

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 075334	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/27/2026
NAME OF PROVIDER OR SUPPLIER Vernon Rehabilitation and Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 180 Regan Road Vernon, CT 06066	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical record, review of facility documentation, review of facility policy/procedures and interviews for one sampled resident (Resident #5) with an allegation of neglect, the facility failed to ensure the potential abuse was reported to the state survey agency. The findings include: Resident #5's diagnoses include a right femur and a right radius fracture. The admission MDS assessment dated [DATE] identified Resident #5 had intact cognition, a functional range of motion deficit affecting an upper extremity, and required total assistance with toileting, and bed mobility. It further noted the resident had an indwelling catheter and was always incontinent of bowel. The physician's orders dated 6/21/26 directed to turn and reposition every 2 hours, float heels in bed as tolerated every shift, and assist of one staff member with bed mobility, transfers, toileting, bathing and dressing. Interview with Resident #5 on 7/21/26 at 10:53 AM identified that during the first week of being admitted to the facility, he/she had a negative interaction with NA#1. Resident #5 identified that NA#1 was rude, yelled, and left him/her in a soiled brief for four hours. The resident further identified that there have been a couple of other times when NA #1 has spoken rudely or he/she has been made to wait over an hour for assistance with incontinent care. Further, Resident #5 noted that one of the nursing supervisors spoke with him/her regarding the situation with NA #1 and noted that NA #1 had not provided care for a while. Resident #5 indicated that the nursing supervisor and the DNS were aware of the details of his/her concerns because he/she has spoken with them about his/her concerns. A review of the state survey agency's reporting portal identified that a reportable event was not submitted regarding Resident #5's allegation of neglect. A request for accident and incident reports regarding Resident #5 was made but there were none regarding any allegations of abuse and/or neglect. Review of an email dated 6/26/26 provided by Resident #5's family member (Person #1), identified that he/she notified the social worker (SW #2) of the negative interaction between Resident #5 and a nurse aide. The email alleged Resident #5 requested assistance to be changed due to incontinence and the nurse aide responded to Resident #5 by accusing the resident of intentionally soiling himself/herself for attention and refused to change the resident. Review of social worker notes for the month of June/2026 and July/2026 failed to identify what action or follow up was taken as a result of the allegation of mistreatment. Interview with the DNS and the ADNS on 7/22/26 at 9:04 AM identified the ADNS conveyed that she conducted the initial interview with Resident #5 regarding the customer service complaint against NA #1 and indicated that it appeared Resident #5 did not want NA#1 providing care due to a personality conflict. The ADNS identified that Resident #5 did not articulate that NA#1 spoke rudely or made Resident #5 wait a long time for care. Interview with the DNS on 7/27/26 at 10:42 AM identified that the family did not send an email to her, and she did not have an email and indicated the initial investigation was initiated based on verbal notification from (continued on next page)		

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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER
REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	SW#2 regarding a NA who was not personable. Interview with SW#2 (no longer works at the facility) on 7/27/26 at 11:44 AM identified that she was the only social worker managing the entire building at that time and briefly looked at the email and knew she would not be able to follow through with it so forwarded it to the DNS. SW#2 indicated that she did not follow up with Resident #5 after forwarding the email to the DNS. Interview with the ADNS on 7/27/26 at 12:10 PM identified that at the time of the initial incident she was only aware of a complaint of a flat affect from the NA#1. The ADNS reviewed the copy of the email referenced above and indicated that she had seen the email for the first time 30 minutes prior to speaking with this Surveyor and identified that if she had that information initially that would have guided the questioning of the resident differently. Interview with the DNS, ADNS, Administrator and Admissions Director on 7/27/26 at 12:30 PM identified that the initial allegation should have been treated as an allegation of neglect/abuse and investigated comprehensively and reported to the state survey agency. The DNS indicated that she had taken the response from the ADNS questioning of Resident #5 as a basis for treating it as a customer service issue. The administrator identified that based on the information the facility had at the time, the customer service response was appropriate and pointed out that the email had been received and reviewed at that time, the Administrator indicated that with the additional information it should have been investigated and reported. A review of the interview with the DNS, and SW#2 identified that although the DNS was in receipt of the email from Person #1 with the allegation of neglect, the DNS failed to ensure the allegation was reported to the state survey agency. Subsequent to surveyor inquiry, a reportable event report was submitted to the state survey agency on 7/21/26. The facility policy for Incidents and Accidents identified incidents/accidents that require an incident/accident report include alleged abuse will be entered into the appropriate form/system within 24 hours of occurrence and all pertinent information documented, which includes the date, time, nature of the incident, location, initial findings, immediate interventions, notifications, and orders or follow up interventions. The facility policy for Abuse, neglect and Exploitation identified the definition of abuse means the willful infliction of injury, intimidation or punishment with resulting physical harm, pain or mental anguish and includes the deprivation of goods or services that are necessary to attain or maintain physical, mental and psychosocial wellbeing. The policy indicates that the facility will provide residents, representatives and staff, information on how and whom they may report concerns, incidents and grievances without the fear of retribution and identified possible indicators of abuse include failure to provide care needs such as comfort, safety, feeding, bathing, dressing, turning and positioning. The policy identified the facility will make efforts to protect residents from further abuse with room or staffing changes, provide emotional support and revise the resident's care plan. In addition, the policy indicated that reporting of the alleged violations to the Administrator, state survey agency, and adult protective services or police within specified time frames will be completed.		

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical record, review of facility documentation, review of facility policy/procedure, and interviews for one sampled resident (Resident #5) with an allegation of mistreatment, the facility failed to ensure an allegation of mistreatment/neglect was thoroughly investigated. The findings include: Resident #5's diagnoses include a right femur and a right radius fracture. The admission MDS assessment dated [DATE] identified Resident #5 had intact cognition, a functional range of motion deficit affecting an upper extremity, and required total assistance with toileting, and bed mobility. It further noted the resident had an indwelling catheter and was always incontinent of bowel. Interview with Resident #5 on 7/21/26 at 10:53 AM identified that during the first week of being admitted to the facility, he/she had a negative interaction with NA#1. Resident #5 identified that NA#1 was rude, yelled, and left him/her in a soiled brief for four hours. The resident further identified that there have been a couple of other times when NA #1 has spoken rudely or he/she has been made to wait over an hour for assistance with incontinent care. Further, Resident #5 noted that one of the nursing supervisors spoke with him/her regarding the situation with NA #1 and noted that NA #1 had not provided care for a while. Resident #5 indicated that the nursing supervisor and the DNS were aware of the details of his/her concerns because he/she has spoken with them about his/her concerns. A review of the state survey agency's reporting portal identified that a reportable event and summary of investigation was not submitted regarding Resident #5's allegation of neglect. A request for accident and incident reports regarding Resident #5 was made but there were none regarding any allegations of abuse and/or neglect. A review of the facility's grievance log/book, identified none pertaining to Resident #5. Review of an email dated 6/26/26 provided by Resident #5's family member (Person #1), identified that he/she notified the social worker (SW #2) of the negative interaction between Resident #5 and a nurse aide. The email alleged Resident #5 requested assistance to be changed due to incontinence and the nurse aide responded to Resident #5 by accusing the resident of intentionally soiling himself/herself for attention and refused to change the resident. Review of social worker notes for the month of June/2026 and July/2026 failed to identify what action or follow up was taken as a result of the allegation of mistreatment. Interview with the DNS on 7/21/26 at 2:35 PM identified the facility did not have an accident/incident (A&I) Investigation completed for the allegation relayed by Resident #5 but had looked into a complaint made by Resident #5 regarding NA#1 being flat (affect) and not engaging while providing care. The DNS indicated that NA#1 was removed from the schedule for the weekend and provided with education regarding customer service and provided a statement. The DNS identified that she was not aware of any concerns regarding neglect or abuse and was notified of the event verbally by the social worker. Interview with the DNS and the ADNS on 7/22/26 at 9:04 AM identified the ADNS conducted the initial interview with Resident #5 regarding the customer service complaint and indicated that it appeared Resident #5 did not want NA#1 providing care due to a personality conflict. The ADNS identified that Resident #5 did not articulate that NA#1 spoke rudely or made Resident #5 wait a long time for care and indicated that regarding this new allegation Resident #5 had been consistent with the details reported to the facility. The DNS and ADNS did not provide documentation of the meeting or actions taken due to information provided by Resident #5. Review of the Resident #5's clinical record failed to identify documentation of a meeting or the information ascertained from the meeting. Interview with NA#1 on 7/22/26 at 1:54 PM identified NA#1 was aware Resident #5 had made a complaint with the facility on 6/26/26 about NA#1 being monotone and not over expressive. NA#1 indicated there was a stressed interaction at the end (continued on next page)		

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	of a night shift when getting Resident #5 up for the day and on an evening shift a day or two later when NA#1 noticed Resident #5's call bell had been alarming for a long time so NA#1 went to Resident #5's room to reassure the resident that another NA would be in shortly to which Resident #5 accused NA#1 of not liking him/her. Interview with the Scheduler on 7/22/26 at 2:02 PM identified NA#1 was removed from the schedule for 6/26 through 6/28/26 per the DNS because she wanted time to provide customer service education. Interview with Person #1 (Resident #5's family member) on 7/22/26 at 2:07 PM identified that a complaint/concern was sent to the social worker on 6/26/26 conveying concerns regarding NA#1. Person #1 identified that Resident #5 indicated being left alone without a call bell and in a soiled brief for hours. Person#1 identified that Resident #5 identified NA#1 shouted during the interaction but identified that he/she had not included that information in the email sent to the social worker. Person #1 indicated that feedback from Resident #5 was that NA#1 no longer provided care. Person#1 further noted that the social worker had responded in an email that the concerns expressed in the email would be passed along to the DNS. Person #1 identified that he/she had received no further information from the facility and no one from the facility had contacted him/her. Subsequent to surveyor inquiry the care plan dated 7/23/26 identified Resident displayed symptoms r/t a traumatic event with interventions of two-person for care. Interview with Person#2 (Resident #5's family member) on 7/27/26 at 10:30 AM identified he/she had texted the Assistant Admission's Coordinator on 6/23/26 at 8:30 AM and notified her of Resident #5's concern of sitting in a soiled brief for a long period and indicated that Resident #5 was reluctant to report a staff member. Person#2 identified that the Assistant Admission's Coordinator noted that she would send an email to the SW#2 regarding the concern. Review of an email chain provided by Person#1 on 7/27/26 at 11:13 AM identified an email sent to SW#2 on 6/26/26 at 1:01 PM indicating Resident#5 had verbalized filing several complaints regarding NA behavior and identified an interaction that a NA told Resident #5 that he/she soiled the brief on purpose to get attention and refused to change the resident. The email requested SW#2 meet with Resident #5 to see if the concerns were valid. Subsequent emails in the email chain dated 6/26/26 at 1:06 PM indicated that the concern had been passed on to the DNS. Interview with the Assistant Admission's Coordinator on 7/27/26 at 11:31 AM identified that she had received a text from Person#2 on 6/23/26 identifying a concern. The Admission's Assistant denied knowing specifics of the allegation but did send an email to SW#2 on 6/23/26 identifying Person#1 and #2 would like to touch base regarding Resident #5 and included contact information for Person #1 and #2. Interview with SW#2 (social worker) on 7/27/26 at 11:44 AM identified that she was the only social worker managing the entire building at that time and briefly looked at the email and knew she would not be able to follow through with it and forwarded it to the DNS. SW#2 denied being notified of any concerns by the Assistant Admission's Coordinator and indicated that she did not follow up with Resident #5. Interview with the DNS on 7/27/26 at 11:47 AM identified SW#2 had forwarded the email received from Person #1 on 6/26/26 at 1:08 PM and that she read the email at that time and indicated that the ADNS was with her and also reviewed the email at that time and knew there was an allegation of a NA refusing to provide care and that the ADNS was the person who interviewed Resident #5 at that time. Interview with the ADNS on 7/27/26 at 12:10 PM identified that at the time of the initial incident she was only aware of a complaint of a flat affect from the NA. The ADNS reviewed the copy of the email provided by the Surveyor and indicated that she saw the email for the first time 30 minutes prior and identified that if she had known of the details at the time she spoke with the resident it would have guided the questioning of the resident differently. Interview with the DNS, ADNS, Administrator and Admissions Director on 7/27/26 at 12:30 PM identified that the initial allegation should have been treated as an allegation of neglect/abuse and investigated (continued on next page)		

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	comprehensively and reported to the state survey agency. A review of the interview with the DNS, and SW#2 identified that although the DNS was in receipt of the email from Person #1 with the allegation of neglect, the DNS failed to ensure the allegation was thoroughly investigated. The facility policy for Abuse, neglect and Exploitation identified the definition of abuse means the willful infliction of injury, intimidation or punishment with resulting physical harm, pain or mental anguish and included the deprivation of goods or services that are necessary to attain or maintain physical, mental and psychosocial wellbeing. The policy indicates that the facility will provide residents, representatives and staff information on how and whom they may report concerns, incidents and grievances without the fear of retribution and identified possible indicators of abuse include failure to provide care needs such as comfort, safety, feeding, bathing, dressing, turning and positioning. The policy identified an immediate investigation is warranted when suspicion of abuse, neglect or exploitation or reports of abuse, neglect or exploitation. The written procedures for investigations include identifying and interviewing all involved persons, including the alleged victim, alleged perpetrator, witnesses and others who might have knowledge of the allegations, focusing the investigation on determining if abuse, neglect, exploitation and/or mistreatment occurred, the extent and cause and providing complete and thorough documentation of the investigation. The policy identified the facility would make efforts to protect residents from further abuse with room or staffing changes, providing emotional support and revision of the resident's care plan for changes as a result of the incident. The policy indicated that reporting of the alleged violations to the Administrator, state agency, adult protective services or police within specified time frames.		