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

February 2, 2022

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 on **October 27, 2021.** 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

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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 _____	10/27/2021

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 An unannounced on-site Emergency Preparedness (EP) review was conducted in conjunction with the annual recertification survey, by the Division of Licensing and Protection from 10/25/21 through 10/27/21. There were no EP regulatory violations identified.	E 000	Allegation of Substantial Compliance Vernon Green Nursing Home, herein after sometimes "facility", has and continues to be in substantial compliance with 42 CFR Part 483 subpart B and State of Vermont Licensing and Operation Rules for Nursing Homes. Vernon Green Nursing Home has or will have substantially corrected the alleged deficiencies and achieved substantial compliance by the date specified herein.	
F 000	INITIAL COMMENTS An unannounced on-site annual re-certification survey was conducted by the Division of Licensing and Protection from 10/25/21 through 10/27/21. The facility was found to have the following regulatory deficiencies:	F 000	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 November 23, 2021. The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies herein. To continue to remain in substantial compliance with state and federal regulations, Vernon Green Nursing Home has taken or will take the actions set forth in this plan of correction.	
F 641 SS=B	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on observation, interviews and record review, the facility failed to assure assessments accurately reflected the resident's status for 23 resident assessments. Findings include: On 10/25/21 review of the facility document MATRIX FOR PROVIDERS, column 10 is labeled Physical Restraints. There are check marks for 23 residents as having physical restraints. On 10/26/21 at 2:00 PM, an interview with the Minimum Data Set (MDS) coordinator reveals that the coding of this column occurred due to the misunderstanding of the instructions in the Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual, Version 1.17.1 October 2019. When asked if there is any	F 641	F 641 The facility has and will continue to ensure that it has established and will maintain accuracy of Resident Assessments **What corrective action will be accomplished for those residents found to have been affected by the deficient practice;** The MDS's that have been incorrectly coded secondary to misinterpretation of the RAI Manual by the MDS Coordinator are being modified to assure they are coded correctly. 11/22/21 **How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;** All residents have the potential to be affected by this alleged deficient practice. 11/22/21	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
M. Bradford Ellis	Executive Director	01/24/2022

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 641	Continued From page 1 intent to restrain residents, his/her response was "no there is no intent to restrain any resident". He/she also indicated that the unit nurses do assessments to determine use of the bedrails "to help with in bed mobility." Instructions on P-5 of the Minimum Data Set (MDS) assessment indicate the following: "If the use of bed rails (quarter-, half-or three quarter, one or both, etc.) meet the definition of a physical restraint even though they may improve the resident's mobility in bed, the nursing home must code their use as a restraint at P0100A." The definition of "physical restraints" according to the RAI Manual, in section P0100 of the MDS assessment is "Any manual method or physical or mechanical device, material or equipment attached or adjacent to the resident's body that the individual cannot remove easily, which restricts freedom of movement or normal access to one's body." An interview on 10/26/21 at 1:40 PM, with a Licensed Practical Nurse (LPN) revealed they don't have anyone with restraints. She/he states "we would need a physician order to use restraints of any kind." Interview with the Director of Nursing (DON) on 10/26/21 at 3:00 PM confirmed that Section P of the MDS is incorrect coding and there is "no intent for any side rails to be used as restraints".	F 641	**What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur;** Director of Nursing or designee will conduct Quality Assurance audits of MDS's to assure accuracy of MDS assessments for Section P. **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. F641: PoC accepted 2/2/22 RNCoitaRN	11/22/21 12/21/21
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered	F 656	F 656 Vernon Green has and will continue to comply with §483.21(b)(l) the facility must develop and implement a comprehensive person-centered care for each resident. Vernon Green, herein after sometimes "facility", requests informal dispute resolution for F-656; respectfully maintains that it was and Is in substantial compliance with federal regulations in respect to F-656; respectfully denies and disputes the allegation that it was deficient in respect to F-656; respectfully denies and disputes that any action or inaction on the part of Vernon Green in respect to F-656 caused any harm or potential for any harm to any facility residents; and requests that F-656 be deleted from the public record.	

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F 656	Continued From page 2 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 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. This REQUIREMENT is not met as evidenced by:	F 656	Based on the following the facility will show: 1.Vernon Green is in substantial compliance with F-656 regarding the development and implementation of a comprehensive person-centered care for each resident. 2. No residents have been harmed or potentially harmed by any alleged deficient practice, and there is no evidence the facility failed to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident. The surveyors allege that the facility failed to implement care plan interventions regarding nutritional status for Res. #36. The surveyors failed to recognize: a.Since the resident admission on 07/09/2019 Res. #36 has consistently received weekly weights as Res #36 was weighed 110 times from 07/09/2019 to 10/19/2021. This would average Res. #36 having a weight taken every 7.6 days. b. On 08/30/2021 Res #36 was place in isolation as a result of a COVID-19 diagnosis. Res. #36 MD's progress note indicate "he needs to be isolated due to the positive antigen test". Again on 9/7 the MD notes "Pt is COVID+ - in isolation". Per our Infection Control policy Res. #36 was not taken from his room to be weighed due to being isolated for infection control purposes. c. Nursing Progress notes from 09/04/2021 through 09/23/2021 indicate that Res #36 is at risk for functional mobility/appetite	

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F 656	Continued From page 3 Based upon interview and record review, the facility failed to implement care plan interventions regarding nutritional status for one resident [Res. #36] of 22 sampled residents, resulting in significant weight loss. Findings include: Review of Res. #36's medical record reveals Res. #36 was admitted to the facility on 7/9/19 with diagnoses that include Vascular Dementia, vitamin B12 deficiency anemias, Gastro-esophageal reflux disease, Vitamin D deficiency, and Weakness. Res. #36's Care Plan identifies the resident's Nutritional Status as being at risk: 'I am at risk for weight loss and altered fluid status. I have variable meal intake related to my physical limitations, cognitive/mood state, and my limited attention span. I take a daily diuretic. I have a history of weight fluctuations related to my fluid balance and receiving a daily diuretic.' Care Plan interventions to be implemented to counter the nutritional risk include "Weigh me weekly and chart. Report any significant weight loss or gain to my physician and family." Additionally, Res. #36's Care Plan identifies the resident at risk for Psychotropic Drug Use, with an intervention of 'monitor for adverse side effects' including 'loss of appetite'. Review of Res. #36's Nutrition Quarterly Assessment dated 9/29/21 reveals the resident's "usual weight range=170-177 lbs." Review of Res. #36's Medical Record reveals the resident's weight documented on 8/23/21 as 169.2 lbs. Further review reveals no weights recorded for greater than 4 weeks, until 9/22/21. On 9/22/21, Res. #36's weight is recorded as 151.8 lbs.: a	F 656	and that Res #36 remains in bed. These notes would indicate that his nutritional status was being monitored while being isolated due to a contagious infection. That after Res #36 recovery from COVID-19 and had improved changes in behaviors with medication changes that Res #36 was gaining weight. **F 656** The facility has and will continue to ensure that it has established and will develop and implement a Comprehensive Care Plan **What corrective action will be accomplished for those residents found to have been affected by the deficient practice;** Resident #36 and other residents that are COVID-19 positive in isolation will have their care plan reflect when unable to come out of room secondary to isolation and following guidelines that have been provided to Long-Term Care Facilities. **How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;** All residents that are on isolation precautions have the potential to be affected by this practice. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur;** Director of nurses or designee will educate MDS Coordinator and Nurses to update care plans with changes. Director of nurses or designee will audit care plans for accuracy.	11/22/21 10/27/21 11/26/21

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F 656	Continued From page 4 loss of 17.4 lbs. since the resident was last weighed. Per Nursing Progress Notes written by the Res. #36's Unit Manager on 9/22/21, 'Today his weight in recliner chair was 151.8lbs. [Res. #36's] last recorded weight was on 8/23/21 and he was 169.2lbs. Since then [Res. #36] has had medication changes due to behavioral issues on 8/30/21...as well as he got a diagnosis of covid-19 on 9/1/21 and did not eat very well during this time ... [Res. #36] has had an overall poor intake - average intake 8/31-9/21/21 = 15.15% of those 66 meals during that time frame. Fax sent to MD to update on this weight loss and overall intake.' Further review of the resident's Nutrition Quarterly Assessment dated 9/29/21 records "After maintaining stable weight for greater than 6 months, resident now has significant weight loss". An interview was conducted with Res. #36's Unit Manager on 10/27/21 at 1:40 PM. The Unit Manager confirmed Res. #36's Care Plan included obtaining and documenting weekly weights on the resident. The Unit Manager confirmed the resident was at risk for weight loss for several factors. The Unit Manager stated "I'm sure some weights were missed", and confirmed weights were not done per the Care Plan for Res. #36 for greater than 4 consecutive weeks, during which the resident suffered, per the dietician's Nutrition Assessment, 'significant weight loss'.	F 656	**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. F656 POC accepted as encircled 2/2/22 PM Note RN	12/21/21
F 692 SS=E	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration.	F 692	**F 692** Vernon Green has and will continue to comply with §483.25(g)(1)-(3) maintaining residents' nutrition and hydration status. Vernon Green, herein after sometimes "facility", requests informal dispute resolution for F-692; respectfully maintains that it was and is in substantial compliance with federal regulations in respect to F-692; respectfully denies and disputes the allegation that it was deficient in respect to F-692; respectfully denies and disputes that any action or inaction on the part of Vernon Green in respect to F-692 caused any harm or potential for any harm to any facility residents; and requests that F-692 be deleted from the public record.	

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F 692	Continued From page 5 (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based upon interview and record review, the facility failed ensure the nutritional status of 2 residents [Res. #36 and #34] of 22 sampled residents were monitored per physician's order and/or per the resident's Plan of Care. Findings include: 1). Review of Res. #36's medical record reveals Res. #36 was admitted to the facility on 7/9/19 with diagnoses that include Vascular Dementia, vitamin B12 deficiency anemia's, Gastro-esophageal reflux disease, Vitamin D deficiency, and Weakness. Res. #36's Care Plan identifies the resident's Nutritional Status as being at risk: 'I am at risk for weight loss and altered fluid status. I have	F 692	Based on the following the facility will show: Vernon Green is in substantial compliance with F-692 regarding the nutrition and hydration status maintenance for Res #34 and Res #36. No residents have been harmed or potentially harmed by any alleged deficient practice, and there is no evidence the facility failed to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident. The surveyors failed to recognize: Resident #36 and #34 were in isolation on precautions and had a Covid-19 positive diagnosis during a Covid-19 outbreak. Resident #36 and #34 have and continue to be followed closely by the MD and the dietician. Resident #36 and #34 were seen/and continue to be seen on several occasions by the MD and was in poor condition secondary to his illness. Residents continue to be monitored for weight loss. Resident #36 and #34 both had diagnosis of COVID19 positive and a decreased appetite during this acute illness in which nutrition was highly encouraged as well as nutritional drinks. Both were on isolation precautions and in their rooms unable to be weighed. Resident #36 was feeling very poor and an appetite stimulant had been ordered with little to no effect. The MD, dietician and families/responsible parties were active in residents plan of care.	

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F 692	Continued From page 6 variable meal intake related to my physical limitations, cognitive/mood state, and my limited attention span. I take a daily diuretic. I have a history of weight fluctuations related to my fluid balance and receiving a daily diuretic.' Care Plan interventions to be implemented to counter the nutritional risk include "Weigh me weekly and chart. Report any significant weight loss or gain to my physician and family." Additionally, Res. #36's Care Plan identifies the resident at risk for Psychotropic Drug Use, with an intervention of 'monitor for adverse side effects' including 'loss of appetite'. Review Res. #36's Medical Chart reveals Physician Orders for Res. #36 dated 12/1/20 reading "Obtain weight and vital signs every week on shower day". Review of Res. #36's Nutrition Quarterly Assessment dated 9/29/21 reveals the resident's "usual weight range=170-177 lbs." Review of Res. #36's Medical Record reveals the resident's weight documented on 8/23/21 as 169.2 lbs. Further review reveals no weights recorded for greater than 4 weeks, until 9/22/21. On 9/22/21, Res. #36's weight is recorded as 151.8 lbs.; a loss of 17.4 lbs. since the resident was last weighed. Per Nursing Progress Notes written by the Res. #36's Unit Manager on 9/22/21, 'Today his weight in recliner chair was 151.8 lbs. [Res. #36's] last recorded weight was on 8/23/21 and he was 169.2 lbs. Since then [Res. #36] has had medication changes due to behavioral issues on 8/30/21 ... as well as he got a diagnosis of covid-19 on 9/1/21 and did not eat very well during this time ... [Res. #36] has had an overall poor intake - average intake 8/31-9/21/21 = 15.15% of those 66 meals during that time frame. Fax sent to MD to update on this weight loss and overall intake.'	F 692	**F 692** The facility has and will continue to ensure that it has established and will maintain residents' nutrition and hydration status. **What corrective action will be accomplished for those residents found to have been affected by the deficient practice;** Residents continue to be monitored for weight loss. Resident #36 and #34 both had diagnosis of COVID19 positive and a decreased appetite during this acute illness in which nutrition was highly encouraged as well as nutritional drinks. Both were on isolation precautions and in their rooms unable to be weighed. Resident #36 was feeling very poor and an appetite stimulant had been ordered with little to no effect. The MD, dietician and families/responsible parties were active in residents plan of care. **How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;** All residents have the potential to be affected by this alleged deficient practice **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur;** Residents weight status will be monitored for weight loss. Dietician, MD and families/responsible parties will continue to be notified of all residents that have poor appetite/weight loss/change in status. Resident weights will be monitored by Director of Nursing or designee and changes will continue to be reported to the MD, dietician and family to make a plan of care in attempt to avoid any further weight loss if unavoidable.	10/27/21 10/27/21 10/27/21

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F 692	Continued From page 7 Further review of the resident's Nutrition Quarterly Assessment dated 9/29/21 records "After maintaining stable weight for greater than 6 months, resident now has significant weight loss". An interview was conducted with Res. #36's Unit Manager on 10/27/21 at 1:40 PM. The Unit Manager confirmed both Physician Orders and Res. #36's Care Plan included obtaining and documenting weekly weights on the resident. The Unit Manager confirmed the resident was at risk for weight loss for several factors. The Unit Manager stated "I'm sure some weights were missed", and confirmed weights were not done as ordered for Res. #36 for greater than 4 consecutive weeks, during which the resident suffered, per the dietician's Nutrition Assessment, 'significant weight loss'. 2. Per record review, Resident #34 sustained a fall with a hip fracture on 3/9/20. Prior to this fall, progress notes and weight values show that Resident #34 had a good appetite and was gaining weight. Resident #34 was getting weekly weights prior to the fall per order review and review of weight values. Resident #34's hip was surgically repaired, and they returned to the facility on 3/17/20. Per review of Resident #34's documented meal intake following return to the facility up until 3/30/20, Resident #34 was only eating 0-25% of meals if meals were eaten at all. Most meals were recorded as refused. Progress notes also show that Resident #34's appetite was poor following the hip fracture. Per a nursing note on 3/27/20 at 10:09 AM, "Resident continues with poor appetite, drinks only sips of fluids offered, takes a few small bites of food offered." Per a nursing note from 3/30/20 at 9:23 AM,	F 692	**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. F692 POC accepted as encircled 12/1/22 PMcolaRN	12/21/21

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F 692	Continued From page 8 "Shower day today with weekly weight. Weight today was 128.4lbs. Admit weight from 3/17/2020 was 141.2lbs in the recliner chair. This is down 12.8lbs in 14 days/2 weeks. Fax sent to MD to update. Called to [resident representative] at this time to update." Per a nursing note from 3/30/20 at 10:10 AM, "Called and spoke with [resident representative] at this time who is updated of the weight loss at this time. [resident representative] is in agreement to discontinue the weights weekly for [Resident #34]'s comfort and dignity. [They are] currently on no supplements at this time but when trialed [they] drink the 'juice supplement' best ... Fax sent to MD and note left for dietitian." Per a nursing note from 3/30/20 at 6:51 PM, "MD signed and returned the fax aware of weight loss noted at this time. Gave new order to: 1) discontinue weekly weight monitoring d/t comfort and dignity. [Resident #34] is on the list for dietitian to review when in next." Per record review, the facility's RD (registered dietitian) assessed Resident #34 on 4/3/2020 for significant weight loss (8.6% loss of admission weight within 30 days). Per the RD progress note from 4/3/2020, "offer house juice supplement 8 oz t.i.d. (three times a day) between meals, offer with snack." Per review of a fax from nursing to the physician sent on 4/13/20, nursing proposed the use of the medication Remeron to stimulate Resident #34's appetite. The physician signed off for a trail of this medication. Per review of obtained weight values for Resident #34, Resident #34 was not weighed after implementation of these new interventions and did not receive another weight until July of 2020. The facility did not assess for effectiveness of these interventions on Resident #34's weight loss.	F 692		

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F 692	Continued From page 9 Per review of the facility's policy, Weight Assessment and Intervention, "3) any weight change greater than or less than 5 pounds within 30 days will be retaken the next day for confirmation ... 10) Interventions for undesirable weight loss should focus first on food. Liquid nutritional supplements may be considered if resident caloric intake remains inadequate to stabilize or increase weight." Per interview on 10/27/21 at approximately 2:30 PM, the Unit Manager stated that the facility discontinues weights for residents who are losing weight for their "comfort and dignity" after interventions to prevent further weight loss have been exhausted and the weight loss is determined to be the result of aging and comorbidities. Per interview on 10/27/21 at approximately 4:30 PM, the Unit Manager confirmed that interventions for Resident #34's significant weight loss were implemented after Resident #34's weights had been discontinued.	F 692		
F 700 SS=E	Bedrails CFR(s): 483.25(n)(1)-(4) §483.25(n) Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. §483.25(n)(1) Assess the resident for risk of entrapment from bed rails prior to installation.	F 700	**F 700** Vernon Green has and will continue to comply with §483.25(n)(1)-(4) insuring that bed rails were assessed for potential resident entrapment. Vernon Green, herein after sometimes "facility", requests informal dispute resolution for F-700; respectfully maintains that it was and is in substantial compliance with federal regulations in respect to F-700; respectfully denies and disputes the allegation that it was deficient in respect to F-700; respectfully denies and disputes that any action or inaction on the part of Vernon Green in respect to F-700 caused any harm or potential for any harm to any facility residents; and requests that F-700 be deleted from the public record.	

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F 700 Continued From page 10

§483.25(n)(2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation.

§483.25(n)(3) Ensure that the bed's dimensions are appropriate for the resident's size and weight.

§483.25(n)(4) Follow the manufacturers' recommendations and specifications for installing and maintaining bed rails.
This REQUIREMENT is not met as evidenced by:
Based on observation, interview and record review the facility failed to assure 23 residents were free from potential restraint with the the use of bedrails. Findings include:

On 10/25/21 review of the facility document MATRIX FOR PROVIDERS, column 10 is labeled Physical Restraints. There are check marks for 23 residents as having physical restraints. On 10/26/21 at 2:00 PM, an interview with the Minimum Data Set (MDS) coordinator reveals that the coding of this column occurred due to the misunderstanding of the instructions in the Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual, Version 1.17.1 October 2019. When asked if there is any intent to restrain residents, his/her response was "no there is no intent to restrain any resident". He/she also indicated that the unit nurses do assessments to determine use of the bedrails "to help with in bed mobility."

Interview on 10/26/21 at 1:42 PM with a Licensed Practical Nurse (LPN), reveals that bed rail assessments are done quarterly (located in the

F 700 Based on the following the facility will show:
3. Vernon Green is in substantial compliance with F-700 regarding the assessment of bed rails for residents use.
4. No residents have been harmed or potentially harmed by any alleged deficient practice, and there is no evidence the facility failed to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident.

The surveyors allege that the facility failed to show accurate assessment measures were conducted to reflect appropriate use.
a.The surveyors failed to discuss this potential finding with the administrator prior to exit. If the administrator would have been made aware that the survey team were investigating the bed rail assessments the administrator could have provided the completed Bed Rail Assessment for residents using bed rails for positioning. Copies of the Bed Rail Assessment have been included with the Informal Dispute Resolution
b. The surveyor indicates on the 2567, page 13 that the "Director of Nursing confirmed in an Interview on 10/27/21 at 10:50am, that staff do discuss and assess bedrails for possible entrapment or restraints but had identified that the Bedrail Assessment Form and permission form does not reflect that an accurate assessment was completed.
The surveyor failed to note that the Director of Nursing stated the Executive Director and Director of Nursing

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F 700 Continued From page 11

paper chart) and that a physician's order is needed for any restraint. She/he also indicates that there are no residents that have restraints and there is a consent form signed by the resident or responsible party regarding side rails located in the paper charts of each resident. This nurse confirmed that residents were incorrectly coded on the MDS in section P0100A as having restraints and that the Side Rail Assessment documentation does not reflect this information.

Review of Vernon Green's resident Side Rail Assessment documentation indicates the following: Name of resident, Diagnosis, Cognitive Status, Visual impairment, Ability to understand, Fear of falling, Poor tolerance, Dizziness, Falls within the past three months, Any injuries, Mobility status, Gait/Balance problems, Contractures, Positioning problems, behavioral problems, Is side rail use appropriate and why, Outcomes and Resident/Responsible party comments. This assessment does not indicate whether the resident is assessed for whether the resident can or cannot voluntarily get out of bed with the presence of bed rails.

Section P0100 of the RAI manual also suggests that if the resident "is immobile and cannot voluntarily get out of bed because of a physical limitation or because proper assistive devices were not present, the bed rails do not meet the definition of a physical restraint." The facility Side Rail Assessments do not specify this information.

Review of Side Rail Permission Forms signed by the resident or responsible party state "able to use side rails as assistive devices to continue to promote and strengthen their independent functional mobility."

F 700 monitor the bed's dimensions and assessed for entrapment.

c. The residents that utilize the bed rails have/are being assessed for proper installation, and entrapment (the Executive Director and Director of Nursing does and continues to assess residents that utilize the bed rail to ensure the bed's dimensions are complete and assessed for entrapment).

Note: Surveyors failed to identify all 14 of the 23 residents impacted in the cited F-700 finding through the Resident Identifier List given to the administrator at the survey exit meeting.

F 700 The facility has and will continue to ensure that it has established and will maintain a program to assess the risk and benefit of resident bed rail use.

What corrective action will be accomplished for those residents found to have been affected by the deficient practice; All resident with bed rails will be reassessed for the use of bedrails to promote independent/ assist with bed mobility. Risks and benefits have been reviewed with resident and/or family/responsible party and informed consents were and continue to be obtained from resident and/or responsible party. We will continue to have informed consents signed by the resident and/or family/ responsible party. We will continue to monitor the residents' risk of entrapment while utilizing the bed rail. We are and will continue to be a restraint free facility. **12/03/21**

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F 700	Continued From page 12 The Side Rails Assessment forms and Permission Forms, reveal that the facilities intent for using side rails are to "help with bed mobility" rather than as restraints, however, they do not show that accurate assessment measures were conducted to reflect appropriate use. The Director of Nursing confirmed in an Interview on 10/27/21 at 10:50 am, that staff do discuss and assess bedrails for possible entrapment or restraints but has identified that the Bedrail Assessment Form and permission form does not reflect that an assessment was completed.	F 700	**How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;** All residents have the potential to be affected by the alleged deficient practice **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur;** Bedrail risk assessment tool will be utilized for risk vs benefit of bed rail use to assist in bed mobility. MDS assessment will be audited to assure accurate coding is in place. **How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** The Director of Nursing or his/her designee will provide ongoing monitoring of this process to ensure compliance. Results of this audit will be brought to the QAPI meeting monthly and/or until 100% compliance is achieved.	**11/27/21** **12/03/21** **12/2121**
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:	F 812	F700 POC accepted as encircled 2/24/22 mmotaRN **F 812** Vernon Green has and will continue to comply with §483.60(i)(2) to store, prepare, distribute and serve food in accordance with professional standards for food service safety. Vernon Green, herein after sometimes "facility", requests informal dispute resolution for F-812 Finding #1; respectfully maintains that it was and is in substantial compliance with federal regulations in respect to F-812 Finding #1; respectfully denies and disputes the allegation that it was deficient in respect to F-812 Finding #1; respectfully denies and disputes that any action or inaction on the part of Vernon Green in respect to F 812 Finding #1 caused any harm or potential for any harm to any facility residents; and requests that F-812 Finding #1 be deleted from the public record.	

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F 812	Continued From page 13 Based on observation, interview, and record review, the facility failed to store and prepare food in accordance with professional standards for food service safety. Findings include: 1. Per observation on 10/25/21, 10/26/21, and 10/27/21 at various points in the day, the facility prepares and plates meals for the facility's residents in a separate building. Meals are plated onto plates inside of insulated covers and chargers that are loaded onto an uninsulated tray cart and brought over to the facility by a small utility vehicle outside. The trip takes approximately 5-10 minutes from the time the meal cart exits the kitchen to the point that the meal cart is in the facility and meals are ready for distribution to residents. Per review of food temperature logs on 10/26/21 at approximately 10:00 AM, the kitchen staff routinely take temperatures of PHFs (potentially hazardous foods - food that requires time/temperature control for safety to limit the growth of germs) once they complete cooking to ensure a safe internal cooking temperature. The logs do not show evidence of kitchen staff routinely taking temperatures of PHFs when being held on the steam table prior to plating (for hot foods) or when being removed from the refrigerator after preparation/cooling and prior to plating (for cold prepared foods). Per interview on 10/26/21 at approximately 10:30 AM, the Dietary Manager confirmed that they do not routinely test temperatures for cold or hot foods after preparing and cooling, during holding, or prior to plating for the journey to the facility. Professional standards for food service safety	F 812	Based on the following the facility will show: 1. Vernon Green is in substantial compliance with F 812 regarding the storage, preparation, distribution and serving of food in accordance with professional standards for food service safety. 2. No residents have been harmed or potentially harmed by any alleged deficient practice, and there is no evidence the facility failed to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident. 3. The CMS interpretive guidelines (from State Operations Manual Appendix PP-Guidance to Surveyors for Long Term Facilities, Rev. 173, 11-22-17) for F 812 clearly states that Potentially Hazardous Foods (PHF) or Time/ Temperature Controls for Safety (TCS) foods may be safely held and served in the danger zone of 41°F to 135°F for up to 4 hours without risk of creating foodborne illness; and that non PHF/ TCS foods pose no foodborne illness potential if held and served in the danger zone for any length of time. The surveyors allege that "without a process to test holding temperatures of cold and hot foods during holding or after preparation and cooling, the facility is unable to verify that these foods are held within the safe holding temperature range." The inference is that	

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F 812	Continued From page 14 indicate that safe holding temperatures (temperatures of foods after cooking/preparing but before being eaten) are above 135 degrees Fahrenheit for hot foods or below 41 degrees Fahrenheit for cold foods. Without a process to test holding temperatures of cold and hot foods during holding or after preparation and cooling, the facility is unable to verify that these foods are held within the safe holding temperature range. 2. Per observation on 10/25/21 at approximately 11:00 AM, the facility kitchen's walk-in refrigerator contained a large tub of cream cheese without an open/discard date, approximately 4 opened containers of pork base without an open/discard date, 2 opened containers of juice without open/discard dates, and a tub of dip without an open/discard date. Per interview on 10/25/21 at approximately 11:10 AM, the DM (Dietary Manager) confirmed that the cream cheese, pork base, and juice containers were all without date labels. Per the DM, all food products need to be labeled with the open date per facility policy to ensure that they can be discarded by the discard deadline. The DM stated that cold beverages are never labeled with open dates because they get used up "usually quickly" before the discard date. The DM also confirmed that the tub of dip (mixed in with resident food items) belonged to staff and was outside the designated area for staff food. 3. Per observation on 10/26/21 at approximately 9:30 AM, the B-Wing storage fridge temperature log had been documented as out of range (above 41 degrees Fahrenheit) for 8 days during the month of October 2021. This fridge contained resident food and drink.	F 812	food safety requires consistent temperature control from the tray line to transport and distribution to prevent contamination. a. The thinking that "food safety requires consistent temperature control from the tray line to transport and distribution to prevent contamination" is taken from the interpretive guidelines (cited in #3 above) Food Service and Distribution section and is referencing various delivery systems used in the nursing home industry and whether these systems provide heating elements to keep foods hot (Vernon Green utilizes such a system) and whether the foods are covered in transportation carts to prevent [cross] contamination (Vernon Green's are). Later in this section of the interpretive guidelines is the statement that problems and risks to avoid in preventing foodborne illness include "holding foods in the danger zone temperatures which are between 41 degrees F and 135 degrees F". The surveyors are using an incorrect standard in this finding to evaluate the facility's compliance with F-812. The surveyors are using the temperature standards for holding food instead of total time for service as outlined next.	

F812 continued from page 15

b. The correct standard is found later in the interpretive guidelines under the "*Key Elements of Noncompliance*: To cite F-812, the surveyor's investigation will generally show the facility failed to do any one of the following: Maintain PHF/TCS foods at safe temperatures, at or below 41 degrees F (for cold foods) or at or above 135 degrees F (for hot foods) except during preparation, cooking, or cooling, and ensure that PHF/TCS food plated for transport was not out of temperature control for more than four hours from the time it is plated" (emphasis added).

c. Vernon Home's Food Temperature and Production Log for meals on October 25 & 26, 2021 indicates that hot food temperatures when placed in the steam table ranged from 168° to 201° F at approximately 7:10 a.m., 11:10 a.m. and 5:10 p.m. prior to plating the meals. This temperature range is higher than the standard requires to begin the four-hour control before the food becomes a hazard.

d. Vernon Home's Kitchen Refrigerator, Freezer and Sanitizer Efficacy Tracking log for October 25 & 26, 2021 that the walk-in cooler was 36.6° - 40.7° at approximately 7:10 a.m., 11:10 a.m. and 5:10 p.m. prior to plating the meals. This temperature range is lower than the standard requires to begin the four-hour control before the food becomes a hazard.

The findings fail to indicate when a food temperature was out of compliance for more than 4 hours from the time that it was put in the steam table or taken from the cooler until the time that it was served to the residents.**F812 What corrective action will be accomplished for those residents found to have been affected by the deficient practice?**

1) Vernon Green will continue to ensure that the foods served to residents will meet the standards set forth in CFR(s) 483.60(i)(1)(2) for Foodservice operations.	10/27/21
2) 11-7 nursing staff were educated on the need to record the refrigerator temperature in the refrigerator's monthly temperature log, indicating on the temperature what corrective action was taken and reporting temperatures out of range to Director of Nursing.	11/12/21
3) The dietary transporter was educated on the need to record the refrigerator temperature in the refrigerator's monthly temperature log, indicating on the temperature what corrective action was taken and reporting temperatures out of range to their supervisor.	11/12/21
4) The dietary transporter was educated on the need to record the refrigerator temperature in the refrigerator's monthly temperature log, indicating on the temperature what corrective action was taken and reporting temperatures out of range to their supervisor.	11/12/21

F812 continued from page 15a

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

All residents have the potential to be affected by this alleged deficient practice. 10/27/21

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

1) Vernon Green will review our meal service protocols with an outside contract 12/06/21
2) The 7-3 B-Wing Charge Nurse will insure the temperatures for this refrigerator are accurately recorded on the posted log by the nursing staff each day; that nursing staff will be retrained to notify their supervisor and the maintenance staff when refrigerator temperatures are out of the stated range; when to move product to another refrigerator when this happens and the reasons these procedures are important 12/04/21
3) The dietary transporter will insure the temperatures for this refrigerator are accurately recorded on the posted log each day. The transporter will be retrained to notify their supervisor when refrigerator temperatures are out of the stated range; when to move product to another refrigerator when this happens and the reasons these procedures are important. 12/04/21
4) The dietary transporter will insure the temperatures for this refrigerator are accurately recorded on the posted log each day. The transporter will be retrained to notify their supervisor when refrigerator temperatures are out of the stated range; when to move product to another refrigerator when this happens and the reasons these procedures are important. 12/04/21

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 will provide ongoing monitoring of this process to ensure compliance. Results of this audit will be brought to the Quality Assurance Performance Improvement (QAPI) meetings and/or until 100% compliance is achieved. 12/21/21

A QAPI plan will be started to ensure that times are recorded on the Food Temperature and Production Log and that prepared milk temperatures are being recorded and that these results being evaluated for meeting the 483.60(l)(1)(2) standard. These will be reported to the QAPI committee meeting. 12/21/21

F812 POC accepted as encircled 2/2/22 PMcotaRN

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F 812	Continued From page 15	F 812		

Per interview on 10/26/21 at approximately the same time as the observation, the B-wing charge nurse confirmed that the 8 days were documented as out of range during October 2021.

Per observation on 10/27/21 at approximately 9:30 AM, the B-wing storage fridge was 42 degrees Fahrenheit according to the thermometer in the fridge.

Per interview on 10/27/21 at approximately the same time as the observation, a B-wing nurse confirmed that the thermometer in the storage fridge read 42 degrees Fahrenheit.

4. Per record review on 10/26/21 at approximately 10:00 AM, the B-wing dining room refrigerator/freezer temperature log for September 2021 had only been filled out with temperature readings for 5 out 30 calendar days. The A-wing clean service room refrigerator/freezer temperature log for September 2021 had only been filled out with temperature readings for 4 out of 30 calendar days.

Per interview on 10/26/21 at approximately 11:30 AM, the dietary manager confirmed that the two refrigerator/freezer temperature logs had not been completed for every day of September 2021 and that both units contained resident food and/or drink. They also confirmed that, at that time, the dietary staff were restricted from the building due to COVID-19 precautions so dietary staff regularly responsible for completing the temperature monitoring were not performing the task.

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F 880 SS=F	Continued From page 16 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; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections;	F 880 F 880	F 880 Vernon Green has and will continue to comply with §483.21(a)(1)(2)(4)(e)(f)the facility must develop and implement an infection prevention and control program. Vernon Green, herein after sometimes "facility", requests informal dispute resolution for F-880; respectfully maintains that it was and is in substantial compliance with federal regulations in respect to F-880; respectfully denies and disputes the allegation that it was deficient in respect to F-880; respectfully denies and disputes that any action or inaction on the part of Vernon Green in respect to F-880 caused any harm or potential for any harm to any facility residents; and requests that F-880 be deleted from the public record. Based on the following the facility will show: 1. Vernon Green is in substantial compliance with F-880 regarding the development and implementation of an infection prevention and control program. 2. No residents have been harmed or potentially harmed by any alleged deficient practice, and there is no evidence the facility failed to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident. The surveyors allege that the facility failed to have implemented an infection prevention and control program. The surveyors failed to recognize: a. The Director of Nursing (DON) provided the surveyors with a record of the infection control tracking log.	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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 _____	10/27/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 880 Continued From page 17

(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 establish an infection prevention and control program that includes a system for preventing identifying, reporting, investigating, and controlling infections and communicable diseases. Findings include:

Per review of the August 2021 Infection Control Log provided by the DON reflects a list of

F 880 b. The infection control tracking log showed the resident, date, type of infection and location of the resident infection and the bacteria. This was charted/documented by the Infection Preventionist (ADON) up until her resignation and our Covid-19 Outbreak. The DON at the time of survey was unable to locate the correct file where her tracking forms were. Attached you will find the 2021 Infection Control logs which includes the infections of residents and any the staff may have had.
C. All residents with infections is discussed at morning meetings and staff huddles on a daily basis. Resident infections are placed on the appropriate precautions as indicated.
d. Infection Control data is shared at quarterly meetings with the Quality Assurance Team.

F 880 The facility has and will continue to ensure that it has established and will maintain an infection prevention and control program.

What corrective action will be accomplished for those residents found to have been affected by the deficient practice; The facility has designated an RN as the infection control nurse and she is enrolled in an Infection Control Preventionist Program currently to replace the previous RN. The training is through ahcancalED "Infection Preventionist Specialized Training – IPCO Version 2." 11/17/21

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F 880	Continued From page 18 residents being treated with an antibiotic, the specific antibiotic prescribed, and the date the antibiotic started. There is no tracking of the infection site, pathogen, signs and symptoms, or summary and analysis of the number of residents/staff with infections. The Facility Infection Prevention Surveillance policy and procedure states, "Data Collection: ... 2. The Infection Preventionist will ensure data collection to complete a comprehensive 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 Per interview with the DON on 10/27/2021 at 12:07 PM the Registered Nurse (RN) who was designated as the Infection Preventionist (IP) has not been employed by the facility since the first week of September. The IP was responsible for tracking and trending facility infections and documenting the data on a computer spread sheet. The DON stated the s/he cannot locate the spread sheet. S/he confirmed that the Infection Control Log did not reflect tracking of infection sites, pathogens, signs and symptoms, or summary and analysis of the number of residents/staff with infections as stated in the Facility Infection Prevention Surveillance policy.	F 880	**How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;** All residents have the potential to be affected. Staff have and will continue to assess for changes and any indication of them not feeling well and is reported to the MD and family/responsible party. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur;** The facility's Infection Control nurse has been identified and is completing the Infection Preventionist Program. The facility's tracking form will be updated to include all infection information in the least amount of forms possible. **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 Infection Control Preventionist (or DON 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.	10/27/21 12/31/21 12/21/21

F880 POC accepted as encircled
2/2/22 pmcd aRN