| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 475008 | A. Building<br>B. Wing | 06/04/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Vernon Green Nursing Home | 61 Greenway Drive<br>Vernon, VT 05354 |

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 0600<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.<br><br>Based on interviews and record review, the facility failed to protect the resident's right to be free from physical abuse by a facility staff member for 1 of 3 sampled residents (Resident #1). This is a repeat deficiency for this facility, with the violation cited during the previous recertification survey, dated 1/14/26. Findings include: Per record review, Resident #1 has diagnoses that include generalized anxiety disorder, major depressive disorder, and moderate dementia with other behavioral disturbance. Progress notes dated 2/22/2026 reflect that Resident #1 had been exhibiting aggressive behaviors of yelling and lashing out at staff. The Resident was sitting in their wheelchair in the nursing station yelling out and kicked the Registered Nurse (RN), grabbing her arm. Per interview with the Director of Nursing (DON) on 6/3/2026 at approximately 3:25 PM, on the evening of 2/22/2026 she received a call from the facility informing her of a staff to resident altercation. The DON stated that when she interviewed the unlicensed Nurse Assistant (NA), she reported that she had reacted to being kicked and spit on by the Resident by slapping him on the cheek because she had PTSD (post-traumatic stress disorder) from experiences in her past. The DON confirmed that the NA had hit the Resident and that the NA stated that she could have walked away. Per interview on 6/3/2026 at 4:46PM the Licensed Nursing Assistant (LNA) who witnessed the altercation stated that she and the NA were sitting at the nurses' station with Resident #1 because s/he was having aggressive behaviors. Another Resident approached and needed help, so the LNA went to help them. When the LNA returned to the nurses' station, Resident #1 and the NA were raising their voices, yelling at each other. Resident #1 tried to kick and spit at the NA. The NA had been sitting on the counter of the nurses' station, and she jumped down and grabbed the Resident's wheelchair and was trying to tip the Resident out of the wheelchair and was yelling at her/him. The LNA was attempting to keep the wheelchair from tipping. The NA slapped Resident #1 once in the face with little contact, so she slapped her/him again.Per interview on 6/4/2026 at 1:55 PM, the Registered Nurse (RN) on duty at the time of the 2/22/2026 incident, expalined that she had asked the NA to sit with the Resident at the nurses' station because the Resident was being a bit combative, but s/he doesn't hit hard. At the time, an LNA was also there, and the RN did not want to leave her alone with the Resident, so she asked the NA to stay with them. She then heard the NA say oh, you want to kick me? The RN said that she looked around the corner and saw the NA holding the Resident's hands and the wheelchair was leaned back with the LNA trying to prevent it from tipping over. The NA then slapped the Resident across the face, leaving a red mark. Per review of the facility summary of investigation submitted to the Licensing Agency by the Director of Nursing on 2/26/2026, the NA had stated that Resident #1 had been trying to hit her and kicked her 3 times in her bad leg. The NA stated that she did not remember if she kicked the Resident, but when s/he was trying to swing at her and spit at her she reacted without thinking and struck the Resident with an open hand on the cheek. The summary documentation confirmed that the conclusion of the incident investigation verified the incident allegation of staff to resident abuse. Based on corrective actions completed on 3/5/2026, prior to the onsite, this citation is designated as past non-compliance with a compliance date of 3/5/2026. The following actions were completed by the facility:The facility reported the incident to the Licensing<br>(continued on next page) |



| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
|---|---|---|
| | | |

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| F 0600<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Agency, police, and the Office of Professional Regulation.The unlicensed Nursing Assistant's employment was terminated.An assessment of all residents was completed to identify any injuries of unknown origin such as bruising or skin tears and changes in behaviors that may indicate abuse. Residents that were intervenable were interviewed regarding abuse and mistreatment. No other residents were identified. Staff were educated on staff to resident abuse and recognizing potential concerns in coworker behaviors.The results of the audits are reported and evaluated during the quality assurance, performance improvement quarterly meetings. |

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| F 0729<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Verify that a nurse aide has been trained; and if they haven't worked as a nurse aide for 2 years, receive retraining.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to follow up to ensure that 1 of 5 sampled staff members (unlicensed Nursing Assistant [NA] #1) who were hired as Licensed Nursing Assistants (LNAs) obtained actual licensure within 4 months of passing a training and competency evaluation program approved by the state. Findings include:Per record review, NA #1's employee file revealed that the unlicensed NA #1 was hired by the facility on [DATE]. An employee information sheet states that she had a job change on [DATE] to an LNA. NA #1 was granted a provisional nursing assistant license by the State Board of Nursing on [DATE] with an expiration date of [DATE]. There was no evidence in the employee file that the facility had followed up to ensure that the NA had obtained their official license when the provisional license had expired. The NA was employed by the facility to perform LNA duties from [DATE] through [DATE] without the required license. During an interview on [DATE] at approximately 3:25PM the Director of Nursing (DON) confirmed that NA #1 had not obtained her nursing assistant license that is required to perform duties of an LNA. The DON also confirmed that the facility had not followed up to ensure that the NA had done so. Based on corrective actions completed on [DATE], prior to the onsite, this citation is designated as past non-compliance with the compliance date of [DATE]. The following actions were completed by the facility:The facility reported the incident to the Licensing Agency, police, and the Office of Professional Regulation.The unlicensed Nursing Assistant's employment was terminated.An audit of all licensed staff was completed to ensure that there were no other staff working without a current license. The facility implemented continued auditing of licensed staff files with a spreadsheet of all staff with dates of license expiration.Staff were educated on staff to resident abuse and recognizing potential concerns in coworker behaviors.The results of the audits are reported and evaluated during the quality assurance, performance improvement quarterly meetings. |