VERMONT

AGENCY OF HUMAN SERVICES
DEPARTMENT OF DISABILITIES, AGING AND INDEPENDENT LIVING

Division of Licensing and Protection
HC 2 South, 280 State Drive
Waterbury, VT 05671-2060
http://www.dail.vermont.gov
Survey and Certification Voice/TTY (802) 241-0480
Survey and Certification Fax (802) 241-0343
Survey and Certification Reporting Line: (888) 700-5330
To Report Adult Abuse: (800) 564-1612December 21, 2022

January 6, 2023

Mr. Bradford Ellis, Administrator
Vernon Green Nursing Home
61 Greenway Drive
Vernon, VT 05354-9474

Dear Mr. Ellis:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **November 18, 2022 .** 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
Licensing Chief

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	475008	A. BUILDING _____ B. WING _____	C 11/18/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VERNON GREEN NURSING HOME	61 GREENWAY DRIVE VERNON, VT 05354

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E 000	Initial Comments An unannounced on-site Emergency Preparedness (EP) review was conducted in conjunction with the annual recertification survey, by the Division of Licensing and Protection from 11/13/2022 through 11/16/2022. There were no EP regulatory violations identified.	E 000	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 and State of Vermont *Licensing and Operation Rules for Nursing Homes*. 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	
F 000	INITIAL COMMENTS An unannounced on-site annual re-certification survey was conducted by the Division of Licensing and Protection from 11/13/2022 through 11/18/2022. The facility was found to have the following regulatory deficiencies:	F 000	such that the alleged deficiencies cited have been or will be substantially corrected on or before December 30, 2022. 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.	
F 656 SS=E	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized	F 656	**F 656** The facility has and will continue to ensure that it has established and will develop and implement a Comprehensive Care Plan **What corrective action will be accomplished for those residents found to have been affected by the deficient practice;** Resident #51 will have [his/her] care plan updated to reflect the healed open area. Resident #11's 06/20/2019 care plan, section B, states "I have glasses that I can wear, but I frequently choose not to". Care Plan is and has been developed for resident #11 vision status. Resident #53 was admitted to Vernon Green for respite care while her husband, her primary care giver, was here for Rehab. Resident #53 had a plan of care prior to admission for home and a plan of care for her return home was already in place.	12.23.2022 11.16.2022 11.16.2022

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: Executive Director | (X6) DATE: January 5, 2023

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 656	Continued From page 1 rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv) In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and record review it was determined that the facility failed to develop comprehensive person-centered care plans for 3 of 23 resident's in a standard survey sample (Resident #11, #51, and #53). Findings include: 1. Per record review Resident #51 was transferred to the hospital for evaluation after a fall on 9/29/2022. A potential stage l pressure ulcer was identified on the resident's coccyx while at the hospital. Upon return from the hospital the area was assessed as an open area however, a care plan to address actual skin breakdown was	F 656	Continued from page 1 **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 that having an open area have the potential to be affected by this practice; All residents that wear glasses have the potential to be affected by the practice; All residents being discharged have the potential to be affected by this practice. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur;** Director of nurses or designee will educate MDS Coordinator and Nurses to update care plans with changes to open areas, eyewear usage and discharge care plans. Director of nurses or designee will audit care plans for accuracy. **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?** The Director of Nursing or his/her designee will provide ongoing monitoring of this process to ensure compliance. Results of this audit will be brought to the QAPI meeting monthly and/or until 100% compliance is achieved. Tag F656 POC Accepted on 01/06/2023 by S.Freeman/P.Cota	11.16.2022 12.30.2022 12.30.2022

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F 656	Continued From page 2	F 656		

not implemented. A progress note written when the resident returned from the hospital on 9/29/2022 states "Upon return from the ED, [s/he] is noted to have an open area on [her/his] coccyx about the size of a pencil eraser. The skin is red and blanchable around it." A fax addressed to the resident's doctor written by the assistant director of nursing (ADON) on 10/11/2022 states area noted to right side of coccyx at this time: Stage lll slough to bed 1.2 x 2 cm and a stage ll 0.4 x 0.4 cm. Another fax dated 10/24/2022 states that the area is improving from last update with measurements of 1.9 X 1,1cm and 0.6 x 0.3cm. This was signed by the physician on 10/31/2022.

A care plan focus started on 7/14/2022 and edited on 10/27/2022 states Pressure Ulcer: I have the potential for skin breakdown r/t my incontinence and decreased mobility, as well as a decline in my ability to participate in my ADL (activities of daily living) care. Interventions included reflect care provided to prevent skin breakdown. However, there is no care plan for actual skin breakdown related to the resident's stage 3 pressure ulcer.

During interview on 11/16/2022 at 2:15 PM the MDS Coordinator confirmed that the resident's stage 3 coccyx wound should have been addressed in the care plan and that it was not.

See F-686

2. During observation of Resident #11 on 11/14/22 at 3:17 PM, it was noted that the resident did not have glasses on while sitting in his/her chair, in his/her room. On observation of the resident on 11/16/22 at 2:03 PM it was noted that the resident did not have glasses on while ambulating in their room with a walker.

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F 656	Continued From page 3 Interview with Licensed Practical Nurse (LPN) indicated that the resident does not consistently wear her/his glasses s/he takes them off frequently and can get angry and agitated if staff encourage her/him to put them on. The care plan does not indicate this information. Interview with Minimum Data Set (MDS) Coordinator, Registered Nurse (RN) on 11/16/22 at 2:45 PM confirms that resident's care plan does reflect that the resident wears glasses daily and that staff should assist her/him with them. The MDS Coordinator also confirmed that the care plan is not accurate related to the resident taking off her/his glasses frequently and becoming agitated when staff encourages her/him to put them on. 3. Record review on 11/15/22 revealed there was not a care plan for Resident #53's discharge from the facility. Interview on 11/15/22 at 1:45 PM with the MDS Nurse, confirmed there was not a care plan created for discharge planning. She/he stated that the discharge was managed by social services and activities and a care plan for discharge was not necessary. Interview on 11/15/22 at 2:00 PM with the Director of Nurses (DON) who stated she/he would expect a discharge care plan for a resident discharging home. The DON confirmed that a discharge care plan was not created. The DON also confirmed that she/he would expect this resident to have a discharge care plan.	F 656		
F 657 SS=D	Care Plan Timing and Revision	F 657		

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F 657	Continued From page 4 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 after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interview, it was determined that the facility failed to revise/update care plans as necessary to ensure person-centered goals for 1 of 23 residents in a standard survey sample. (Resident #4) Observation on 11/14/22 at approximately 10 AM	F 657	**F 657** The facility has and will continue to ensure that it has established and will develop and implement a Comprehensive Care Plan **What corrective action will be accomplished for those residents found to have been affected by the deficient practice;** Resident #4's communication book was added to the plan of care prior to end of survey. **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 that have tools to assist with care have the potential to be affected. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur;** Our clinical records do not indicate that Resident #4 is hard of hearing, uses a white board and/or has a walker as the resident has good hearing and non-ambulatory. As resident #4 does have a speech impediment, a communication book is available to facilitate communication with staff and/or family. Director of nurses or designee will educate MDS Coordinator and Nurses to update care plans with changes. Director of nurses or designee will audit care plans for accuracy. **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?** The Director of Nursing or his/her designee will provide ongoing monitoring of this process to ensure compliance. Results of this audit will be brought to the QAPI meeting monthly and/or until 100% compliance is achieved.	11.16.2022 11.16.2022 12.30.2022 12.30.2022

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F 657	Continued From page 5	F 657	Tag F657 accepted on 01/06/2023 by S.Freeman/P.Cota	

of Resident #4 who was sitting in a chair in her/his bedroom. Prior to entering the residents room, a staff nurse stated that the resident has a communication board in the basket of her/his walker that staff use it to communicate with her/him. The communication board was retrieved from the basket on her/his walker along with a black erasable marker.

Interview on 11/14/22 at approximately 10:05 PM with Resident#4, utilizing the communication board revealed that she/he is very hard of hearing. She/he had no complaints with the care she/he receives at this facility.

Review of Resident #4's care plan revealed a "Problem" and was listed as "Category: Communication I have Expressive aphasia secondary to my CVA [cerebral vascular accident]." The goal associated with this problem was revealed as "I will have my needs anticipated daily". The residents communication board was not listed on this or any other care plan created for this resident.

Interview on 11/16/22 at 9:50 AM with the facility's Social Worker (SW), it was confirmed that the resident had a communication board and a white board.

On 11/16/22 at 10:05 AM the SW brought a black book with pictures on a metal ring to the surveyor and explained that the resident "uses this book to show the staff what [pronoun omitted] would like by pointing to the pictures." When the SW was asked if this picture book is care planned the SW stated, "It should be".

On 11/16/22 at 10:12 AM the SW returned to the

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F 657	Continued From page 6 conference room and stated that she/he spoke with the MDS person and she/he stated, "It's in there now". It was confirmed on 11/16/22 at 10:15 AM by the SW that Resident #4's communication book and white board was not care planned until it was brought to the attention of the SW on 11/16/22.	F 657		
F 661 SS=D	Discharge Summary CFR(s): 483.21(c)(2)(i)-(iv) §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). (iv) A post-discharge plan of care that is developed with the participation of the resident and, with the resident's consent, the resident representative(s), which will assist the resident to adjust to his or her new living environment. The post-discharge plan of care must indicate where the individual plans to reside, any arrangements that have been made for the resident's follow up care and any post-discharge medical and non-medical services.	F 661	**F 661** The facility has and will continue to ensure that it has developed a discharge summary for residents being discharged from the facility. **What corrective action will be accomplished for those residents found to have been affected by the deficient practice?** Resident #53 was discharged from the Vernon Green on 09.06.2022 and continues to live in his/her home. **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 affected by this alleged deficient practice. **What measures will be put into place or what systemic changes you will make to endure that the deficient practice does not recur;** Resident #53 was admitted to Vernon Green for respite care while [his/her] spouse was here for short term rehabilitation services Resident #53 had a plan of care prior to admission with the same plan of care for their return home. Director of Nurses or designee will conduct Quality Assurance audits of discharged residents to assure the discharge summary has been completed.	11.16.2022 11.16.2022 12.30.2022

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F 661	Continued From page 7 This REQUIREMENT is not met as evidenced by: Based on record review and interview the facility failed to create a discharge summary including a recapitulation of the resident's stay for 1 of 23 residents in a standard survey sample. (Resident #53) Findings include: Record review on 11/15/22 of Resident #53's medical record revealed the facility did not create a discharge summary. The discharge summary is completed at the time of discharge and is to include 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, as well as discharge instructions for the resident and/or resident's caregiver(s). Interview on 11/15/22 at 1:45 PM with the Minimum Data Set (MDS) Nurse who stated that there was not a discharge summary in the residents medical record. Interview on 11/15/22 at 2:00 PM with the Director of Nursing (DON) who stated she/he would expect a discharge summary that included a recapitulation of the resident's stay and a final summary of the residents status, to include resident's discharge instructions and medications.	F 661	F 661 Continued from page 7 **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;** The Director of Nurses/designee will provide ongoing monitoring of this process to ensure compliance. Results of this audit will be brought to the Quality Assurance Performance Improvement committee meeting and/or until 100% compliance is achieved. Tag F661 POC Accepted on 01/06/2023 by S.Freeman/P.Cota	12.30.2022
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that-	F 686	**F 686** The facility has and will continue to ensure that residents receive treatment and services to prevent and heal pressure ulcers.	

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F 686	Continued From page 8 (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and record reviews the facility failed to ensure that 1 of 4 residents in the applicable sample (Resident #51) received necessary treatment and services consistent with professional standards of practice to promote healing, prevent infection, and prevent new ulcers from developing. Findings include: Per record review Resident #51 was transferred to the hospital for evaluation after a fall on 9/29/2022. A potential stage l pressure ulcer was identified on the resident's coccyx while at the hospital. Upon return from the hospital on 9/29/2022 a progress note states "Upon return from the ED, [s/he] is noted to have an open area on [her/his] coccyx about the size of a pencil eraser. The skin is red and blanchable around it." There were no measurements of the wound documented. Review of additional progress notes reveal that there was no further documentation regarding the residents coccyx wound until 10/9/2022, 10 days later. Progress notes regarding the wound continue on 10/5, 10/9, 10/14, 10/22, 10/24, 10/26, 10/27, 10/31, 11/1, and 11/3/2022. There is no further documentation in the progress notes regarding the coccyx wound after 11/3/2022.	F 686	F 686 continued from page 8 **What corrective action will be accomplished for those residents found to have been affected by the deficient practice?** Resident #51 was receiving treatment/and had signed physician orders for treatment to aid in the healing of the open area and was healed at the time of survey utilizing the ordered treatment plan. Area continues to be monitored to assure it remains healed. **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 affected by this alleged deficient practice. **What measures will be put into place or what systemic changes you will make to endure that the deficient practice does not recur;** The Director of Nurses or designee will audit treatments to assure all treatments are in the eMAR and care plan when ordered/active and are removed from the eMAR when no longer necessary. **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;** The Director of Nurses/designee will provide ongoing monitoring of this process to ensure compliance. Results of this audit will be brought to the Quality Assurance Performance Improvement committee meeting and/or until 100% compliance is achieved. Tag F686 POC Accepted on 01/06/2023 by S.Freeman/P.Cota	11.16.2022 11.16.2022 12.30.2022 12.30.2022

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F 686	Continued From page 9 A fax addressed to the resident's doctor written by the assistant director of nursing (ADON) on 10/11/2022 states area noted to right side of coccyx at this time: Stage lll slough to bed 1.2 x 2 cm and a stage ll 0.4 x 0.4 cm. The fax included a request to change the treatment to cleanse, apply Hydrofera Blue to wound bed every other day and cover with mepilex 4x4 Another fax dated 10/24/2022 states that the area is improving from last update with measurements of 1.9 X 1,1cm and 0.6 x 0.3cm. This was signed by the physician on 10/31/2022. A care plan focus started on 7/14/2022 and edited on 10/27/2022 states Pressure Ulcer: I have the potential for skin breakdown r/t my incontinence and decreased mobility, as well as a decline in my ability to participate in my ADL care. Interventions included reflect care provided to prevent skin breakdown. However, there is no care plan for actual skin breakdown related to the resident's stage three pressure ulcer. Resident #51 also has an active physician's order that states "UNNA boot dressing to right lower extremity. Apply mepilex absorbent dressing to dorsal aspect of right foot then wrap; Change UNNA boot dressing every three days on Mon, Wed, Fri." An ADL (activity of daily living) Functional / Rehabilitation Potential care plan reflects "I have recently developed some significant edema in bilateral lower extremities. I am at risk for infection, weight gain, decreased functional activity. Interventions include: Continue with f/u as scheduled and treatments to lower legs as ordered by [physician]. Monitor lower extremity circulation [every shift due to] Unna Boot	F 686		

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F 686	Continued From page 10 placement." During interview on 11/16/2022 at 2:15 PM the MDS Coordinator confirmed that there was no physician order for the coccyx wound in the Electronic Medical Record, there was no documentation of dressing changes being completed in the Electronic Treatment Administration Record, and the resident's coccyx wound was not addressed in the care plan. Per interview with the assistant director of nursing (ADON) on 11/16/2022 at 2:30 PM the resident does have a wound that is probably almost healed by now. The ADON stated that their last visit to assess was in October and s/he is going to go look at it now. This surveyor escorted to observe the wound. There was a mepilex dressing on the resident's coccyx with a date written on it in black marker that stated 11/9/2022, seven days prior to this change. There was a purple piece of Hydrofera Blue dressing and what appeared to be a closed wound with pinkish and purple border on the resident's coccyx. The ADON cleaned and measured the wound and stated that it was healing well. At this time the ADON confirmed that there was no Physicians order in the electronic medical record and that the nurses were not signing the treatments off in the electronic treatment administration record (TAR). During the observation the ADON was also asked if the resident had the Unna Boot treatment in place, s/he lifted up the resident's pant leg to look and stated "No, it is no longer needed." However, there is an active order and the care plan reflects that it is still in use. This was also confirmed by the ADON.	F 686		
F 689 SS=G	Free of Accident Hazards/Supervision/Devices	F 689		

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F 689	Continued From page 11 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 §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 staff interview and record review the facility failed to provide adequate supervision for 1 of 4 residents who were at risk for falls in the applicable sample (Resident #39). Findings include: Per record review Resident #39's care plan reflects that s/he is at risk for falls. On 12/20/2021 after s/he experienced a fall, a care plan intervention was added that states "ensure the resident is in line of sight of staff when out of room." S/he has since experienced falls on the following dates; 01/03/2022, 2/24/2022, 2/26/22, 2/28/22, 6/30/22, 7/3/22, 7/21/22, 7/29/22, 8/3/2022, 8/15/22 10:40 am, and 1:00 PM. The fall on 8/15/2022 resulted in a hip fracture. Review of the care plan reflects that the resident is at risk for falls. On 12/20/2021 after a fall, a care plan intervention was added to ensure the resident is in line of sight of staff when out of room. However, after 10 additional falls the resident continued to ambulate throughout the unit independently and without being in the line of sight at all times. The care plan had not updated to reflect a need for increased supervision or additional assistance prior to the last fall on	F 689	**F689** The facility has and will continue to ensure that residents are free of accident hazards. **What corrective action will be accomplished for those residents found to have been affected by the deficient practice?** Staff educated on the importance of following and updating the plan of care as they relate to falls. **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 affected by this alleged deficient practice. **What measures will be put into place or what systemic changes you will make to endure that the deficient practice does not recur;** As the survey team correctly documented, "care plan intervention [on 12/20/21] was added to ensure the resident is in line of sight of staff when out of room". The wording "at all times" was incorrectly stated by the survey team, as this phrase is not part of the 12/20/21 care plan intervention. It should also be noted that for two of the falls being cited, 2/26/22 and 7/29/22, there is no clinical record that a fall actually occurred by this resident on those dates. Therefore, the survey findings should reference eight falls and not the ten cited. Six of the eight falls being cited regarding resident #39 took place in the resident's room/bathroom with four of the bedroom falls being in close proximity to the resident's bed. Not indicated by the survey team is that a bed alarm was added to the resident's care plan on 1/3/2022. The 8/8/2022 progress note referenced by the surveyor team would indicate the resident was being correctly monitored by staff when out of his/her room. Physical therapy was being provided to resident #39 at the time of the 8/8/2022 progress note.	12.20.2022 11.16.2022

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F 689	Continued From page 12 8/15/2022 that resulted in a fractured hip. A progress note written on 8/8/2022 at 2:45 PM states "[Name omitted] is ambulating on the unit today with [her/his] rolling walker. [S/he] is leaning to the right while ambulating. [Her/his] walker is drifting to the right as well, and [s/he] is often bumping into objects. On 8/15/2022 at 10:40 am the resident was "found by a [Licensed Nurse Assistant] (LNA) in [her/his] bathroom on the floor. [S/he] was laying on [her/his] right side, holding [her/his] walker which was also laying on it's side. The walker was facing backwards. [S/he] complained of a sore hip from being on the floor. She was able to move all extremities. [S/he] denied hitting [her/his] head. When [s/he] was stood up with 3 assist, [s/he] went pale, became clammy and passed out. [S/he] did not fall at that time. This writer held [her/him] up by placing [her/him] on a knee. [S/he] came to moments later..." On 8/15/2022 at 1:00 PM, "[Name omitted} attempted to stand from [her/his] wheelchair. [S/he] fell, hitting [her/his] head on the floor. [S/he] landed again on [her/his] right side. [S/he] reports increasing discomfort in [her/his] right hip. [Her/his] right leg appears to be a half inch shorter than the left. [S/he] has a skin tear to the right external elbow, and complaints of a headache... [Name omitted} will remain one-on-one with staff." During an interview with the MDS Coordinator on 11/16/2022 at 11:20 AM s/he stated that s/he and the Assistant Director of Nursing are responsible for updating the care plan as needed. When asked how s/he knew when the care plan needed to be updated s/he stated that the ADNS will tell her/him or s/he gets information from staff on the unit. The MDS Coordinator also confirmed that	F 689	F689 continued from page 12 Staff have been educated on the monitoring of residents with increased fall risks. Staff have been educated on proper documentation to show their interventions with resident regarding the assistance provided. Residents will be monitored for increased assistance. **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;** The Director of Nurses/designee will provide ongoing monitoring of this process to ensure compliance. Results of this audit will be brought to the Quality Assurance Performance Improvement committee meeting and/or until 100% compliance is achieved. Tag F689 POC Accepted on 01/06/2023 by S.Freeman/P.Cota	12.30.2022 12.30.2022

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F 689	Continued From page 13 the resident's care plan did not reflect a need for assistance or increased supervision from being in line of sight when out of room.	F 689		
F 812 SS=D	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined that the facility failed to store resident foods seperate from staff foods and opened beverages were not dated for 1 of 2 kitchenettes. Observation on 11/13/22 at 8:40 PM of 1 kitchenette refrigerator revealed an opened and undated bottle of light cranberry juice - 64 ounce; a bottle of lemonade on the door with the first name written on the side of the bottle; a bottle of soda that had been opened and was not dated	F 812	**What corrective action will be accomplished for those residents found to have been affected by the deficient practice?** Meals and drinks were sealed and labeled. Staff meals were removed from resident refrigerator No potential for harm or harm occurred with this practice. **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 affected by this alleged deficient practice. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur;** Staff will be educated on storing of their meal items in the staff refrigerator in the staff lounge. Staff have been educated on proper storage of their food items and to dating all open items. Director of Nurses or designee will audit to assure there is no comingling of food items. **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;** The Administrator/or designee will provide ongoing monitoring of this process to ensure compliance. Results of this audit will be brought to the Quality Assurance Performance Improvement committee meetings and/or until 100% compliance is achieved. Tag F812 POC Accepted on 01/06/2023 by S.Freeman/P.Cota	11.16.2022 11.16.2022 12.30.2022 12.30.2022

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F 812	Continued From page 14 and did not have a persons name on it; a box of thickened water that was open and was not dated; and a paper plate with another paper plate on top, wrapped in plastic wrap with the same first name on the bottle of lemonade (referenced above) was written on the plastic wrap on the top of the plate; a paper plate with another paper plate on top and wrapped in plastic wrap with a different persons name was written on the plastic wrap on the top. Interview on 11/13/22 at 8:55 PM with an Licensed Practical Nurse (LPN) who confirmed the fridge in the kitchenette was for residents. She/he stated that staff have their own designated fridge in the staff breakroom and staff food and drink should not be commingled with resident food. The LPN confirmed that the thickened water and light cranberry juice were opened and not dated. The LPN confirmed that the bottle of lemonade and the bottle of soda belonged to staff, and the 2 paper plates were staff meals as well.	F 812		
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(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(i) Medical records. §483.70(i)(1) In accordance with accepted	F 842	F842 **What corrective action will be accomplished for those residents found to have been affected by the deficient practice?** Residents code status changed when inpatient at another facility and the form was in the discharge packet upon return. Upon finding said form, a discussion was had with the resident, family and MD and a decision for DNR was initiated and the correct form is now in the resident's chart.	11.16.2022

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F 842	Continued From page 15 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(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (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(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(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.	F 842	F842 continued from page 15 **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 affected by this alleged deficient practice. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur;** Social Services will on admission obtain/discuss code status with responsible parties. If not obtained on admission, Social Services will continue to work with the responsible parties and MD to obtain code status. All resident records will be reviewed by the Director of Social Service to assure clinical records are accurate per the residents' code status. **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;** Social Services will provide ongoing monitoring of this process to ensure compliance. Results of this audit will be brought to the Quality Assurance Performance Improvement (QAPI) meetings and/or until 100% compliance is achieved. Tag F842 POC Accepted on 01/06/2023 by S.Freeman/P.Cota	11.16.2022 12.30.2022 12.30.2022

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F 842	Continued From page 16 §483.70(i)(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. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility failed to ensure that records are complete, accurately documented, readily accessible, and systematically organized related to a resident's Advanced Directives for 1 of 23 sampled residents (Resident # 39). Findings include: Per record review Resident #39's Physician ordered code status reflected in the electronic medical record (EMR) is "Full Code" indicating that if the resident were to experience cardiac or respiratory arrest, s/he would want life sustaining measures performed in attempt to prolong their life. Per review of the resident's COLST (Clinicians Orders for Life Sustaining Treatment) located in the resident's paper chart, the resident's desired code status is a DNR (Do not Resuscitate). During interview with the unit Licensed Practical Nurse (LPN) on 11/15/22 at 2:03 PM s/he confirmed that the physicians order in the EMR was "full code" and the COLST form indicating that the resident's code status was DNR did	F 842		

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F 842	Continued From page 17 contraindicate each other. When asked how a nurse would determine treatment in the event of an arrest s/he stated that they would refer to the documented code status "flagged" on the EMAR (electronic medication administration record) or look to the COLST form in the paper chart. When the resident's EMAR was reviewed with this LPN, the place where the code status would be flagged was blank, there was no code status indicated.	F 842		
F 880 SS=D	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 §483.70(e) 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:	F 880	**F 880** The facility has and will continue to ensure that it has established and will maintain an infection prevention and control program. **What corrective action will be accomplished for those residents found to have been affected by the deficient practice?** Staff have and will continue to use COVID rapid response test if symptomatic, unvaccinated and/or testing is required by the facility to reduce resident exposure to potential COVID infections. **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 affected. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur;** The facility's Director of Nursing and/or the Infection Control nurse will conduct training sessions on the appropriate procedures for the use of COVID rapid response testing kits with all the facilities staff. All staff have been assigned training for Infection Control and Prevention training.	

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F 880	Continued From page 18 (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility 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:	F 880	F880 continued from page18 **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;** The Director of Nurses or designee will provide ongoing monitoring of this process to ensure compliance. Results of this audit will be brought to the QAPI meeting monthly and/or until 100% compliance is achieved. Tag F880 POC Accepted on 01/06/2023 by S.Freeman/P.Cota	

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F 880	Continued From page 19	F 880		

Based on observations, interviews and review of facility documentation, the facility failed to maintain their infection prevention process to prevent the development and transmission of communicable diseases and infections.

Findings include:

On 11/16/22 at 10:30 AM while enroute to the bathroom, upon entrance to a locker/storage room and attached bathroom located in the A Unit resident hall, next to a conference room, surveyors observed a used COVID-19 Polymerase Chain Reaction (PCR) test card on the carpeted floor. The card contained the nasal swab placed for testing purposes. Test results were "positive" for COVID-19 indicated by two red lines in the results window of the card.

The (Minimum Data Set) MDS assessment coordinator observed the test on the floor and positive results. S/he was not aware of who's test this was and confirmed that it should not have been left on the floor, and that testing is to be done in a room located at the front of the building before entering resident care areas. S/he proceeded to find a receptacle to dispose of the test card. In the meantime, a Licensed Nurse Assistant (LNA) entered the room, looking for the test and noticed it on the floor. S/he proceeded to bend forward to pick it up without wearing gloves. S/he was wearing an N95 mask, as the facility had a handful of residents who were positive for COVID-19. A surveyor questioned the LNA as to why s/he was attempting to pick up the card ungloved and who the card belonged to. The LNA was aware that the test was positive and who it belonged to. S/he had received a phone call from a co-worker located outside of the building to find

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	475008	A. BUILDING _____ B. WING _____	C 11/18/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VERNON GREEN NURSING HOME	61 GREENWAY DRIVE VERNON, VT 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
F 880	Continued From page 20	F 880		

the card because s/he dropped it. The LNA was "not thinking" when she attempted to pick up the card ungloved and would not reveal the coworkers name but stated that the Director of Nursing (DON) knew who this employee was.

The Director of Nursing (DON) was conversing with someone in an office behind closed doors at the time of this incident, which was discussed after, with surveyors. The DON confirmed who the staff member was. S/he had lost the card after retesting. This person had initially tested positive a few weeks ago. Per review of employee immunization documentation, nursing work schedules and COVID-19 Policies and procedures, this employee was immunized with two COVID boosters as well as the LNA who attempted to pick up the positive test card. The employee who lost his/her test card had worked on 11/03/22 from 5:21 am-2:01 PM, tested positive later, and was out of work until 11/12/22 (10 days). S/he proceeded to randomly test with positive results on 11/16/22 the same day s/he lost the test card found by surveyors. This staff member did not display symptoms per the DON.

Facility policy Titled: COVID-19 Testing and Cohorting (05/04/20) state under paragraph Testing: indicates "Staff with a positive COVID-19 test result are able to come off isolation and return to work on day 6 if they are asymptomatic for at least 24-hours and two consecutive negative test results."

The other policy, Novel Coronavirus (2019-nCoV) employment Management (Origination Date 03/23/20, Issue date 09/22/22) under paragraph, Employee Return to Work Criteria states the same information as the above policy.

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F 880	Continued From page 21 According to Vermont State Long Term Care Guidance for Operations During COVID-19 Health Emergency (10/19/22). If COVID-19 is confirmed, staff should follow Centers for Disease Control and Prevention (CDC) guidelines "Criteria for Return to Work for Healthcare Personnel with SARS-CoV2 Infection." Which includes the following: Health Care Professionals (HCP) with mild to moderate illness who are not moderately to severely immunocompromised could return to work after the following criteria have been met: At least 7 days have passed since symptoms first appeared if a negative viral test* is obtained within 48 hours prior to returning to work (or 10 days if testing is not performed or if a positive test at day 5-7 HCP who were asymptomatic throughout their infection and are not moderately to severely immunocompromised could return to work after the following criteria have been met: At least 7 days have passed since the date of their first positive viral test if a negative viral test* is obtained within 48 hours prior to returning to work (or 10 days if testing is not performed or if a positive test at day 5-7. In addition to the above, per Vermont State Long Term Care Guidance, "testing is not necessary for asymptomatic people who have recovered from SARS CoV-2 infection in the prior 30 days. Testing should be considered for asymptomatic individuals who have recovered in the prior 31-90 days using an antigen test instead of a nucleic	F 880		

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F 880	Continued From page 22 acid amplification test (NAAT). This is because some people may remain NAAT positive but not be infectious during this period." Interview on 11/16/22 at 11:35AM with the DON, confirms that staff COVID-19 testing should have been done in an area located before entrance to resident care areas and although an accidental misplacement, the test card should have been disposed of properly and if handled by a non-tester, the correct Personal Protective Equipment (PPE) i.e., mask, gown, and gloves should have been worn. The asymptomatic employee that tested positive on day 14 was well past the return date for work which does follow the guidance according to Vermont State Guidance and the Centers for Disease Control (CDC), however, the facility policies and procedures conflict with this guidance because of the different time frames for return to work and the need for two consecutive negative test results. Both facility policies have not been revised as necessary to reflect the most current Vermont State and CDC guidance.	F 880		