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	10/30/2024

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 40258 Based on observation, interview, and record review the facility failed to implement care planned interventions for 2 of 29 Residents in the sample (Resident # 30) related to positioning, and (Resident #25) related to pressure ulcer prevention, pain control, and nutritional risks. Findings include: 1. Per recd review Resident #25 has advanced dementia. S/he developed an in house acquired stage 2 (partial thickness loss of dermis presenting as a shallow open ulcer with a red or pink wound bed, without slough. May also present as an open/ruptured serum-filled blister) pressure ulcer on her/his left heel and has experienced a significant weight loss of 11.84% over 3 months. A Nurses Progress note dated 9/10/2024 12:12 PM reads a fluid-filled blister was noted at outer edge of left heel found this AM during therapy session; resident c/o discomfort when blister was pushed on; the skin over the blister is dry/calloused; the right heel is slight pink . A Care Plan Problem with a start date of 2/19/2022 stated that Resident #25 has the potential for skin breakdown related to incontinence and decreased mobility, as well as a decline in ability to participate in ADL (Activities of Daily Living) care. A listed approach to care with a start date of 10/17/2024 reads Provide me with pressure relief boots on in r/c [reclining chair]. Another approach with a start date of 2/19/2022 is Assist me with frequent position changes. Per observation on 10/28/2024 at 3:00 PM Resident #25 was observed lying in a reclining chair. There were no pressure relief boots on her/his feet. During an interview on 10/28/24 at approximately 4:15 PM a Licensed Nurse Assistant (LNA) who is familiar with Resident #25 confirmed that the Resident should have pressure relief boots on when up in the reclining chair, and that s/he did not have them on. The LNA retrieved the boots from the Resident's room and applied them to the Resident's feet. During observations on 10/29/2024 at 12:40 PM Resident #25 was seen asleep in a reclining chair leaning to the right with a pillow on the arm of the chair under the right side of her/his head. There were no pressure relief boots on her/his feet. This Surveyor observed the Resident lying in the recliner from 12:40 PM - 4:10 PM without being assisted with repositioning. At 4:10 PM s/he was still lying in a recliner leaning to the right with her/his head on a pillow on the arm of the chair. S/he had not been repositioned and there were no pressure relief boots on her feet per care plan. (continued on next page)

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

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Per interview with a LNA on 10/29/2024 at 4:20 PM Residents are usually toileted and repositioned about every two hours. The LNA confirmed that Resident #25 did not have pressure relief boots on her/his feet and that s/he should. The LNA retrieved the boots and applied them to Resident #25's feet. Further review of Resident 25's record revealed a Dieticians Progress Note dated 9/11/2024 that states Recommend increase in supplement to TID [three times per day] to provide 750 cal/27 gm pro., and Centrum silver QD [every day] to support wound healing and deter weight loss. See care plan. A Care Plan Problem for Nutritional Status last edited on 10/23/24 states I have a [history] of weight loss along with behavioral changes, and I am at risk for additional weight loss. I have increased pro/cal/vit [protein/calories/vitamin] needs for wound healing (Stage] II area 9/10/24). I can no longer feed myself due to decline in cognition. Care Plan interventions last edited on 9/11/24 state Provide me with my nutritional supplement as ordered. Increase to TID recommended 9/11/24 to support wound healing. Provide vitamins as ordered to support wound healing-centrum silver recommended. A Dietician Progress Notes dated 10/28/2024 reveals that Resident #25 had not started centrum tab or had any increase in her/his dietary supplement; this [was] recommended by dietician to support wound healing; sent fax to Doctor [name omitted] r/t [related to] this;. Review of Resident #25's October 2024 Medication Administration Record (MAR) revealed that the increase in dietary supplement and the administration of the Centrum Silver did not start until 10/29/2024. During an interview on 10/30/2024 at 3:33 PM the Director of Nursing confirmed that the the recommendations made by the dietician on 9/11/2024 had not been implemented until 10/29/2024. 50336 2. Per observation on 10/28/2024, at 05:19 PM Resident #30 was sitting at the dining table in a reclining chair. S/he was leaned over the left side of the chair with his/her face at eye level with the edge of the table. Resident #30 was not repositioned from his/her side prior to being given his/her meal. At 5:30 PM on 10/28/2024 the License Nursing Assistant (LNA) brought resident's tray to the table and without repositioning Resident #30, s/he handed the resident a half a sandwich. Resident #30 remained in the leaned over to the left side of the chair and was not repositioned prior to his/her meal. Resident #30 remained on his/her left side at eye level with the table while s/he attempted to eat the sandwich. Per record review Resident #30 was admitted to the facility with a diagnosis of Vascular Dementia, dysphasia and reflux disease. His/her care plan included .due to my medical diagnosis of dysphasia, I am an aspiration risk . Approach starting 3/14/2023 I need to be seated upright in the chair at 90 degrees for all intake . I need to be seated upright for 45-60 minutes after every meal to decrease my chance of reflux. Per further record review Speech, Language and Pathology note dated 6/8/2024 in section titled Impact on burden of care / daily living without interventions implemented, [Resident #30] is at risk for aspiration and general discomfort during intake due to severity of [his/her] cough [and] clearing [his/her] airway . (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Per interview on 10/28/2024 at 5:45 PM with the LNA staff confirmed that Resident #30 should have been repositioned and sat up prior to meal, and that s/he requires observation and assistance with all meals.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. 51189 Based on observations, staff interviews and record reviews, the facility failed to revise the comprehensive care plan for two of twenty nine Residents in the sample (Resident #9 and Resident #15) as the Residents' plans of care changed related to Activities of Daily Living (ADLs) and Nutritional Status for Resident #9, and a fall with major injury at the facility for Resident #15. Findings include: 1. Per Observation on 10/28/24 and 10/29/2024, Staff were seen assisting Resident #9 with eating a meal. This surveyor observed the need for total assistance. Per record review, Resident #9's current Care Plan Problem category Nutritional Status states I have a history of weight loss. I continue to be at risk for weight loss and altered fluid status due to my variable meal intake at times, related to my cognitive/ mood state, as well as possible medication side effects. This Problem category has an Approach dated 12/04/2023 that states I am dependent on you to assist me with my meal to help me have sufficient intake. I will occasionally feed myself a drink. There is another Approach, dated 04/29/2021 that states Set my meal up for me to encourage my independent eating Resident #9's current Care Plan Problem category ADLs Functional Status/ Rehabilitation Potential states I have a self care deficit secondary to my physical limitations, as well as a decline in my functional strength and endurance with poor activity tolerance. This Problem category has an Approach dated 09/26/2022 that states Cue me for mouth and hair care and assist me as needed and as I will allow. There is another Approach that states Provide setup for my ADL care at my bedside or in my bathroom, which ever I may prefer. Encourage and cue me as needed to wash what I can and provide me with assistance as needed. Per interview on 10/30/2024, at 3:37 pm with Licensed Nursing Assistant (LNA) Resident #9 will open his/her mouth to be fed and to allow us to brush his/her teeth, but otherwise is dependent on staff for all ADLs. Per interview 10/30/24, at 3:45 pm, MDS Coordinator confirmed that the current Care Plan is incorrect/ contradictory and has not been revised. 50431 2. Per the facility's Falls Risk Assessment and Care Planning policy, 5. Assessment data shall be used to identify underlying medical conditions that may increase the risk of injury from falls . 6. The staff, with the support of the Attending Physician and therapy department, will evaluate functional and psychological factors that may increase fall risk, including ambulation, mobility, gait, balance, excessive motor activity, Activities of Daily Living (ADL) capabilities, activity tolerance, continence, and cognition .The care plan will be reviewed and revised by the charge nurse or designee after each fall and additional nursing staff will be notified through shift reports and communication logs. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Per record review, on 9/28/24 at approximately 7:54 PM Resident #15 had an unwitnessed fall in his/her room. Resident #15 was transported to the hospital by EMS [Emergency Medical Services]. Per record review of physician documentation, Resident #15 was admitted to the hospital for Left Hip fracture with small extraperitoneal pelvic hemorrhage (a left broken hip with some internal bleeding). S/he had surgery to fix his/her broken hip. Per record review of Resident #15's care plan states I am at risk for falling R/T my decreased activity tolerance, as well as my decreased safety awareness. This was last edited on 9/5/24. There are no new revisions in this section of the care plan after Resident #15's fall and hospitalization . Per interview with the DON [Director of Nursing] on 10/30/24 at 10:06 AM it was confirmed that Resident #15's care plan was not revised after his/her fall with major injury.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50336 Based on observation, interview and record review the facility failed to meet professional standards related to a Licenced Nursing Assistant (LNA) acting outside his/her scope of practice by administrating medications to one resident in the sample (Resident # 205). Findings include Per observation at approimately 2:00 PM on 10/28/2024 the LNA was observed administrating medications to Resident #205 while at the nurse's station. Per Interview with a Licensed Nurse on 10/28/2024 at approximately 2:05 PM s/he stated that s/he or the other Nurse were unable to administer the medication to the Resident. S/He stated that they delegated the task to the LNA because s/he had a good rapport with Resident #205. Per Interview with the LNA on 10/28/2024 at 3:40 PM s/he confirmed that s/he gave Resident #205 his/her medications crushed in ice cream. The LNA stated that this was not the first time s/he has been delegated by nurses to give medications. The LNA stated that s/he has not been trained by the facility to give medications. According to the [NAME] State Board of Nursing and the LNA scope of practice An LNA may not perform activities which exceed the scope of practice defined by their level of licensure. This means that the LNA may not perform, even if directed to do so, an activity not appropriate to their level of licensure or otherwise prohibited by law. Examples of activities not within the LNA scope of practice include: nursing assessments, nursing judgments, and development of the plan of care. Durnig interview on 10/30/2024 at approximately 4:00 PM the Director of Nursing confirmed that administrating medications to residents is not in a LNA's scope of practice, and that the LNA should not do so.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50431 Based on interviews and record review the facility failed to provide adequate supervision to maintain safety for one (1) resident (Resident #15) out 2 sampled residents. Findings include: Per record review Resident #15 was admitted to the facility on [DATE] with diagnoses of Atrial Fibrillation (an irregular heartbeat), depression, hypertension (high blood pressure), and dementia. Resident #15's care plan states I am at risk for falling R/T [related to] my decreased activity tolerance, as well as my decreased safety awareness. This was last edited on 9/5/24. Per record review, on 9/28/24 at approximately 7:54 PM Resident #15 had an unwitnessed fall in his/her room. Resident #15 was transported to the hospital by EMS [Emergency Medical Services]. Per record review of physician documentation, Resident #15 was admitted to the hospital for Left Hip fracture with small extraperitoneal pelvic hemorrhage (a left broken hip with some internal bleeding). S/he had surgery to fix his/her broken hip. Per the facility's Falls Risk Assessment and Care Planning policy, 5. Assessment data shall be used to identify underlying medical conditions that may increase the risk of injury from falls . 6. The staff, with the support of the Attending Physician and therapy department, will evaluate functional and psychological factors that may increase fall risk, including ambulation, mobility, gait, balance, excessive motor activity, Activities of Daily Living (ADL) capabilities, activity tolerance, continence, and cognition. 7. The staff will seek to identify environmental factors that may contribute to falling, such as lighting and room layout. Per record review of the facility's internal report, there is no documentation of an evaluation and analysis of hazards and risks in Resident #15's environment that could have caused the unwitnessed fall. There is no implementation of individualized, resident-centered interventions to reduce Resident #15's risks for falls related to possible hazards in the environment.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. 40258 Based on interview and record review the facility failed to ensure that recommendations made by the Registered Dietician were implemented to support wound healing and deter weight loss for 1 of 29 Residents in the sample (Resident #25). Per record review Resident #25 had experienced a significant weight loss of 11.48% over 3 months, and had a stage 2 (partial thickness loss of dermis presenting as a shallow open ulcer with a red or pink wound bed, without slough. May also present as an open/ruptured serum-filled blister) facility acquired pressure ulcer. A Registered Dietician's Progress Note dated 9/11/2024 states Recommend increase in supplement to TID [three times per day] to provide 750 cal/27 gm pro., and Centrum silver QD [every day] to support wound healing and deter weight loss . Further review of the record revealed a Dietician Progress Notes dated 10/28/2024 that states that Resident #25 had not started centrum tab or had any increase in her/his dietary supplement; this [was] recommended by dietician to support wound healing; sent fax to Doctor [name omitted] r/t [related to] this;. Review of Resident #25's October 2024 Medication Administration Record (MAR) revealed that the increase in dietary supplement and the administration of the Centrum Silver did not start until 10/29/2024. During an interview on 10/30/2024 at 3:33 PM the Director of Nursing confirmed that the the recommendations made by the dietician on 9/11/2024 had not been implemented until 10/29/2024.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50336 Based on record review and interview, the facility failed to implement 14 day stop dates on prescribed as needed (PRN) psychotropic medications for 3 out of 5 residents in the sample (Resident's #24, #205 and #45). Findings include 1. Per record review, Resident #24 was admitted with a diagnosis of Alzheimer dementia and had the following medication orders written by the facility Provider on 10/7/2024: Quetiapine tablet; 25 mg; amt: 1 tab; oral .Twice A Day - PRN There was no documented evidence in the orders of a stop date for the antipsychotic medication as required or rationale by the Provider to extend the medications. 2. Per record review, Resident #205 was admitted on [DATE] with a diagnosis of lewy body dementia. S/He had the following PRN medication orders written by the facility Provider on 10/22/2024: Trazodone tablet; 50 mg: 1/2 tablet PRN three times a day without a stop date and Risperidone 0.25 mg, 1 tablet as needed without evidence of a stop date. Per interview with the Director of Nursing [DON] on 10/30/2024 at 10:20 AM. The DON stated and confirmed that PRN medications for Resident #24 and #205 did not have a stop date and should have. Per facility policy titled (PRN Psychotropic Medications) reviewed on 7/11/2024 PRN orders for psychotropic drugs are limited to 14 days. If the attending physician or prescribing practitioner believes it is appropriate for the PRN order to be extended beyond 14 days, the following must be met i. The attending physician or prescribing practitioner evaluates the resident for appropriateness of that medication and ii. The rationale for extending the PRN order for more than 14 days is documented in the resident ' S medical record. The duration of the PRN order must also be documented. 5. PRN orders for antipsychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. 50431 3. Per record review, Resident #45 was admitted to the facility on [DATE] with diagnoses of bipolar disorder (a mental illness causing extreme mood swings) and vascular dementia (chronic cognitive impairment due to decreased blood flow to the brain). (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Per further record review Resident #45 had the following medication order: Lorazepam (a medication used to treat anxiety) 0.5 milligram (mg) tablet: Take one tablet by mouth once daily as needed. The medication order was placed on 9/19/24 with a stop date of 12/15/24. There is no Medical Provider documentation to support a prescribed as needed order beyond 14 days for Resident #45. Per interview with Registered Nurse #1 on 10/29/24 at 3:43 PM it was confirmed that Resident #45's order for Lorazepam had been extended past 14 days with no physician rationale.