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) 564-1612

January 3, 2024

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 recertification survey conducted in conjunction with a complaint investigation on **December 4, 2023.** 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

Enclosure

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 12/04/2023

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
E 000	Initial Comments The Division of Licensing and Protection conducted an annual emergency preparedness survey on 11/30/023. The facility was found to be in substantial compliance with emergency preparedness regulations.	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 Operations Rules for Nursing Homes. Vernon Green Nursing Home has or will have substantially corrected and 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 January 6th 2024. The statements made on this plan of correction are not an admission to and do not constitute n agreement with the alleged deficiencies herein. To continue to remain in substantial compliance with the state and federal regulations, Vernon Green Nursing Home has taken or will take the actions set forth in this plan of correction.	
F 000	INITIAL COMMENTS An unannounced onsite annual rectification survey was conducted in conjunction with one investigation of a facility reported incident Federal Complaint # VT 00020861 on 11/27/2023 - 12/4/2023 to determine compliance with 42 CFR Part 483 requirements for long-term care facilities. On 11/27/2023, the survey team identified and notified the facility of deficiencies at the Immediate Jeopardy (IJ) level at F689 related to unsafe water temperatures. The IJ Template was provided to the Administrator (LNHA) on 11/27/23 at 1:55 PM. The IJ was found to be removed on 11/30/2023, prior to the conclusion of the recertification portion of the survey. An on-site extended survey was conducted between 11/30/23 - 12/4/23, due to a determination of substandard quality of care. There were regulatory findings as a result of this survey.	F 000		
F 550 SS=E	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each	F 550	**F-550 Vernon Green has and will continue to comply with CFR(s): 483.10 (a)(1)(2)(b)(1)(2) maintaining Residents Rights/Exercise of rights.**	1/6/24

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: M. Bradford Ellis
TITLE: Executive Director
(X6) DATE: 12.29.23

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 550	Continued From page 1	F 550		

resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident.

§483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source.

§483.10(b) Exercise of Rights.
The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States.

§483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility.

§483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart.
This REQUIREMENT is not met as evidenced by:
Based on observation, resident interview, staff interview, and record review, the facility failed to provide a respectful and dignified dining experience that enhances residents' quality of life as evidenced by failure to serve meals to residents at a table at approximately the same time, and the facility failed to ensure care was

What corrective action will be accomplished for those residents found to have been affected by the deficient practice;

- Resident # 33 was given a urinal & a bedpan for resident's toileting needs
- Resident # 33 was seen by Social Service to ensure resident # 33 was being offered the urinal and/or bedpan and that resident #33 was no longer feeling humiliated and residents # 33 toileting needs were being met.
- Resident #26, Resident #22 & resident #20 were not able to be identified on the Sample list provided by Department of Public Health.

How you will identify other residents having the potential to be affected by the same deficient practice and what corrective actions will be taken.

- Interviews will be conducted with those residents that have a BIMS of 12 or higher to identify that their toileting needs are being met.
- All resident that sit together could be potentially affected by this practice of not serving all resident meals together.

What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur;

- Education to nursing staff on providing residents with respect and dignity related to toileting needs.
- Education to staff on dining process with serving all residents at the same time that are sitting together at the same table so that residents can experience a respectful and dignified dining experience.

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provided to residents with respect and dignity as evidenced by the failure to assist with care related to toileting for one 1of 25 sampled residents (Resident #33).

Findings include:

1. Per record review, Resident #33 has resided at the facility since 10/17/2022 with diagnoses that include Depression, muscle weakness, and a BIMS of 12 (A cognitive screening measure that evaluates memory and orientation indicating moderately impaired cognition).

Per interview with Resident # 33 on 11/27/2023 at approximately 2:10 PM, Resident # 33 expressed feeling "humiliated" about being incontinent of urine and feces. S/He is not offered the bedpan, urinal, or bathroom but is instructed to go "in my underwear, and they will clean me.", stating "I know I'm a lot of work, and I feel bad if I ask for help; I'm a veteran and fought for my country; this feels bad." The resident was noticeably upset while speaking of this.

Per interview on 11/28/2023 at 2:49 PM, Licensed Nursing Assistant (LNA) #1 stated Resident #33 is moved to the bed by using a mechanical lift that requires two people to use and then assisted to use the bedpan. S/he says," A bedpan is kept in the bathroom for that purpose." S/he was unable to produce a bedpan when asked.

Per interview on 11/28/2023 at 2:53 PM with LNA #2, s/he explained they may try to provide toileting or the bedpan to Resident # 33, "but it's hard, s/he is a Hoyer lift, and we need a second person, so s/he wears an incontinence brief, it makes it easier ... We don't have the staff to

- Audits will be done of those residents that score a 12 or higher on their BIMS for meeting toileting needs. 20% will be interviewed weekly x4 then monthly x3 thereafter to ensure compliance.
- Meal observation audits will be completed 2x a week for 4 weeks during different meal services then every other week x 1 month then monthly x3 thereafter to ensure compliance.

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 and/or until 100% compliance is achieved.

Tag F 550 POC accepted on 1/3/24 by N. Baker/P. Cota

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manage the residents who need the Hoyer to move them ... Usually, s/he is incontinent anyway by the time we return, so we just put her/him on the bed and change her/him."

On 11/29/2023 at 1:28 PM, two LNAs were observed checking Resident #33's incontinence brief. S/he was incontinent of urine and was not assisted to use a bedpan or urinal.

Per interview with LNA on 11/29/2023 at approximately 1:45 PM, the LNA stated that Resident#33 was already incontinent, so they provided incontinent care and did not offer the resident assistance using the urinal.

On 11/28/2023 at approximately 3:25 PM, the Director of Nursing confirmed that it was undignified and disrespectful to Resident #33 to instruct her/him to urinate in his incontinence briefs and not assist her/him to use the urinal or bedpan.

2. Per observation of the dinner meal on 11/27/23 at approximately 5:30 PM, Resident #26 was sitting at a table with another resident. Resident #26 had been served their meal but was not eating. This was noticed by a staff member who asked Resident #26 why they weren't eating. Resident #26 stated "I'm waiting for [them] to get [their] tray before I eat" and pointed to the other resident sitting at the table who had not yet been served.

Shortly after, Resident #22 was observed sitting at a large table with 5 other residents. All 5 of the other residents had been served their meals and were eating. Resident #22 was visibly upset with a scowl expression and tense body language.

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F 550	Continued From page 4 Some of the other residents at the table were observed giving small bits of their own food to Resident #22 on a napkin. When interviewed, Resident #22 stated "my tray is at the bottom of the [meal tray] cart. I always get served last, even while the rest of the table has their food." It was another several minutes before Resident #22 was served their dinner meal. Per observation of the lunch meal on 11/28/23 at approximately 11:30 AM, Resident #20 was observed sitting at a table with two other residents. Resident #20 had not been served the lunch meal. One of the other residents at their table had eaten half of their lunch while the second resident had just been served. When asked how long they had been waiting for their lunch meal, Resident #20 stated that it had been several minutes. "I usually don't mind waiting but I really like the cheeseburgers, so I hope that I get mine soon." It was another two minutes before a staff member noticed that Resident #20 did not have their lunch yet. In between the other two residents at the table receiving their lunch and Resident #20 receiving their lunch, a separate table of 4 residents had been served. Per interview on 11/28/23 at approximately 3:30 PM, the Director of Nursing confirmed that these residents had not been served their meals in a dignified manner.	F 550		
F 600 SS=G	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,	F 600	**F-600 Vernon Green has and will continue to comply with CFR(s): 483.12 (a)(1), free from Abuse and Neglect.**	1/6/24

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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 observations, interviews, and record review, the facility failed to protect the resident's right to be free from sexual abuse by a resident for 1 of 25 residents in the sample (Resident # 19), and the facility failed to protect the resident's right to be free from neglect for 1 of 25 residents in the sample (Resident #33). Findings include:

1. Per record review, Resident #19 has diagnoses that include major depressive disorder, advanced dementia with behavioral disturbances, and delusional disorders. Resident # 19's Activities of Daily Living (ADL)/Rehab Potential care plan reflects that s/he requires extensive to total staff assistance with ADLs. Review of Resident #19's Behavioral Symptoms care plan reveals that s/he wanders about the unit in her/his wheelchair. An MDS (Minimum Data Set, an assessment tool used for implementing standardized assessment and for facilitating care management in Long Term Care) dated 9/22/23 states that Resident #19 was unable to participate in the BIMS (Brief Interview for Mental Status) assessment due to severe cognitive impairment. Per Reveiw of the facility internal investigation a witness statement written by a

F 600

What corrective action will be accomplished for those residents found to have been affected by the deficient practice;

- Resident #19 now has an "At Risk" for sexual abuse care plan in place
- Resident #19 now has a "victim" Care plan in place
- Resident #53 Aricept was discontinued on 8.12.23
- Resident #53 has had no recent sexual inappropriateness towards any residents or staff since the D/C of Aricept
- Resident # 33 was given a urinal & a bedpan for resident's toileting needs.
- Resident # 33 was seen by Social Service to ensure resident # 33 was being offered the urinal and/or bedpan and that resident #33 did not have any psychological harm and that toileting needs were being met.

How you will identify other residents having the potential to be affected by the same deficient practice and what corrective actions will be taken.

- Interviews will be conducted with those residents that have a BIMS of 12 or higher to identify that their toileting needs are being met.
- Review of the last 30 days of nurses notes will be completed to see if any resident(s)have had any sexual behaviors and if so then if the behavior was addressed & the physician notified of behaviors.

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licensed nursing assistant (LNA)dated 8/12/23 states "I came out of [another resident's room] and saw (Resident #19) chair in [Resident #53's room], so I went to remove [him/her]. As I came around the corner I saw (Resident #53) holding (Resident #19) by the wrist, as (Resident #53) mastersterbated in close proximity to (Resident #19) face. Resident #19 appered to be covered in urine from the chest down. Resident #53's pant legs were soaked as well. (Resident #19) was removed from the room and (Resident #53) was put back to bed." A nurse progress note written on 8/13/23 at 8:38 PM reveals that the day after the incident Resident #19 "was monitored and redirected all shift attempting to go into other residents' rooms several times. Wandering excessively all shift, very unsettled .... Had to be kept in Rose room for supper due to excessive wandering, attempted several unsafe risings during the shift from his/her wheelchair, continued to redirect and occupy resident all shift. Very resistant and combative during HS [hour of sleep] care."

Per resident care plan dated 9/21/23 Resident #19 " I may look to "go home", and may wander about the unit in my wheelchair looking for away out, and I may be difficult to redirect at times. Without meaning to, I may wander into other's personal spaces.... I may be resistive or combative with care. I may become combative/aggressive with attempts at redirection or repositioning in my wheelchair." Further record review reveals that Resident #19's care plan last updated on 9/21/23 does not reflect that s/he is vulnerable to, at risk for, or an actual victim of abuse after the 8/12/23 incident. The care plan also has no interventions in place to protect Resident #19 from further incidents of abuse.

F 600

What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur;

- Education to staff on proper interventions being implemented to protect residents if another resident is experiencing sexual behaviors
- Education to staff that physicians need to be notified of residents that are having any sexual behaviors.
- Education to nursing staff on providing residents with respect and dignity related to toileting needs.
- Audits will be done of those residents that score a 12 or higher on their BIMS for meeting toileting needs. 20% will be interviewed weekly x4 then monthly x3 thereafter to ensure compliance.
- Nurses notes will be reviewed at the Morning Interdisciplinary Meeting to identify if any residents exhibited any sexual behavior towards residents and/or staff and also to determine if the physician was notified.
- Behavior meetings will be completed weekly.

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 and/or until 100% compliance is achieved.

Tag F 600 POC accepted on 1/3/24 by N. Baker/P. Cota

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F 600	Continued From page 7 Per review of Resident #53's medical record, s/he has a diagnosis of Alzheimer's disease and had been exhibiting a recent increase in sexual behaviors toward staff and other residents. An MDS quarterly assessment dated 7/27/23 reflects that Resident #53 has a BIMS score of 3 indicating severe cognitive impairment. S/he ambulated independently with a walker. Per a Nursing Progress Note dated 8/7/2023 a new physician order was recieved on 7/31/23 to increase daily Aricept to 10 mg. The Progress Note states that Residnet #3 "had some copies of clinic notes in chart that came from "The Memory Clinic". The notes state that "7/15/19 Aricept 10 mg seemed to precipitate an increase in agitation in patient." The Physician was notified of the notes from the Memory Clinic and nursing will continue to document every shift to monitor x 21 days. Nurses progress notes written between 8/8/23 and 8/13/23, both prior to and after the incident reflect that Resident #53 had required redirection by staff due to sexual comments and requests made to staff and other residents, fondling her/his own genitals, touching staff's buttocks and crotch areas, and attempting to kiss staff and another resident. A nurses progress note written on 8/12/23 at 2:22 PM states "Since 7/31/23 [Resident #53] has had a documented increase in sexual libido and acting on urges in inappropriate places ..." The progress note also reflected that Resident #53's bed alarm should be re-positioned to the end of the bed to ensure that s/he cannot turn it off, alerting staff to his/her movement within his/her room. A nurses progress note written on 8/13/23 states "during the night Resident #53 wandered into another resident's room bed alarm was in place resident was able to turn it off alarm". Resident #53's care plan	F 600		

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initiated on 8/10/23 identifies a problem of "I may be sexually inappropriate towards staff and other residents." There were no documented interventions implemented to protect other residents until 8/12/23 after the incident that involved Resident #19. There is also no evidence in the record that the Physician was notified of the increase in behaviors until 8/12/23 after the incident that involved Resident #19.

During an interview on 11/27/23 at 2:30 PM a Licensed Practical Nurse (LPN) confirmed that Resident #19 is always in eyesight during his/her shift but does wander in his/her wheelchair and will attempt to go into other resident rooms.

During an interview on 11/30/23 at 12:37 PM the Social Services Director confirmed that she/he was aware of the resident-to-resident abuse incident between residents #19 and #53. She/he also confirmed there is no care plan in place that addresses the fact that Resident #19 is at risk for or is an actual victim of abuse.
2. Per record review, Resident #33 has resided at the facility since 10/17/2022 with diagnoses that include Depression, muscle weakness, and a BIMS of 12 (A cognitive screening measure that evaluates memory and orientation, indicating moderately impaired cognition).

Per interview on 11/27/2023, at 2:10 PM, Resident #33 expressed feeling "humiliated" about being incontinent of urine and feces, and is told to go in her/his underwear, and they will clean her/him up. Per the resident, there was a urinal and a bedpan provided, but they are no longer available to her/him. Resident #33 explains that although it is difficult to transfer using the Hoyer

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lift (a mechanical lift used to move residents from one point to another), which requires additional staff, staff do not come back in time when s/he needs assistance, and s/he ends up soiling her/his clothes. Resident #33 says, "I know I am a lot of work, and I feel bad if I ask for help; I'm a veteran and fought for my country; this feels bad."

Per record review: A care plan problem reviewed on 9/7/2023 reads, "s/he may experience episodes of incontinence ... I require your assistance using the bathroom, secondary to my cognitive and physical limitations." Another progress note, dated 09/14/23, "S/he may experience episodes of incontinence ...S/he requires assistance using the bathroom and may choose to keep a urinal at the bedside. A progress note dated 9/22/23 "I need to have a BM (bowel movement). It's stinging my butt, [incontinent of large BM and urine]." Another care plan intervention implemented on 10/17/2022: "Offer me the bedpan or bedside commode with my routine comfort checks during the night ... I prefer to use the urinal at night, but I may spill it and need staff assistance to empty it." Another intervention dated 10/17/2022 "offer and assist me with using the bathroom pre and post-mealtime and at HS (before bed) and on request ... Remind me to ask you for assistance whenever I need the bathroom." The facility is failing to implement Resident # 33's interventions as identified in her/his care plan, by not offering the bed pan and urinal, resulting in the resident waiting for extended periods of time and urinating in her/his clothes resulting in embarrassment and humiliation.
Although there was no evidence that this practice caused physical harm to the Resident, the fact

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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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that Resident #33 expressed feelings of embarrassment and humiliation reflects psychological harm.

Per interview on 11/28/2023 at 2:49 PM, Licensed Nursing Assistant (LNA) #1 stated Resident #33 must be moved to the bed using the Hoyer lift and then offered the bedpan. S/he says,"A bedpan is kept in the bathroom for that purpose." S/he was unable to produce a bedpan when asked.

Per interview on 11/28/2023 at 2:53 PM with LNA #2, s/he explained they may try to provide toileting or the bedpan to Resident # 33, "but it's hard, s/he is a Hoyer lift, and we need a second person, so s/he wears an incontinence brief, it makes it easier ... We don't have the staff to manage the residents who need the Hoyer to move them ... Usually, s/he is incontinent anyway by the time we return, so we just put him/her on the bed and change her/him."

On 11/29/2023 at 1:28 PM two LNAs were observed checking Resident #33 incontinence brief. S/he was incontinent of urine and was not offered to use the bedpan or urinal. Per interview with the LNA after the observation, at approximately 1:45 PM, the LNA stated, Resident #33 was already incontinent, so they provided incontinent care and did not offer the urinal.

An interview with Resident #33 on 11/29/2023 at approximately 1:55 PM revealed that s/he had not been offered the bedpan, toilet, or urinal since s/he was given morning care at approximately 6:55 AM.

On 11/28/2023 at approximately 3:25 PM, the Director of Nursing confirmed that staff was not

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F 600	Continued From page 11 providing the necessary care and assistance to Resident #33 by not implementing his/her care plan and not offering him/her the use of the bedpan, urinal, or bathroom.	F 600		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the	F 609	**F-609 Vernon Green has and will continue to comply with CFR(s): 483.12 (b)(5)(i)(A)(B)(c)(1)(4) Reporting of Alleged Violations.** **What corrective action will be accomplished for those residents found to have been affected by the deficient practice;** ▪ Incident of alleged violation of neglect and/ or misappropriation has been reported to the licensing board ▪ Incident of alleged violation of neglect and/ or misappropriation has been reported to adult protective services ▪ Incident of alleged neglect and/or misappropriation has been reported to State Agency. **How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;** ▪ Reports of any residents that are subjected to any violations of neglect and/or misappropriate that are made by staff, the facility will immediately report to appropriate state and regulatory agencies and no later 24 hours after.	1/6/24

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F 609	Continued From page 12 facility failed to ensure that all alleged violations of neglect and/or misappropriation of resident property are reported immediately but not later than 24 hours after the allegation is made to the State Agency and Adult Protective Services. Findings include: Per an Adult Protective Services (APS) report filed in June of 2022 and forwarded to the State Agency, an Licensed Practical Nurse (LPN) abandoned their shift on 6/15/2022 and was suspected of taking narcotics from the medication cart. The LPN was an agency staff member, and the report was made by the LPN's travel agency. Per interview on 12/29/23 at approximately 11:00 AM, the Administrator confirmed that they remember this incident vaguely and that they were made aware of it by the Director of Nursing (DON) employed at the time. All they could provide was a copy of an email sent to them by the DON at the time, confirming that the LPN had left their shift early without handing off care to, or counting off the narcotics with, another nurse. There was an incorrect count on one of the narcotic medications when the DON went in to reconcile the narcotic count. The Administrator denied being able to find any evidence that the facility reported this incident to the State Agency. Per review of the State Agency Complaint and Incident Intake database, there is no evidence that the facility reported these allegations to the State Agency.	F 609	**What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur;** ▪ Education to staff on reporting any neglect and/or misappropriation to DON and/or administer so that alleged violation can be reported immediately to appropriate state and regulatory agencies and no later 24 hours after. ▪ Education to the current DON and administrator on any reports made in regards to neglect and/or misappropriation must be reported to appropriate state and regulatory agencies and no later than 24 hours. ▪ Administrator /Designee will oversee that the DON has reported any alleged incident to appropriate regulatory agencies. The Administrator/designee will "Sign-off" on the submitted report. ▪ Monthly X3 audit will be completed for any alleged violation made to ensure that they were submitted to appropriate agency and the administrator/designee has "signed off" on the report **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 and/or until 100% compliance is achieved. **Tag F 609 POC accepted on 1/3/24 by N. Baker/P. Cota**	
F 610 SS=D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse,	F 610	**F-610 Vernon Green has and will continue to comply with CFR(s): 483.12 (c) (2)-(4). Investigate/Prevent/Correct Alleged Violation**	1/6/24

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F 610	Continued From page 13 neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility failed to ensure that all alleged violations of neglect and/or misappropriation of resident property are thoroughly investigated, and all findings are reported to the State Agency within 5 days of the allegation. Findings include: Per an Adult Protective Services (APS) report filed in June of 2022 and forwarded to the State Agency, an Licensed Practical Nurse (LPN) abandoned their shift on 6/15/2022 and was suspected of taking narcotics from the medication cart. The LPN was an agency staff member, and the report was made by the LPN's travel agency. Per interview on 12/29/23 at approximately 11:00 AM, the Administrator confirmed that they remember this incident vaguely and that they were made aware of it by the Director of Nursing (DON) employed at the time. All they could	F 610	**What corrective action will be accomplished for those residents found to have been affected by the deficient practice;** ▪ No residents have been identified as affected **How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;** ▪ Reports of any residents that are subjected to any violations of neglect and/or misappropriate that are made by staff, the facility will immediately start an investigation and ensure that the investigation was thoroughly conducted. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur;** ▪ Education to staff on reporting any neglect and/or misappropriation to DON and/or administer so that a thorough investigation can be completed. And any alleged violation can be reported immediately to appropriate state and regulatory agencies and no later 24 hours after. ▪ Education to the current DON and administrator on any reports made in regards to neglect and/or misappropriation must be reported to appropriate state and regulatory agencies and no later than 24 hours ▪ Administrator /Designee will oversee that the DON has completed an investigation to reported incident. Administrator/designee will "Sign-off" on the investigation form ▪ Monthly X3 audit will be completed for any alleged violation made to ensure that they were submitted to appropriate agency and the administrator/designee has "signed off" on the investigation	

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F 610	Continued From page 14 provide was a copy of an email sent to them by the DON at the time, confirming that the LPN had left their shift early without handing off care to, or counting off the narcotics with, another nurse. There was an incorrect count on one of the narcotic medications when the DON went in to reconcile the narcotic count. The Administrator denied being able to find any evidence that the allegations were thoroughly investigated by the facility.	F 610	**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 and/or until 100% compliance is achieved. **Tag F 610 POC accepted on 1/3/24 by N. Baker/P. Cota**	
F 656 SS=D	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 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	F 656	**F-656 Vernon Green has and will continue to comply with CFR(s): 483.21 (b)(1)(3), Develop/ Implement Comprehensive Care Plan** **What corrective action will be accomplished for those residents found to have been affected by the deficient practice;** ▪ Resident # 3 discharged from facility on 12.10.23. ▪ Resident # 52 now has a care plan for communication based on the residents Care Area Assessments (CAA). **How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;** ▪ 100% Audit of those current residents that have wounds, to ensure they have Person Center Care Plans in place. ▪ Review of new admissions skin assessment for the last 7 days for accuracy of documented skin concerns. ▪ 100% audit of the last 60 days of residents that had a trigger for a CAA for communication were audited to ensure that person center care plan was developed.	1/6/24

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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 observation, interview, and record review the facility failed to develop a comprehensive person-centered care plan that addresses preventative measures related to skin care for 1 of 25 residents in the sample (Resident #3) and a resident's communication needs for 1 of 25 residents (Resident #52). Findings include:

1. Per record review Resident #3 was admitted to the facility on 9/12/2023 with diagnoses that include heart failure, atrial fibrillation (an irregular, often rapid heart rate), and peripheral vascular disease (PVD) (circulation disorder). An Admission Nursing Assessment completed on 9/12/23 reflects that there were no pressure or vascular wounds identified and the resident only required routine skin care. An Admission Physicians Progress Note dated 9/13/2023

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What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur;

- Education to MDS & DON/Designee of completion of Person Centered Care, care plans to be developed when there is a trigger for a CAA from the MDS for communication
- Weekly audit of any residents triggered CAA's for communication will be completed x 4 weeks, then monthly x3
- Education to MDS & DON/Designee on those that have wounds to have a Person Center Care, Care plan in place.
- Monthly audit x3 of those residents that have wounds will be completed to ensure there is a person centered care plan in place.
- New admissions to the facility will have a skin check completed with-in 48 to 72 hours by the DON/Designee to ensure that the admission skin assessment is accurate and care plan is in place x3 months.
- Monthly audit x3 of new admission skin checks with-in 48 -72 hours are completed and skin assessment form is accurate of any admitted skin concerns. Also to check that a Care plan has been developed for any concerning admitted skin areas.

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.

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F 656	Continued From page 16 reflects "dermal stasis changes consistent with PVD... decreased sensation to feet." Review of Resident #3's care plan does not identify dermal stasis changes or interventions related to the risks related to decreased sensation to feet such as elevating legs and avoiding pressure on heels. A Nursing Progress Note written on 11/23/2023 states "During hs [hour of sleep] care LNA [licensed nursing assistant] noted heel leaking. When LPN [licensed practical nurse] took a look. It appears to be an old wound. It has a scab on it. The area around is very dry and cracking. It was cleaned with wound cleanser and mepilex applied..." A physicians Progress Note dated 11/24/23 reflects pressure ulcers of right and left heels stage 2 (partial-thickness loss of skin with exposed dermis) with recommendations to elevate legs when able and avoid pressure on heels. Per observations made on 11/27/23 at 1:00 PM Resident #3's left hand was noted to be dusky reddish in color and swollen. There were three necrotic (death of cells or tissue through disease or injury) areas noted on the first and third finger of the left hand. The right hand was also red and dusky. The thumb had two callous areas and the first finger had a large necrotic area. A Physicians Progress note dated 11/29/23 states "[Name omitted] has PVD [peripheral vascular disease] and has had dermal stasis changes (caused by poor circulation and blood flow) to hands and feet since admission. [S/he] has thickened skin and red/purple discoloration to hands and feet. [S/he] has several small scabbed over necrotic areas that are present and have been being monitored without any signs of	F 656	**Tag F 656 POC accepted on 1/3/24 by N. Baker/P. Cota**	

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infection. One of those areas is on her left ring finger where had necrotic area to fingertip and today was noted to have lifted up nail and was asked to examine. [Name omitted] is aware that finger hurts today but does not recall any trauma to hand. No drainage noted by staff... [S/he] has upcoming [appointment] with wound care center regarding an area on RLE [right lower extremity] and will ask them to assess PVD changes to hands and feet as well. [Representative] is aware of these areas of concern." A care plan was not initiated to address the risks associated with, or specific interventions related to the resident's dermal stasis of their hands and feet.

During interview on 11/30/23 at 12:08 PM the MDS Coordinator confirmed that the care plan did not address the actual status of #3's skin and did not include appropriate interventions.

2. Per record review Resident # 52 was admitted to the facility with diagnoses that include Alzheimer's Disease and anxiety. A Progress Note written on 5/19/23 by Social Services states that Resident #52 "is being reviewed for [her/his] admission care plan, [name omitted] is from Colombia and [her/his] first language is Spanish. [S/he] speaks a mix of Spanish and English and when [s/he] starts becoming upset, will mostly speak quickly/progressively louder in Spanish...".

Per review of Resident #52's Care Area Assessment (CAA - Process that provides guidance on how to focus on key issues identified during a comprehensive assessment and directs facility staff and health professionals to evaluate triggered care areas to be addressed in the care plan) within the Minimum Data Set (MDS, an assessment tool used for implementing

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F 656	Continued From page 18 standardized assessment and for facilitating care management in Long Term Care) dated 5/18/23 and 8/13/23 documented under section 4. Communication: states "Resident triggers for communication [due to] difficulties [s/he] experiences in communicating [with] others. [S/he] experiences difficulties [with] word finding [due to] English being a second language, as [s/he] is originally from Colombia, but is normally able to speak English unless [s/he] is anxious or frustrated, when [s/he] will revert to Spanish. [Her/his] word finding difficulties are also impacted by [her/his] impaired cognition and altered thought patterns [due to her/his] dementia as well as [her/his] daily antipsychotic and antidepressant medications, which are used to help [her/him] manage the [symptoms] of [her/his] dementia, including behavioral outbursts." The CAA also states that Resident # 52 "is at risk for continued impaired communication [due to] resident's dementia, medication regimen, and bilingual status as noted above." Resident #52's care plan does not address impaired communication as identified in the MDS CAA. During interview on 11/29/23 at 3:46 PM the MDS Coordinator confirmed that the MDS/CAA assessments dated 5/18/23 and 8/13/23 determined that the Resident #52 triggered for communication and that a care plan should have been developed to identify care needs related to potential language/communication barrier.	F 656		
F 657 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-	F 657	**F-657 Vernon Green has and will continue to comply with CFR(s): 483.21(b)(2)(i)-(iii), Care Plan Timing and Revision**	1/6/24

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(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 staff interview and record review, the facility failed to revise the comprehensive care plan as the resident's plan of care changes for 2 of 21 sampled residents (Resident #3, and #11).
Findings include:

1. Per record review Resident #3 was admitted to the facility on 9/12/2023 with diagnoses that include heart failure, atrial fibrillation (an irregular, often rapid heart rate), and peripheral vascular disease (PVD) (circulation disorder). An Admission Nursing Assessment completed on 9/12/23 reflects that there were no pressure or

F 657

What corrective action will be accomplished for those residents found to have been affected by the deficient practice;

- Resident #3 discharged from facility on 12.10.23
- Resident # 11 Care plan has been updated to reflect the current antipsychotic medication that is prescribed as well as the DX of Major Depressive Disorder with psychotic features.

How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;

- 100% of residents that take a psychotropic medication have been audited to ensure that that care plans have been updated to addresses their current medication regimen.
- Education to MDS & DON/designee on completing and updating comprehensive care plans for those receiving a psychotropic medication.
- 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 audit x3 will be completed for any new psychotropic medication prescribed to a resident to ensure there is a care plan has been updated to reflect the current medication regime.

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 and/or until 100% compliance is achieved.

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 12/04/2023

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 657	Continued From page 20	F 657	**Tag F 657 POC accepted on 1/3/24 by N. Baker/P. Cota**	

vascular wounds identified and the resident only required routine skin care. An Admission Physicians Progress Note dated 9/13/2023 reflects "dermal stasis changes consistent with PVD... decreased sensation to feet."

A Nursing Progress Note written on 11/23/2023 states "During hs [hour of sleep] care LNA [licensed nursing assistant] noted heel leaking. When LPN [licensed practical nurse] took a look. It appears to be an old wound. It has a scab on it. The area around is very dry and cracking. It was cleaned with wound cleanser and mepilex applied..." A physicians Progress Note dated 11/24/23 reflects pressure ulcers of right and left heels stage 2 (partial-thickness loss of skin with exposed dermis) with recommendations to elevate legs when able and avoid pressure on heels.

Review of Resident #3's care plan does not identify dermal stasis changes or interventions related to the risks related to decreased sensation to feet such as elevating legs and avoiding pressure on heels. The care plan was not updated to address the stage 2 pressure ulcers to bilateral heels identified on 11/23/23.
2. Per record review, Resident #11 has diagnoses of Dementia without Behavioral Disturbance as well as Major Depressive Disorder. Resident #11's medication list includes the following order: "Seroquel (Quetiapine) tablet 25 mg twice a day for Major Depressive Disorder with psychotic features". Resident #11's care plan includes a Problem focus that states, "I have a diagnosis of Depression. I no longer take any antidepressant medication."

Per interview on 11/29/23 at approximately 4:00

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F 657	Continued From page 21 PM, the Director of Nursing confirmed that this care plan was not updated to match the current medication regimen.	F 657		
F 658 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 staff interview and record review, the facility failed to provide services related to nutritional maintenance that meet professional standards for one of 5 sampled residents (Resident #18). Findings include: Per record review, Resident #18 was admitted to the facility on 2/24/2017 with a diagnosis of Dementia. The record did not show any documented weights in the last 3 years for Resident #18. Per review of the care plan, there is a care plan problem that states, "I am at risk for weight loss and altered fluid status. I have variable meal intake related to my decline in visual function and variations in my cognitive mood state. I am dependent on staff for all meal and fluid consumption. My Weight monitoring was discontinued 5/29/18." There is no weight monitoring order in Resident #18's chart. Per interview on 11/28/23 at approximately 3:00 PM, the Minimum Data Set (MDS) nurse confirmed that weights have been discontinued for Resident #18. They stated that the reason the weights were continued is for "comfort and dignity	F 658	**F-600 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;** ▪ Residents # 18 has a new order to be weighed monthly due to not being "end of life and/or comfort care." Resident current weight is 134.2. ▪ Resident # 18 care pan has been updated to reflect the new order for monthly weights ▪ Resident was seen by dietitian on 12/16/23 and noted that residents consumes >75% at meals. **How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;** ▪ 100% of those residents that have had weight discontinued, have been reviewed with their physicians for accuracy of the discontinued weights. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur;** ▪ Education to staff that residents are to be weighted per MD order and weights cannot be discontinued for "staff convenience and if a weight cannot be obtained then staff to notify the nurse and/or DON for alternatives and suggestions.	1/6/24

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F 658

Continued From page 22
related to [their] advancing dementia" and that sometimes they discontinue weights for residents with diagnoses of dementia because "their weight loss is unavoidable."

On 11/28/23 at approximately 4:00 PM, the MDS nurse provided a faxed order request dated 5/28/18 from a nurse to the Medical Director at the time. The faxed order states "we are unable [to] obtain weight due to difficulty. [they are] no longer able to ambulate onto [the] scale and we are unable to get [them] on the scale with the chair [they use]. May we discontinue?" The Medical Director's response is "yes" and the order was signed on 5/29/18.

Per phone interview on 11/28/23 at approximately 3:30 PM, the current Medical Director stated that they could not provide specific details about Resident #18 at that time due to not having access to the records, but that some residents with Dementia are determined to be at risk for unintended weight loss despite intervention. For their "comfort and dignity", weights may be discontinued and other data used as the primary tool for identifying changes in nutritional status.

Per interview on 11/29/23 at approximately 12:30 PM, the current Medical Director stated that Resident #18 is not currently on end-of-life or comfort care, as they have been stable for years with the care they have been receiving. The Medical Director confirmed that Resident #18 appears to have had their weights discontinued by the former Medical Director for staff convenience and not for reasons related to Resident #18's best interests.

Rapid unintentional weight loss in elderly is

F 658

- Any new discontinuation of a residents weight will be audited monthly X3 to ensure they were not discontinued for "staff Convenience".
- Residents weights that have been D/C will also be reviewed in Risk meeting 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 and/or until 100% compliance is achieved.

Tag F 658 POC accepted on 1/3/24 by N. Baker/P. Cota

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F 658	Continued From page 23 usually indicative of underlying disease. Weight loss and low BMI in older persons are associated with mortality in many studies. Consistent and accurate weight tracking for those residents who are not considered "end of life" is essential for identifying the need for intervention to promote health and monitoring overall health status. Miller, S.L., Wolfe, R.R. The danger of weight loss in the elderly. J Nutr Health Aging 12, 487-491 (2008). https://doi.org/10.1007/BF02982710	F 658		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and record reviews the facility failed to provide care for a resident with bilateral necrotic (death of cells or tissue through disease or injury) wounds as identified in physician's progress notes. Findings include: Per record review Resident #3 was admitted to the facility on 9/12/2023 with diagnoses that include heart failure, atrial fibrillation (an irregular, often rapid heart rate), and peripheral vascular disease (circulation disorder).	F 684	**F-684 Vernon Green has and will continue to comply with CFR(s): 483.25, Quality of Care** **What corrective action will be accomplished for those residents found to have been affected by the deficient practice;** ▪ Resident # 3 discharged from facility on 12.10.23 **How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;** ▪ 100% of residents that have a current wound will be audited to ensure there are wound assessment notes in place for the last 30 days and Care plan reflects current area. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur;** ▪ Monthly audit x3 of those residents that have wounds will be completed to ensure there is a person-centered care plan in place.	1/6/24

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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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F 684	Continued From page 24 A Physicians Progress note dated 11/29/23 states "[Name omitted] has PVD [peripheral vascular disease] and has had dermal stasis changes (caused by poor circulation and blood flow) to hands and feet since admission. [S/he] has thickened skin and red/purple discoloration to hands and feet. [S/he] has several small scabbed over necrotic areas that are present and have been being monitored without any signs of infection. One of those areas is on her left ring finger where had necrotic area to fingertip and today was noted to have lifted up nail and was asked to examine. [Name omitted] is aware that finger hurts today but does not recall any trauma to hand. No drainage noted by staff... [S/he] has upcoming [appointment] with wound care center regarding an area on RLE [right lower extremity] and will ask them to assess PVD changes to hands and feet as well. [Representative] is aware of these areas of concern." Per observations made on 11/27/23 at 1:00 PM Resident #3's left hand was noted to be dusky reddish in color and swollen. There were three necrotic areas noted on the first and third finger of the left hand. The right hand was also red and dusky. The thumb had two callous areas and the first finger had a large necrotic area. Further record review revealed that there was no evidence of wound assessment of the necrotic wounds. The care plan did not reflect the necrotic wounds, including interventions for treatments, daily wound monitoring, weekly wound assessments related to the actual wounds. During an interview on 11/29/23 at approximately 1:00 PM the Director of Nursing confirmed that	F 684	▪ Monthly audit X3 will be completed on those with wounds to ensure there are weekly assessment documentation is being completed ▪ Director of Nurses or designee will complete weekly wound rounds and document assessment in the medical records ▪ Education to staff on documentation of new wounds and incident reports to be 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?** 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 and/or until 100% compliance is achieved. **Tag F 684 POC accepted on 1/3/24 by N. Baker/P. Cota**	

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F 684	Continued From page 25 s/he had recently identified that wounds were not being assessed throughout the facility.	F 684		
F 686 SS=G	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- (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 25 residents in the applicable sample (Resident #3) received necessary treatment and services consistent with professional standards of practice to promote healing, prevent infection, and prevent new ulcers from developing. As a result, Resident #3 developed two stage 2 (partial-thickness loss of skin with exposed dermis) pressure ulcers after admission to the facility. Findings include: Per record review Resident #3 was admitted to the facility on 9/12/2023 with diagnoses that include heart failure, atrial fibrillation (an irregular, often rapid heart rate), and peripheral vascular disease (circulation disorder). An Admission Nursing Assessment completed on 9/12/23	F 686	**F-686 Vernon Green has and will continue to comply with CFR(s): 483.25 (b)(1)(i)(ii), Treatment/Svcs to prevent/heal pressure ulcers** **What corrective action will be accomplished for those residents found to have been affected by the deficient practice;** ▪ Resident # 3 was discharged from the facility on 12.10.23 ▪ Resident #3 was Care Planned for weekly skin assessment. Per residents Treatment Administration History with a look back from 11/1/23 to 12/10/23 resident had skin check preformed per care plan with supporting documentation on the following dates; 11/7/23; 11/14/23; 11/21/23; 11.28.23; 12/1/23 documented in the medical record. **How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;** ▪ 100% of residents that have a current wound will be audited to ensure there are wound assessment notes in place for the last 30 days and Care plan reflects current area and revise as appropriate. ▪ 100% audit of residents skin check with-in the last two weeks have been audited to ensure completion of skin checks.	1/6/24

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F 686

Continued From page 26
reflects that Resident #3 had a red rash on areas of their upper body, scabs on their right and left elbows and knees, and a small mark on their left side buttock fold. There were no pressure wounds identified on the admission assessment.

A 48 Hour Post Admission Interdisciplinary Care Plan dated 9/14/23 reflected that the resident required "Routine" skin care, had no special treatments, and no pressure ulcers. A care plan focus started on 9/14/23 states that Resident #3 has the potential for skin breakdown related to incontinence and decreased mobility. Interventions implemented on 9/14/23 include "check my skin thoroughly with my ADL care, incontinence care, and with my weekly shower. Report any [signs or symptoms] of breakdown to the nurse in charge and my [physician]." There are no preventative interventions in place to protect against the increased risk of development of pressure ulcers related to impaired circulation.

Review of Resident #3's admission MDS (Minimum Data Set, an assessment tool used for implementing standardized assessment and for facilitating care management in Long Term Care) dated 9/21/23 the facility had determined that Resident #3 was at increased risk for developing pressure ulcers. It also revealed that Resident #3 did not have pressure ulcers but was at risk for pressure injury and should s/he experience impaired skin integrity, s/he may experience delayed wound healing not only due to hypothyroidism, but also altered perfusion related to atrial fibrillation and congestive heart failure.

Progress notes reveal that Resident #3 developed injuries that progressed to bilateral heel stage two pressure ulcers. A progress note

F 686

What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur;

- Education to staff that skin impairments/ wounds are to be documented at time of discovery and an incident report completed
- Education to MDS & DON/Designee on updating are care plans for new skin/ wound impairments
- Education to licensed staff on completing weekly skin assessment as ordered with documentation to support skin check being completed
- Weekly wound rounds by the DON or designee with proper documentation in the medical record
- Monthly audit X3 will be completed on those with wounds to ensure there are weekly assessment notes being completed
- Monthly audit x3 of 30% of resident's will be audited to ensure that skin checks are being completed per care plan

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 and/or until 100% compliance is achieved.

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F 686	Continued From page 27	F 686		

dated 11/23/2023 states "During hs [hour of sleep] care [Licensed Nursing Assistant] noted heel leaking. When [Licensed Practical Nurse] took a look, it appears to be an old wound. It has a scab on it. The area around is very dry and cracking. It was cleaned with wound cleanser and mepilex applied. Notified [physician] via fax." There is no evidence in the record that reflects the date the pressure ulcers were developed. A Physicians Progress Note dated 11/24/23 reflects that nursing had sent the Physician a "fax about potential areas of concern on [bilateral] heels ... Left heel has open pressure wound that was draining moderate amount of serous material and sticking to [her/his] sock - area cleaned and mepilex applied. Right heel has mild amount of serous drainage from heel and area cleaned and mepilex [foam dressing] applied there as well." The progress note further states pressure ulcer of right heel stage 2. Area cleaned and mepilex applied. Elevate legs when able. Avoid pressure on heels. Pressure ulcer of left heel stage 2. Area cleaned and mepilex applied. Elevate legs when able. Avoid pressure on heels. There is no documentation of measurements in the record to establish the size of the pressure ulcers.

Further record review revealed that there was no evidence of wound assessment of the bilateral heel pressure ulcers. There were no interventions implemented in the care plan that reflect preventive measures for heel pressure ulcers. In addition, the care plan was not revised to reflect the pressure ulcers when they developed, including interventions for pressure ulcer treatments, daily wound monitoring, weekly wound assessments related to the actual ulcers, or the Physicians recommendations to elevate legs when able and avoid pressure on heels.

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F 686	Continued From page 28 There was no evidence that weekly skin checks were performed as per the care plan. Per interview on 11/30/23 at 12:08 PM the MDS Coordinator confirmed that the care plan did not address the bilateral heel stage two pressure areas and interventions specific to the risk of developing pressure ulcers to the lower extremities related to impaired circulation. During an interview on 11/29/23 at approximately 1:00 PM the Director of Nursing confirmed that s/he had recently identified that wounds were not being assessed per policy.	F 686		
F 689 SS=L	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 §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 observation, staff interview, and record review, the facility failed to ensure that resident environments were free of accident hazards related to safe handwashing water and bathing water temperatures. The facility failed to have an adequate water temperature monitoring process in place that resulted in critically high water temperatures in resident rooms and in a shower/tub room. These failures resulted a likely risk of serious burns to residents and created an immediate jeopardy situation. Findings include:	F 689	**F-689 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;** ▪ All residents have the potential to be affected however no Residents have been identified as affected **How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;** ▪ Signs have been hung on the shower rooms to indicate to staff to not use until further notice. ▪ Signs have been hung in the resident rooms over sink areas indicating to not use until further notice.	1/6/24 11/27/23 11/27/23

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F 689 Continued From page 29

Per observation on 11/27/23 at 11:45 AM, the water from the resident handwashing faucet in room #109 was too hot to use when this surveyor went to wash their hands following resident interview. The faucets are located outside of the resident bathrooms in the main part of the resident rooms. The water temperature was taken at this faucet with a digital thermometer, which read exactly 120 degrees Fahrenheit at its hottest. The water temperature was then taken in additional resident rooms and in shower/tub rooms used for resident bathing. At 11:50 AM, the faucet water in resident room #111 read 124.1 degrees Fahrenheit at its hottest. At 11:52 AM, the faucet water in resident room #210 read 126.0 degrees Fahrenheit at its hottest. At approximately 12:00 PM, the B wing bathtub faucet water read 123.9 degrees Fahrenheit at its hottest.

Per interview on 11/27/23 at 12:15 PM, the facility's Maintenance Director stated that the boiler with the mixer valve for hot water is set at 115 degrees Fahrenheit and is located under the main dining room in the basement. Rooms closer to the boiler are likely to be hotter, as the water takes less time to travel from the boiler to the faucets the closer they are to the boiler. The Maintenance Director stated that they check and record water temperatures every day at approximately 7:30 AM, when water usage is at its highest in the facility due to morning care. They confirmed that water temperatures are not taken in resident rooms, also due to morning care, and that water temperatures are taken from somewhere in the common areas or main lobby. When asked if they were ever aware of water temperatures being hot before, they confirmed

F 689

- Education has been provided to staff for the use of not using the residents sinks or showers until further notice. — 11/27/23
- Education to staff regarding what to do if a resident's sink water is to hot — 11/28/23
- Education to staff on not to use the bath tub until further notice. Facility is looking at a thermometer that goes into the tub to alert if water is too hot — 11/28/23
- Maintenance has adjusted the mixer valve. — 11/27/23
- Maintenance/Designee has temped all the resident rooms sink on both units (B-Wing temps @ 3pm range from 116.4 to 118.4) (A-Wing temps @ 3:30pm range from 105.8 to 117.1). — 11/27/23
- Maintenance/Designee has re-tempted the B-Wing Bath Tub with a reading of 117.6 and the shower of 109.8 — 11/27/23
- Maintenance/Designee has re-tempted both units showers with a reading of 104.9 — 11/27/23
- Maintenance/Designee has re-tempted all the residents room sinks for a second time to make sure that the water temps stay consistent temp range. A wing temp @ 5 pm range 112.6 to 119.4. B wing temps @ 4:15pm 103.1 to 110.3 — 11/28/23
- Maintenance/Designee will re-temp all residents sinks and bath tub and shower rooms (after the first and second temping) every 4 hours for 24 hours to ensure and maintain proper temperatures

What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur;

- Maintenance/Designee will temp 50% of residents room sinks weekly x 8 weeks then monthly x4

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	475008	A. BUILDING ______ B. WING ______	C 12/04/2023

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 689	Continued From page 30 that they had been made aware of it in the past, but that when the temperature of the boiler was turned down, the staff and residents would complain that there is not enough hot water at high usage times. For this reason, they set the boiler temperature back at 115 degrees Fahrenheit. When asked, the Maintenance Director confirmed that residents wash their hands and receive showers/baths at all times of the day. The Maintenance Director then confirmed that the facility's policy regarding water temperatures states that any water temperature above 120 degrees Fahrenheit is too hot and unacceptable. After the interview at approximately 12:30 PM, this surveyor and the Maintenance Director measured the temperature of the water in room #111 with our respective thermometers. This surveyor's thermometer read 122.1 degrees Fahrenheit, and the Maintenance Director's thermometer read 121.9 degrees Fahrenheit. The Maintenance Director confirmed that this is too hot for the water that residents have access to. Per review of the facility policy titled "Water Temperature Precautions - Anti Scald", the policy states, "water heaters that service resident rooms, bathrooms, common areas, and tub/shower areas shall be set to temperatures of no more than 120 degrees Fahrenheit ...". Review of the facility's water temperature monitoring log for November 2023 shows that no temperatures exceeded 120 degrees Fahrenheit, but that water temperatures were recorded at 119.3 on the 7th, 119.6 on the 15th, 119.1 on the 23rd, and 119.2 on the 24th at times of high water use in the facility.	F 689	▪ Maintenance/Designee will temp shower rooms and bath weekly x8 them monthly x 4 ▪ Maintenance will add to their daily temps log of checking 3 room sinks on the A Wing and 3 room sinks on B Wing & Bath. Water temps will be taken also in the PM (3 room sinks on the A Wing and 3 room sinks on B Wing & Bath). ▪ Any temperature concerns will be brought to administrator attention. **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 his/her designee will provide ongoing monitoring of this process to ensure compliance. Results of this audit will be brought to the QAPI meeting and/or until 100% compliance is achieved. **Tag F 689 POC accepted on 1/3/24 by N. Baker/P. Cota**	

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F 689	Continued From page 31 Serious burns are likely within minutes of skin exposure to water around 120 degrees Fahrenheit or greater. Resident rooms #109 and #111 are on the long-term care unit and rooms #210 and the B wing tub room are located on the memory care unit where the facility's most cognitively impaired and vulnerable residents are located. Resident room faucets are easily accessible to anyone entering a resident room. The facility confirmed their water temperature monitoring process does not include a way to ensure measuring temperatures in resident rooms or at varying times of day. The facility also confirmed that they had been alerted to hot water concerns in the past but took no lasting action to address the issue. For these reasons, there was an immediate risk of harm to residents that was likely to result in serious burns.	F 689		
F 730 SS=E	Nurse Aide Peform Review-12 hr/yr In-Service CFR(s): 483.35(d)(7) §483.35(d)(7) Regular in-service education. The facility must complete a performance review of every nurse aide at least once every 12 months, and must provide regular in-service education based on the outcome of these reviews. In-service training must comply with the requirements of §483.95(g). This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to complete a performance review of every nurse aide at least once every 12 months and therefore could not provide the requiered in-service education based on the outcome of the reviews, for 3 of 3 in the applicable sample. Findings include:	F 730	**F-730 Vernon Green has and will continue to comply with CFR(s): 483.35 (d)(7) Nurse Aide Performance Review- 12hr/yr in-Service** **What corrective action will be accomplished for those residents found to have been affected by the deficient practice;** ▪ No Residents have been identified as affected **How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;** ▪ Audit of 100% of nurse aides and licensed staff have been audited for performance evaluations. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur;** ▪ Education to staff on the facility completing a performance evaluation at least every 12 months for nurse aides and licensed nurses and will complete competencies based on the outcomes of the evaluations.	1/6/24

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F 730	Continued From page 32 A review of three Licensed Nursing Assistants (LNA) revealed there was no evidence that annual evaluations had been conducted; additionally, there was no evidence of yearly competencies in any of the five employee files. An interview on 11/29/2023 at approximately 4:39 PM with the Administrator and the Director of Nursing confirmed they could not produce documentation of either performance reviews or competencies related to the performance review.	F 730	▪ Nurse aide and licensed staff evaluations have been completed. ▪ Nurse aide and Licensed staff competencies have been completed. ▪ Facility does annual evaluations yearly during the month of February. HR will do an audit bringing of March to ensure that evaluation were completed. ▪ DON/designee will complete competencies based on the individuals performance evaluations. **Tag F 730 POC accepted on 1/3/24 by N. Baker/P. Cota** **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 and/or until 100% compliance is achieved.	1/6/24
F 740 SS=E	Behavioral Health Services CFR(s): 483.40 §483.40 Behavioral health services. Each resident must receive and the facility must provide the necessary behavioral health care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Behavioral health encompasses a resident's whole emotional and mental well-being, which includes, but is not limited to, the prevention and treatment of mental and substance use disorders. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review the facility failed to assess for and provide residents with the necessary behavioral health care and services to maintain the highest practicable, mental, and psychosocial well-being for 1 of 25 residents sampled. (Resident #48). Findings include; During a telephone interview on 11/27/23 at 3:04 PM conducted with Resident #48's Representative, the family is working with the	F 740	**F-740 Vernon Green has and will continue to comply with CFR(s): 483.40, Behavioral Health Services** **What corrective action will be accomplished for those residents found to have been affected by the deficient practice;** ▪ Resident #48 has had a trauma assessment completed ▪ Resident #48 has had a diagnosis added to their medical record of trauma ▪ Resident #48 has had a trauma care plan added to their plan of care ▪ Resident #48 will see a behavioral health specialist upon the behavioral health starting. (facility has a signed agreement with MediTelecare that was signed 12/28/23 with potential start date in the facility in Mid January 2024)	

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F 740	Continued From page 33	F 740		

facility regarding the resident's history of mental illness and trauma. The Representative has communicated the resident's history of growing up in an extremely abusive environment to the facility. Per record review there is no mental illness other than anxiety listed on the resident diagnosis/problem list, and a history of trauma is not reflected on the resident's diagnosis/problem list. The resident's care plan does not address a history of trauma.

Review of Physician orders included an order for psychiatric evaluation/consult as needed (PRN). Resident #48 also has a physician's order for Lorazepam (Lorazepam is in a class of medications called benzodiazepines. It works by slowing activity in the brain to allow for relaxation) 0.5 mg by mouth, give AM dose before performing AM care.

There is also a physician order for Buspirone (an anxiolytic agent used for short-term treatment of generalized anxiety and second-line treatment of depression) to be given three times a day.

Review of resident care plan reveals Behavioral Symptom problems stating "I may be combative or verbally abusive towards others, including swearing, biting, digging my nails into staff, or pinching .... I also have a history of wandering into other's personal spaces and rummaging through their belongings".

The following events are documented in Resident #48's care plan; aggressive during care, aggressive to staff during comfort check causing injury to staff, slapping another resident on the face (unwitnessed), grabbed and slapped another resident, slapped Licensed Nurse Aide (LNA)

How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;

- Social service has completed 100% audit of trauma assessments for all current residents in the facility
- Social service to do monthly X3 audit on any new admission for completion of trauma assessments
- Care plans have been implemented for those that assesses for any trauma per the trauma assessment

What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur;

- Education to MDS & DON/designee of development of Trauma care plans based of the trauma assessment completed by Social Services
- Social Service educated on completing of the trauma assessment for all new admissions
- Resident will see behavioral health services upon starting in facility

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 and/or until 100% compliance is achieved.

Tag F 740 POC accepted on 1/3/24 by N. Baker/P. Cota

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F 740	Continued From page 34	F 740		

across the face, pinched LNA, dug, and clawed staff during transfers.

Review of facility assessment; Page 4, Types of diseases and conditions that are common to Vernon Green residents and the care that is provided, under Category is psychiatric/mood disorders including impaired cognition, mental disorders, Depression, Bipolar Disorder, Post-Traumatic Stress Disorder, Anxiety Disorder, and behaviors that need interventions.

On 11/29/23 at 9:51 AM, an interview with the Director of Nursing (DON) confirms there are no behavioral health services or mental health services offered to the residents in the facility.

On 11/30/23 at 3:19 PM, an interview with Social Services Director reveals that s/he does not do any kind of post-traumatic stress disorder (PTSD) or trauma assessment for the residents and does not know if nursing does an assessment of this type. S/he confirms that there is no PTSD or trauma assessment in place for Resident #48. S/he also states that the facility has not been able to obtain a Mental Health/Behavioral service provider. S/he confirms that there are currently no behavioral health services available for any of the residents in the facility.

On 11/30/23 at 03:23 PM, an interview with Minimum Data Set (MDS) Coordinator Registered Nurse reveals that s/he does not do any kind of Trauma or PTSD assessment for the residents and that S/he "goes by the admission paperwork."

On 11/30/23 at 2:30 PM, an interview with the facility administrator confirms that Behavioral Health services are not being offered to the

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F 740	Continued From page 35 residents in the facility, as there is no provider for the facility contracted and there has not been a provider since 2022.	F 740		
F 756 SS=E	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly	F 756	**F-756 Vernon Green has and will continue to comply with CFR(s): 483.45 (c)(1)(2)(4)(5), Drug Regimen Review, Report irregular, Act on** **What corrective action will be accomplished for those residents found to have been affected by the deficient practice;** ▪ Resident # 11pharmacy recommendation for dates 9.26.23 & 10.25.23 have been addressed and AIMS test have been completed and are in the medial record ▪ Resident #27 AIMS test have been completed per pharmacy recommendation and is in the medical record ▪ Resident #19 AIMS test has been completed per pharmacy recommendation and is in the medical record **How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;** ▪ 100% of residents have been audited to identify if on an antipsychotic medication and if AIMS test was competed with-in the 6 months period. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur;** ▪ Monthly audit x3 will be completed of pharmacy recommendation to ensure follow through for AIMS testing	1/6/24

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F 756	Continued From page 36	F 756		

drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident.
This REQUIREMENT is not met as evidenced by:
Based on staff interview and record review, the facility failed to ensure that monthly pharmacist drug regimen reviews, recommendations, and attending physician responses are completed and documented in the resident record for 3 of 5 sampled residents (Resident #11, #27, and #19).
Findings include:

1. Per Resident # 11 record review, two progress notes from the facility's pharmacist consultant on 9/26/23 and 10/25/23 state, "Medication regimen reviewed: see report for recommendations." Both reports were requested from the Director of Nursing (DON).

Per interview on 11/29/23 at 4:00 PM, the DON confirmed that the documented reports containing the pharmacist's recommendations and any physician response taken could not be located or verified as having been completed.

2. Per record review Resident #27 receives Seroquel 25 milligrams (mg) once a day. Seroquel is an antipsychotic medication that requires the Abnormal Involuntary Movement Scale testing (AIMS) which is a rating scale that was designed to measure involuntary movements known as tardive dyskinesia (TD). TD is a disorder that sometimes develops as a side effect of long-term treatment with neuroleptic antipsychotic medications. Pharmacist consultant

- Education to staff on process for the pharmacy recommendation to be completed. DON will be responsible for having the physician response to the pharmacy recommendation on a monthly basis.

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 F 756 POC accepted on 1/3/24 by N. Baker/P. Cota

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F 756	Continued From page 37	F 756		

progress notes dated 8/28/23, 9/26/23, and 10/25/23 state " Medication regimen reviewed; see report for recommendations." Further review revealed that the three reports were not available in the record.
Per interview on 11/29/23 at 4:23 PM with the Director of Nursing (DON), S/he was able to get copies of the reports from 8/28/23, 9/26/23, and 10/25/23 from the pharmacy, all 3 reports indicated the AIMS testing was past due to be done for resident #27. The DON confirmed that the pharmacy recommendations were not addressed by the facility and the AIMS testing had not been done during those three months. The DON reveals that S/he performed the AIMS testing herself for the November pharmacy consults when S/he started the DON position.

3. Per record review Resident #19, receives Seroquel 25 milligrams (mg) twice a day, which is an antipsychotic medication that requires AIMS testing. The pharmacist consultant progress notes dated 8/28/23, and 9/26/23, state "medication regimen reviewed; see report for recommendations." Further review revealed that both reports were not available in the record.
Per interview on 11/30/23 at 1:25 PM with the Director of Nursing (DON), S/he was able to get copies of the reports from 8/28/23, and 9/26/23, from the pharmacy. The reports indicated the AIMS testing was due in August and then overdue in September. The DON confirmed that the pharmacy recommendations were not addressed by the facility and the AIMS testing had not been done during those two months.

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F 761	Continued From page 38	F 761		
F 761 SS=E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure that all drugs and biologicals are kept in locked compartments only accessible to authorized personnel as evidenced by medication carts being left unlocked and unattended. Findings include: 1. Per an Adult Protective Services (APS) report filed in June of 2022 and forwarded to the State	F 761	**F-761 Vernon Green has and will continue to comply with CFR(s): 483.45 (g)(h)(1)(2); Label/ Store Drugs and Biologicals** **What corrective action will be accomplished for those residents found to have been affected by the deficient practice;** ▪ No Residents have been identified as affected **How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;** ▪ Random observation of licensed staff medication carts to ensure they are locked and no keys left on medication carts 3x a week x 4 weeks. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur;** ▪ Education to licensed staff on locking medication cart when they walk away ▪ Education to licensed staff on not leaving keys on top of the medication cart ▪ Monthly observation x3 of nurses carts on different shifts to ensure they are locked and no keys left on top of carts **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 and/or until 100% compliance is achieved.	1/6/24

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F 761	Continued From page 39 Agency, an Licensed Practical Nurse (LPN) abandoned their shift on 6/15/2022, leaving the medication cart keys with the medication cart, unattended. Per interview on 11/29/23 at approximately 11:00 AM, the Administrator confirmed that this incident occurred. They also provided a copy of an email from the former Director of Nursing confirming that this had occurred. 2. Per observation on 11/28/23 at approximately 12:00 PM, an RN was seen leaving their medication cart to administer a resident's medication in their room. The cart was unlocked and a drawer of resident medications was open. The RN confirmed that the medication cart should not be left like this. 3. Per observation on 11/29/23 at approximately 8:20 AM, an LPN was seen leaving their medication cart to administer a resident's medication across the dining room. The cart was left unlocked. The LPN confirmed that the medication cart should not be left like this. 4. On 11/28/23 at 2:10 PM, it was observed that the medication cart that was in the hallway on the A-wing unit was left unattended with the keys that unlock the cart in the lock and the lock was in the open position. The drawer of the med cart was easily opened, and medications were easily accessible. There were residents present at this time as it is also a common area for residents to ambulate and sit. The keys were removed from the cart and the cart was locked. Interview on 11/28/23 at 2:13 PM with the licensed Practical Nurse (LPN) who was assigned	F 761	**Tag F 761 POC accepted on 1/3/24 by N. Baker/P. Cota**	

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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
F 761	Continued From page 40 to the med cart that was left unattended and unlocked. The LPN confirms that she should not have left the medication cart unlocked and should not have left the keys in the lock and that doing so is unsafe practice. 11/28/23 2:30 PM Interview with the Director of Nurses informed of LPN leaving keys in the med cart unlocked. S/he confirms that is an unacceptable practice and will provide re-education to that nurse.	F 761		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview the facility failed to store and prepare food in accordance with professional standards for food	F 812	**F-812 Vernon Green has and will continue to comply with CFR(s): 483.60(i)(1)(2); Food procurement, storage/Prepare/Serve-Sanitary** **What corrective action will be accomplished for those residents found to have been affected by the deficient practice;** ▪ No Residents have been identified as affected **How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;** ▪ The two dented cans of tomatoes were removed from the self and discarded ▪ Ice cream that was unlabeled in the freezer was discarded. ▪ The unwrapped and unlabeled birthday cake was discarded. ▪ The 3 containers of cottage cheese that were not dated were removed and discarded. ▪ The open can of beef base and Italian dressing were discarded. ▪ Block of butter that was not wrapped or dated was discarded	1/6/24

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 12/04/2023

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F 812

Continued From page 41
safety. Findings include:

During a tour of the facility kitchen accompanied by the Food Service Manager (FSM) on 11/27/23 at 11:00 AM the canned food shelf was noted to contain two dented cans of tomatoes. The FSM removed the dented cans and confirmed that they should not have been placed on the shelf for use. In the walk-in freezer there was a tray of bowls filled with scoops of ice cream that was unlabeled. The FSM stated that they were from yesterday and they should be dated. There was a tray of birthday cakes on the shelf that was not covered or wrapped, the FSM confirmed that the cakes should be covered and stated that they will not be used.

In the walk-in refrigerator there were 3 open containers of cottage cheese that were not dated, the FSM removed them. Other open food items with no labels were a can of beef base and Italian dressing. There was a large block of butter that was half used and open on top shelf with no date or wrap. There was dust and residue noted on the sprinkler head, and around the creases of the wall and ceiling and dust on the fans and lights.

In the food prep area, there was a large pipe above the prep table that had a large amount of dust in the vents and on the outer pipe. The FSM stated that s/he thought it was part of the air conditioning unit and that it was not in use.

During the tour on 11/27/23 at 11:00 - 11:30 AM the FSM confirmed the above findings.

F 812 (Plan of Correction)

- Dust that was noted in the sprinkler head, creases of the wall and on the fans and lights were cleaned.
- Large pipe and vent above the prep table that was noted to have dust was cleaned

What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur;

- Education to the dietary staff on proper food storage for dating of food items, not using dented cans, food to be covered and dated
- Food Service Manager to audit weekly for cleanliness of kitchen (ie.. looking for dust in vents, pipes fans, lights, & sprinkler head)
- Food service Manager to do rounds in the kitchen 3X week X4 weeks then every other week X1 month then monthly X3 thereafter.

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 his/her designee will provide ongoing monitoring of this process to ensure compliance. Results of this audit will be brought to the QAPI meeting and/or until 100% compliance is achieved.

Tag F 812 POC accepted on 1/3/24 by N. Baker/P. Cota

F 835 SS=F

Administration
CFR(s): 483.70

F 835 (Plan of Correction)

F-835 Vernon Green has and will continue to comply with CFR(s): 483.70

Completion date: 1/6/24

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F 835

Continued From page 42

§483.70 Administration.
A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.
This REQUIREMENT is not met as evidenced by:
Based on observations, interviews, and review of facility records, policies, and procedures, the facility Administration failed to use its resources efficiently to attain or maintain the highest practicable well-being of each resident. Findings include:

During the extended recertification survey conducted from 11/27/23 through 12/4/23 the survey team determined that the facility provided substandard care, including a concern that rose to the level of immediate jeopardy, and identified numerous other patterns of ineffective management of the facility.

The survey team determined that the facility had failed to ensure the resident environments were free from the risk of serious harm related to water temperatures, failed to ensure residents were free from abuse and neglect, failed to provide behavioral health services to residents requiring these services, and failed to ensure that the facility had a complete Infection Prevention and Control Program.

Additionally, the facility failed to have proper systems in place to ensure that all residents had appropriate care plans and drug regimen reviews completed and that all staff received necessary competencies and trainings to provide quality care.

F 835

What corrective action will be accomplished for those residents found to have been affected by the deficient practice;

- No Residents have been identified as affected
- How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;
- Facility has hired a new Director of nurses
- System/process in place for monitoring water temperatures
- Facility has developed process/systems to ensure residents are free from abuse and neglect
- Facility now has a written contract/agreement with a behavioral health service company to now provide the behavioral health services to those residents requiring it.
- Facility has updated & reviewed the Infection prevention and control policy.
- Facility has developed an antibiotic steward policy and program
- Facility has established proper system/process for residents to have appropriate care plans
- Facility has developed a process/system for completion of drug regimen reviews for residents
- Facility has completed competencies with nursing staff so residents can receive the highest quality of care at the facility.
- Facility has developed a process to monitor the hot water temperatures
- Facility has developed a process to ensure that any allegation of neglect and/or misappropriation are reported to the proper agencies.
- The facility has developed a process for a infection control program which includes surveillance for communicable disease and development of an antibiotic stewardship program.

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F 835	Continued From page 43 Many times throughout the extended survey, supporting documentation for residents and staff was requested without the facility being able to provide the documentation. Many times, the Administrator and/or current Director of Nursing (DON) would state that the former DON retained all responsibility and accountability for ensuring that various aspects of facility management were completed. Furthermore, it was also stated many times throughout the survey that when the former DON left, that no other facility staff member had been made aware during the former DON's employment how the former DON retained or organized critical documentation such as staff competencies and infection tracking. These issues highlighted how the Administrator was not involved enough in the day-to-day management of the facility to ensure that systems were in place or working appropriately to provide high-level care to residents. Per interview on 11/27/23 at approximately 12:30 PM, the Administrator was not aware of previous concerns regarding the temperature of resident water or the details of the Maintenance Director's system for monitoring water temperatures. Similarly, per interview on 11/29/23 at approximately 10:45 AM, the Administrator confirmed that they had not taken any action to ensure that an allegation of misappropriation and neglect by a staff member had been investigated and reported, despite having awareness of the incident. Neither the Administrator nor the current DON could offer explanation how the facility was conducting infection and communicable disease surveillance or antibiotic stewardship when the	F 835	▪ The facility has developed an Legionella policy and procedure ▪ Facility has developed a process/system for completing and monitoring Licensed Nursing Assistant & Licensed staff yearly evaluations. ▪ Facility has obtained a transfer agreement & Laboratory agreement with Brattleboro Memorial Hospital for residents. ▪ Facility has educated staff on QAPI and it's process. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur;** ▪ Weekly meetings will be established with the DON and Administrator to discuss current systems/processes to ensure that the administrator is involved in the day to day management. ▪ Weekly meetings will be established with the IDT team (Maintenance, Social Services, HSK, Rehab etc) to ensure that the administrator is involved in the day to day management. ▪ Administrator shall review the 2567 and the POC with the Vernon Green BOD ▪ Monthly Operations Reports shall be provided by the Administrator to the Board of Directors **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 DON/administrator or his/her designee will provide ongoing monitoring of this process to ensure compliance. Results of the audits will be brought to the QAPI meeting and/or until 100% compliance is achieved.	

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F 835	Continued From page 44 former DON was employed. The Administrator also confirmed on 11/29/23 at 3:20 PM that the facility had no legionella testing/surveillance program despite knowing that this was a regulatory requirement. An interview on 11/29/2023 at approximately 4:39 PM revealed the Administrator could not produce staff evaluations for 3 of 3 sampled files of Licensed Nursing Assistants (LNAs); s/he shared that as far as s/he knows the process was that the Director of Nursing (DON) would provide a list of evaluations that were due, and s/he would sign off on them. After that, s/he did not know the next step in the process or if the process was completed. An interview on 11/29/2023 at approximately 11:15 AM with Human Resource manager confirmed that s/he had been in the position since January 2023 and that s/he was consolidating data that was "all over the place". S/he also confirmed that s/he could not produce the annual evaluations or competencies for the Staff. She confirmed the process to be that the evaluations and the competencies were filed in the hard files; however, the documents were not in the sampled files. The Administrator could not offer any additional information on where these files could be. The Administrator further demonstrated a lack of knowledge of the regulatory requirements when they confirmed on 12/4/23 at 1:15 PM that the facility did not have a transfer agreement with a hospital, arrangements for laboratory/behavioral health services, or facility-wide QAPI training due to an unawareness of the requirements for such agreements/trainings.	F 835	**Tag F 835 POC accepted on 1/3/24 by N. Baker/P. Cota**	

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F 837 SS=F	Governing Body CFR(s): 483.70(d)(1)(2) §483.70(d) Governing body. §483.70(d)(1) The facility must have a governing body, or designated persons functioning as a governing body, that is legally responsible for establishing and implementing policies regarding the management and operation of the facility; and §483.70(d)(2) The governing body appoints the administrator who is- (i) Licensed by the State, where licensing is required; (ii) Responsible for management of the facility; and (iii) Reports to and is accountable to the governing body. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to have a governing body that is responsible for implementing policies regarding the management and operations of the facility and that holds the facility Administrator accountable for the management of the facility. Findings include: The facility's Governing Body is made up of a Board of Directors (BOD). Per review of a member list for the facility's Board of Directors, the BOD consists of a Chair, a Vice Chair, A Treasurer, a Clerk, a President/COO, and 7 other elected members. A "Board of Directors Policies and Procedures" document was provided dated 2/4/2011. No more-recent version of the policy could be found or provided by the facility. The policy includes the following: "Vision, Values, and Mission	F 837	**F-837 Vernon Green has and will continue to comply with CFR(s): 483.70(d)(1)(2); Governing Body** **What corrective action will be accomplished for those residents found to have been affected by the deficient practice;** ▪ No Residents have been identified as affected ▪ How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken; ▪ No Residents have been identified as affected ▪ What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur; ▪ Administrator shall review the 2567 and the POC with the Vernon Green Board of Directors ▪ Monthly Operations Reports including operational policies being reviewed or edited shall be provided by the Administrator to the Board of Directors ▪ The Board of Director policy and procedure dated 2/4/11 has been reviewed/revised as indicted. ▪ Facility assessment has been updated to include that the Executive Director shall serve as the Chief Executive for the Corporation representing the Corporations operation while reporting to the Board of Directors. **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 his/her designee will provide ongoing monitoring of this process to ensure compliance.	1/6/24

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F 837	Continued From page 46 Procedures: Responsibility: Chairperson, President, Board of Directors Action: Oversees implementation, receives regular reports of progress, determines corrective action, celebrates success. Policy Oversight Process ... It is the role of the board to review and approve a policy development process, ensure that there is accountability for compliance and there are means of monitoring and updating. The board also reviews and approves specific policies. Responsibility: Board of Directors (BOD) Action: Establishes the policy oversight process, sets priorities for policy development, reviews and gives final approval to recommended policies Board Job Description The specific functions of the Board are as follows: ... 2. Select the Chief Executive 3. support the executive and monitor his performance 4. ensure effective organizational planning ... 8. Establish and monitor organizational policies ... 10. Ensure compliance with laws and ethical standards for governance" Per review of the Facility Assessment, the assessment states that the Executive Director (Administrator) reports to the Board of Directors but nowhere in the assessment is the BOD's role in the management of the facility outlined. There is no evidence that the BOD had any participation in the Facility Assessment. Per interview on 11/29/23 at approximately 1:35	F 837	**Tag F 837 POC accepted on 1/3/24 by N. Baker/P. Cota**	

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F 837 Continued From page 47

PM, the BOD Chair described the BOD's current level of involvement with the management of the facility. They stated that the BOD has a quarterly meeting with the administrator in which the administrator reports to the BOD on several areas of performance, including financial, personnel, and quality (including survey results). They went on to say if there are any areas of performance that don't meet expectations, the administrator is expected to develop and present a plan to the BOD on how it will be addressed. When asked what role the BOD plays in assisting the Administrator with corrective actions, the Chair stated that they "rely on [the Administrator] to say what [they need] and follow through with plans of correction." The Chair confirmed that they play no part in validating that corrective actions have been successful or participating in the creation or revision of corrective actions. When asked to what level is the BOD aware of the operations of the facility, the Chair stated that they receive a "high level review" of operations but they do not have detailed knowledge of what the Administrator does to run the facility. Finally, the Chair confirmed that the BOD plays no role in the day-to-day operations of the facility, nor in the creation or implementation of policies and procedures.

Per interview on 12/4/23 at approximately 1:15 PM, the Administrator was discussing challenges they have faced in obtaining necessary resources for the facility's residents. When asked if the BOD is aware of these challenges, the Administrator confirmed that they have brought them to their attention. When asked if the BOD has done anything to assist the Administrator in obtaining these resources, the Administrator stated, "It's not that type of relationship."

F 837

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F 840 SS=F	Use of Outside Resources CFR(s): 483.70(g)(1)(2) §483.70(g) Use of outside resources. §483.70(g)(1) If the facility does not employ a qualified professional person to furnish a specific service to be provided by the facility, the facility must have that service furnished to residents by a person or agency outside the facility under an arrangement described in section 1861(w) of the Act or an agreement described in paragraph (g)(2) of this section. §483.70(g)(2) Arrangements as described in section 1861(w) of the Act or agreements pertaining to services furnished by outside resources must specify in writing that the facility assumes responsibility for- (i) Obtaining services that meet professional standards and principles that apply to professionals providing services in such a facility; and (ii) The timeliness of the services. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility failed to have written arrangements with agencies outside the facility that furnish laboratory and behavioral health services. Findings include: Per review of all written arrangements with outside services provided by the facility, written arrangements for behavioral health services and laboratory services could not be found. Per review of the facility assessment, "psychiatric/mood disorders" is among the list of "Types of diseases and conditions that are common to [the facility's] residents and the care	F 840	**F-840 Vernon Green has and will continue to comply with CFR(s): 483.70 (g)(1)(2), Use of outside resources.** **What corrective action will be accomplished for those residents found to have been affected by the deficient practice;** ▪ Any resident that requires behavioral health services could potentially be affected. ▪ How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken; ▪ No Residents have been identified as being affected **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur;** ▪ Facility has obtained a written service agreement from outside provider for laboratory services at Brattleboro Memorial hospital signed 12/28/23 ▪ Facility has written service agreement with MediTelecare Behavioral telehealth signed 12/28/23 **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.	1/6/24

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F 840	Continued From page 49 that is provided". The "Facility Resources" section also includes "laboratory services" in the "Services" subsection. Per interview on 12/4/23 at approximately 11:30 AM, the Administrator confirmed that they receive laboratory services from a local hospital that supplies the facility with lab equipment and processes their lab samples. The Administrator also confirmed that they were receiving behavioral health services through an outside agency up until 2022 when the agency stopped sending staff in to provide those services. Per interview on 12/4/23 at approximately 1:15 PM, the Administrator confirmed that the facility does not have an arrangement in writing with the local hospital that furnishes their laboratory services. The Administrator also confirmed that the facility never had a written arrangement with the agency that was providing behavioral health services prior to that agency abruptly ending their services. The Administrator stated that this cessation of behavioral health services was unexpected and undesired by the facility, and that they have had no success finding alternative behavioral health services since then.	F 840	**Tag F 840 POC accepted on 1/3/24 by N. Baker/P. Cota** **F-843Vernon Green has and will continue to comply with CFR(s): 483.70(j)(1)(2); Transfer Agreement**	
F 843 SS=F	Transfer Agreement CFR(s): 483.70(j)(1)(2) §483.70(j) Transfer agreement. §483.70(j)(1) In accordance with section 1861(l) of the Act, the facility (other than a nursing facility which is located in a State on an Indian reservation) must have in effect a written transfer agreement with one or more hospitals approved for participation under the Medicare and Medicaid programs that reasonably assures that-	F 843	**What corrective action will be accomplished for those residents found to have been affected by the deficient practice;** ▪ No Residents have been identified as affected **How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;** ▪ No Residents have been identified as affected	1/6/24

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F 843	Continued From page 50 (i) Residents will be transferred from the facility to the hospital, and ensured of timely admission to the hospital when transfer is medically appropriate as determined by the attending physician or, in an emergency situation, by another practitioner in accordance with facility policy and consistent with state law; and (ii) Medical and other information needed for care and treatment of residents and, when the transferring facility deems it appropriate, for determining whether such residents can receive appropriate services or receive services in a less restrictive setting than either the facility or the hospital, or reintegrated into the community will be exchanged between the providers, including but not limited to the information required under §483.15(c)(2)(iii). §483.70(j)(2) The facility is considered to have a transfer agreement in effect if the facility has attempted in good faith to enter into an agreement with a hospital sufficiently close to the facility to make transfer feasible. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility failed to have a written transfer agreement with one or more hospitals approved for participation under the Medicare and Medicaid programs that meets requirements of the regulation. Findings include: During entrance conference on 12/4/23 at approximately 9:45 AM, the facility's written transfer agreement with a local hospital was requested. Per interview on 12/4/23 at approximately 11:30 AM, the Administrator stated that the facility has	F 843	**What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur;** ▪ Facility has a Patient/resident transfer agreement with Brattleboro Memorial Hospital dated 12.8.23 **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. **Tag F 843 POC accepted on 1/3/24 by N. Baker/P. Cota**	

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F 843 Continued From page 51

never had a written transfer agreement with a hospital.

F 880 SS=F Infection Prevention & Control
CFR(s): 483.80(a)(1)(2)(4)(e)(f)

§483.80 Infection Control
The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable 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:
(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;

F 843

F 880 — Completion date: 1/6/24

F-880 Vernon Green has and will continue to comply with CFR(s): 483.80(a)(1)(2)(4)(e)(f); Infection & Control

What corrective action will be accomplished for those residents found to have been affected by the deficient practice;

- Nurse that preformed the dressing change on resident # 14 was re-educated on infection control and providing privacy to residents. The nurse also had a Dressing Change competency completed.

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 to licensed staff on providing privacy while do a dressing to on a resident.
- Education to licensed staff on proper infection control while preforming a dressing change
- Licensed staff to have a dressing change competency completed.

What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur;

- Facility's policy and procedure manual titled Infection Prevention and Control dated 10/25/21, has been reviewed/revised & updated as appropriate
- DON/IP has a proper tracking forms for antibiotic use as well as tacking to monitor for any other communicable disease and/or to identify any clusters or trends with-in the facility.

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F 880	Continued From page 52 (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: Based on staff interview and record review, the facility failed to maintain an infection control program that is reviewed/updated annually and includes a system for preventing and tracking infections and communicable diseases for residents and staff as evidenced by lack of an infection surveillance system or water	F 880	▪ DON/IP has implemented the use of the McGeers Criteria to monitor for proper antibiotic use. ▪ The facility has developed and implemented a Legionella Water management Program. ▪ IP nurse will conduct rounds on units to monitor licensed staff for proper infection control techniques. **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 and/or until 100% compliance is achieved. **Tag F 880 POC accepted on 1/3/24 by N. Baker/P. Cota**	

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Continued From page 53
management program. The facility failed to ensure staff uses proper Personal Protection Equiptment (PPE) and hand hygiene for 1 of 25 residents sampled (Resident #14).
Findings include:

1. Per review of the facility's policy and procedure manual titled "Infection Prevention and Control", the issue date on the manual reads "10/25/21". This is the policy/procedure manual used by the facility as the foundation for their Infection Prevention and Control Program.

Per interview on 11/28/23 at approximately 1:45 PM, the Director of Nursing (DON) was asked to provide evidence that the Infection Prevention and Control Program has been reviewed and updated (as necessary) since 10/25/21. On 11/29/23 at approximately 11:30 AM, the DON confirmed that the facility's Infection Prevention and Control Program is not updated and reviewed on an annual basis.

2. Per review of the facility's policy and procedure manual titled "Infection Prevention and Surveillance", the following section titled "Data Collection" states the following:

"1. The unit charge nurses will identify residents with symptoms or identified infections and complete the Criteria for Infection Report Forms for the respective type of infection:
a. Urinary Tract Infection
b. Respiratory Tract Infection
c. Gastrointestinal Tract Infection
d. Skin, Soft Issue, and Mucosal Infection

2. The Infection Preventionist (IP) will ensure data collection to complete a Comprehensive

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Monthly infection Control Log for surveillance activities on:
a. The infection site
b. Pathogen
c. Signs and symptoms
d. Resident location
e. Summary and analysis of number of residents/staff with infections

3. The Infection Preventionist or designee will be alerted to identify any necessary interventions in order to identify trends or clusters for action.

4. The Infection Preventionist will keep an updated map of infections to identify any clusters or trends."

Per interview on 11/28/23 at approximately 1:45 PM, the DON/IP stated that they had only been in their role for about 6 weeks. During their onboarding, they only had a week of overlap with the outgoing DON/IP and they spent a total of two working days together. There was much that was not formally handed off. There are many files and folders from the former DON/IP that have not been sorted through and the current DON/IP is unsure of what documentation has been maintained and what has not. Since starting, the current DON/IP has implemented a Comprehensive Monthly Infection Control Log but has not yet located any logs, maps, or reporting forms used by the previous DON/IP to track facility-wide infections and concerning symptoms for staff and residents.

Per interview on 11/29/23 at approximately 11:30 AM, the current DON/IP confirmed that neither they or the Administrator could locate any evidence that the former DON/IP was collecting

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F 880	Continued From page 55	F 880		

comprehensive infection and symptom data for the facility to track infections and communicable diseases.

3. Per interview on 11/29/23 at 3:20 PM, the Administrator stated that the facility does not have a program or system for testing their water for legionella or identifying risk areas where legionella can grow. They stated that they chlorinate their water, which is "supposed to kill legionella" but could not provide evidence of a process or policy for this. The Administrator confirmed that they were aware of the requirement for legionella testing but had hoped that chlorinating the water would be sufficient.

4. During observation on 11/28/23 at 2:07 PM, Resident #14 was in the day room area for A wing and C wing units. Resident #14 was sitting in a recliner chair in the company of 8 other residents in the same area. A licensed Practical Nurse (LPN) approached Resident # 14 and proceeded to roll up his/her left pant leg and remove a dressing from the resident's shin, it was observed that the LPN did not have gloves on when s/he removed the dressing and did not perform hand hygiene. The LPN left the pant leg rolled up and then asked Resident #14 if he/she could look at his/her elbow, still not performing hand hygiene or applying gloves with the old dressing from the Left shin in his/her hand. The LPN first rolled up the resident's left sleeve and stated, "That's a good elbow", then went to the right elbow rolled up the resident's sleeve, and removed a dressing from that site, again with no gloves applied or hand hygiene performed. The LPN returned to the medication cart and brought back a dressing for the resident's right elbow, this time returning with gloves on to apply the new dressing. The

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F 880	Continued From page 56 nurse then walked back to the medication cart and removed his/her gloves and performed hand hygiene with hand sanitizer. During interview on 11/28/23 at 2:13 PM the LPN confirmed that s/he should have asked the resident to move to a private area for the dressing change and that s/he should have worn gloves while removing the dressings from the left shin and right elbow, s/he also confirmed that s/he should have performed hand hygiene between sites stating "I have only been working here for a week. I'm just getting to know the residents." During an interview on 11/28/23 at 2:30 PM with the Director of Nurses (DON) regarding the observation of the LPN removing dressings in a public area, not wearing gloves, and not performing hand hygiene properly. The DON confirmed that this is poor practice.	F 880		
F 881 SS=F	Antibiotic Stewardship Program CFR(s): 483.80(a)(3) §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)(3) An antibiotic stewardship program that includes antibiotic use protocols and a system to monitor antibiotic use. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility failed to establish an antibiotic stewardship program that includes antibiotic use protocols. Findings include: Per review of the facility's policy and procedure	F 881	**F-881 Vernon Green has and will continue to comply with CFR(s): 483.80(a)(3); Antibiotic Stewardship Program** **What corrective action will be accomplished for those residents found to have been affected by the deficient practice;** ▪ No residents were identified as being affected **How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;** ▪ No residents were identified as being affected **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur;**	1/6/24

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F 881	Continued From page 57 manual titled "Infection Prevention and Control", it states the following: The Infection Prevention and Control Program includes: 4. an antibiotic use program that includes antibiotic use protocols and a system to monitor antibiotic use. Elements of the program include: - Antibiotic Stewardship and review including reviewing data to monitor the appropriate use of antibiotics in the resident population. Per review of the facility provided antibiotic tracking documents, there is evidence that the facility had been running monthly reports on all residents who were receiving antibiotics and the reasons for antibiotic use. However, no policy or procedure manual was provided by the facility for the Antibiotic Stewardship Program. There was no evidence provided of a formalized program for Antibiotic Stewardship with protocols for antibiotic use, participating staff and their responsibilities, definitions of "appropriate" antibiotic use, or procedures that the facility will implement to decrease unnecessary use of antibiotics. Per interview on 11/29/23 at approximately 11:30 AM, the Director of Nursing confirmed that the facility could not provide evidence of protocols for antibiotic use or any policies governing the Antibiotic Stewardship Program.	F 881	▪ Facility's policy and procedure manual titled Infection Prevention and Control dated 10/25/21, has been reviewed/revised as appropriate ▪ Facility has developed an Antibiotic Stewardship policy ▪ Facility has created an "Antibiotic Stewardship" Tracking binder to include data for appropriate antibiotic use. ▪ DON/IP will oversee the antibiotic stewardship program ▪ Data from antibiotic report will be brought to QAPI for review **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 and/or until 100% compliance is achieved. **Tag F 881 POC accepted on 1/3/24 by N. Baker/P. Cota**	
F 944 SS=C	QAPI Training CFR(s): 483.95(d) §483.95(d) Quality assurance and performance improvement. A facility must include as part of its QAPI program	F 944	**F-944 Vernon Green has and will continue to comply with CFR(s): 483.95 (d) QAPI Training**	1/6/24

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mandatory training that outlines and informs staff of the elements and goals of the facility's QAPI program as set forth at § 483.75.
This REQUIREMENT is not met as evidenced by:
Based on staff interview and record review, the facility failed to include mandatory training that outlines and informs staff of the elements and goals of the facility's QAPI program as part of the QAPI program. Findings include:

Per review of the training records for 7 sampled staff members, none of the 7 staff members had any evidence of training on the facility's QAPI program.

Per interview on 12/4/23 at approximately 12:00 PM, the Assistant Administrator stated that the elements and goals of the facility's QAPI program are discussed with staff informally on orientation. They also said that the Administrator shares information in morning meeting following the quarterly QAPI meetings, but that there is no attendance taken to ensure that all staff receive this information.

Per interview on 12/4/23 at approximately 1:15 PM, the Administrator confirmed that the facility has no formal mandatory training for staff regarding the facility's QAPI program.

F 944

What corrective action will be accomplished for those residents found to have been affected by the deficient practice;

- No residents have been identified as being affected

How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;

- No resident have been identified as being affected

What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur;

- Education on QAPI program has been completed to staff
- QAPI education will be added to the yearly required staff in servicing
- HR/designee will oversee yearly that the QAPI in servicing has been completed for staff

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 and/or until 100% compliance is achieved.

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