fall onto the clean dishes and result in contamination. Per observation, during a follow up tour of the kitchen on 1/14/2026 at 8:45 AM, some ductwork, which had three vents, was running along the width of the kitchen, passing over food preparation area and dish washing stations. The three vent registers were covered in dark substances and dust.	F0812	**F0812 Vernon Green has and will continue to comply with CFR(s): 483.60(i)(1)(2) Food Procurement, Store/ Prepare/Serve-Sanitary.** **What corrective action will be accomplished for those residents found to have been affected by the deficient practice;** The air ducts were cleaned on 1.20.26 **How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;** All residents have the potential to be impacted **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur;** A monthly cleaning schedule will be maintained and monthly audit x 3 months will be completed on the cleanliness of air ducts.	**1/20/2026** 2/25/2026 2/25/2026

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(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
F0812 SS = F	Continued from page 26 Per interview with the kitchen manager on 1/14/2026 at 8:50 AM, s/he confirmed the dark substance and dust on the three vents had the potential to contaminate food preparation areas and the dishwashing stations. S/he did not know when the vents were last cleaned. Per interview, on 1/14/2026 at approximately 2:00 pm, the maintenance supervisor confirmed the kitchen vents needed to be cleaned.	F0812	F0812 Continued **How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** Results of the audits will be discussed at monthly QAPI meetings for further recommendations. The Assistant Administrator or designee will oversee compliance of the plan of correction. **Tag F0812 POC accepted on 4/8/26 by S. Stem**	02/25/2026
F0880 SS = E	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 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	F0880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 475008	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 01/14/2026

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F0880 SS = E	Continued from page 27 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 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 observation, interview and record review the facility failed to ensure appropriate infection prevention and control related to disinfecting a shared electric shaver that is used for multiple residents. Findings include: Per observations in the B-Wing shared shower room on 1/14/2026 at 9:16 AM an electric razor was noted on the shelf by the bathtub; this electric shaver did not have a resident name on it. At the time of the observation, the Registered Nurse confirmed that the shaver was used for multiple residents when they needed a shave. During an interview with 2 Licensed Nursing Assistants (LNAs) on 1/14/2026 at approximately 11:30 AM when asked who	F0880	**F0880 Vernon Green has and will continue to comply with CFR(s): 483.80(a)(1)(2)(4)(e)(f), Infection Prevention & Control.** **What corrective action will be accomplished for those residents found to have been affected by the deficient practice;** The electric razor was discarded. **How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;** Education provided to nursing staff regarding appropriate razor cleaning procedures and usage	**1/14/2026** **2/25/2026**

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F0880 SS = E	Continued from page 28 the electric shaver belonged to, they stated that it is used for residents who need a quick shave after their bath. The LNAs were asked about the cleaning method used between residents and they stated that they use an alcohol pad to clean it. Per review of the facility Infection Control Policy issued 3/16/2020 states that "equipment or items in the patient environment likely to have been contaminated with infectious body fluids must be handled in a manner to prevent transmission of infectious agents... Also, equipment or items in the patient environment likely to have been contaminated with infectious body fluids must be handled in a manner to prevent transmission of infectious agents (e.g., wear gloves for direct contact properly sterilize equipment before use on another patient)." Per interview on 1/14/2026 at 1:17 PM with the Director of Nursing, she had not been aware that staff were using this specific shaver, nor had she been aware that they were using the shaver for multiple residents. The Director of Nursing confirmed that the use of an alcohol pad was not an appropriate or effective way to clean the shaver between use.	F0880	**F0880 Continued** **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur;** Audits will be completed weekly x 4 weeks then monthly for 3 months to ensure appropriate razor usage and cleaning procedures. **How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** Results of the audits will be discussed at monthly QAPI meetings for further recommendations. The Director of Nursing or designee will oversee compliance of the plan of correction. **Tag F0880 POC accepted on 4/8/26 by S. Stem**	02/25/2026 02/25/2026
F0923 SS = E	Ventilation CFR(s): 483.90(i)(2) §483.90(i)(2) Have adequate outside ventilation by means of windows, or mechanical ventilation, or a combination of the two. This REQUIREMENT is NOT MET as evidenced by: Based on observation and interview the facility failed to ensure there was adequate mechanical ventilation on the memory care unit to prevent excessive buildup of mildew and urine odors. Findings include: During the initial tour of the licensed memory care unit (B-Wing) on 1/12/2026 at 11:28 AM a strong odor of mildew was noted on entrance to the unit. After walking by room #201 the mildew odor mixed with the smell of urine was present down the entire hall. The damp, mildew, urine smells remained throughout the length ogf the survey. During a walkthrough of B-Wing with the Director of Maintenance on 1/14/2026 at 10:16 AM he was asked about the dampness and musty smell in the air, he stated that some residents are incontinent and will try to go to the bathroom in all different places such as on the rug. The facility has carpet extractors that will clean the urine out of the rugs. When a resident is incontinent on the rug, staff try cleaning it right	F0923	**F0923 Ventilation** **Vernon Green has and will continue to comply with CFR(s): 483.90(i)(2), Ventilation.** **What corrective action will be accomplished for those residents found to have been affected by the deficient practice;** Room 201 carpet has been extracted, the carpet extraction schedule has been reviewed and updated and floor dryers shall be run at the time extraction and a log will be maintained to ensure ventilation system is working properly. **How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;** All B-wing resident have the potential to be impacted	02/25/2026 02/25/2026

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F0923 SS = E	Continued from page 29 away and also try to get it done in the evening time when everyone isn't walking around. When questioned if the rugs have enough time to dry, he expressed that it is difficult to get them to dry in the wintertime as they cannot open windows or run the HVAC (heating, ventilation, and air conditioning) as frequently as in the summer because it makes it too cold for the residents. He confirmed that the dampness and the odors have been an ongoing issue. When asked if he keeps a log of how often he runs the ventilation system he stated that no he did not.	F0923	F093 Continued **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur;** Audits will be completed weekly x 4 weeks then monthly for 3 months to ensure carpet extracting is taking place and the ventilation log is being maintained. **How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** Results of the audits will be discussed at monthly QAPI meetings for further recommendations. The Administrator or designee will oversee compliance of the plan of correction. **Tag F0923 POC accepted on 4/8/26 by S. Stem**	**2/25/2026** **2/25/2026**