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	01/14/2026

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 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure there were competent nursing staff for one of five nurses and five of five Licensed Nursing Assistants in the sample. Findings include:1.Review of the State of [NAME]'s Title 26 : Professions and Occupations- Chapter 028 : Nursing Subchapter 004 : NURSING ASSISTANTS, A person shall not practice nursing or nursing-related functions as defined in section 1641 of this subchapter without being licensed by the Board.The State of [NAME] definitions include Nursing assistant means an individual who performs nursing or nursing-related functions under the supervision of a licensed nurse and Nursing or nursing-related functions means nursing-related activities as defined by rule, which include basic nursing and restorative duties for which a nursing assistant is prepared by education and supervised practice. Per the State of [NAME] statutes, in order for a Licensed Nursing Assistant to handle and administer medications to a nursing home resident, the Assistant must have completed a Board-approved medication administration education program and an examination as set forth by rules adopted by the Board; and (C) is endorsed by the Board and authorized to administer medication in a nursing home. The statutes further state a Medication nursing assistant means a licensed nursing assistant who is under the supervision of a nurse holding a currently valid endorsement authorizing the delegation to the nursing assistant of tasks of medication administration performed in a nursing home. [Title 26: Professions and Occupations, Chapter 028: Nursing, Subchapter 004: NURSING ASSISTANTS, (Cite as: 26 V.S.A. 1641) 1641. Definitions, 1644. Prohibitions; offenses.] Review of Prescribed Orders for Resident #5 include Lidocaine External Patch 4 % (Lidocaine patch is a topical anesthetic used to stop pain,) Apply to left and right hip topically at bedtime on 12 hours. off 12 hours. and remove per schedule. An interview was conducted with the Staff Nurse for Resident #5 on Jan. 13 at 9:11 AM. The Staff Nurse stated the LNAs [Licensed Nursing Assistants] take off the lidocaine patches. The Staff Nurse stated that no LNA had reported removing the lidocaine patches to her. Per observation on 1/13/26 at 9:14 AM the Staff Nurse then entered Resident #5's room to administer the resident their oral medications and did not check Resident #5 to remove the left and right Lidocaine patches before or after administering the medications and leaving the room. Per record review, review of the facility's Job description: Licensed Nurse Assistant reveals no mention of assisting with medication administration. (continued on next page)

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

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of 5 sampled LNA's training and competencies revealed no training regarding medication administration or assisting with medication administration for any of the 5 LNAs. An interview was conducted with the facility's Administrator on 1/13/26 at 12:24 PM. The facility's Administrator reported there are no Licensed Nursing Assistants in the facility that are certified/trained to assist with medication administration, including removal of lidocaine patches. 2.Per review of employee training and competency files it was noted that a Registered Nurse who was hired on12/16/2025 had no proof that the facility had assessed her for skills competency. One of five Licensed Nursing Assistant's flies reviewed revealed no proof of competency assessment for 2024 and 2025. Per interview with the Director of Nursing on 1/14/2026 at 1:17 PM, S/He stated the RN is very new; and new staff are given a packet of competencies to go through with their preceptor and then they return them when they are done. The DON confirmed that the RN was working shifts and had not handed in her competencies yet. The DON also confirmed that the LNA did not have proof of competency for 2024 and 2025 competency packet and there was no evidence of training.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation and interview, the facility failed to ensure cleanliness of the kitchen, the food prep area, and the dish storage area. Contamination from biological, chemical and/or physical means can have an adverse effect on all residents. Findings include: Per observation, during the initial tour of the kitchen on 1/12/2026 at approximately 11:10 AM, there was a large metal box style vent above and to the right of a rack of clean plate covers. Vent grates were covered in dust and several pieces of a white flaky substance.Per interview with a member of the kitchen staff on 1/12/2026 at 11:12 AM, s/he confirmed that the dust and/or pieces of flaky substance from the vent could fall onto the clean dishes and result in contamination.Per observation, during a follow up tour of the kitchen on 1/14/2026 at 8:45 AM, some ductwork, which had three vents, was running along the width of the kitchen, passing over food preparation area and dish washing stations. The three vent registers were covered in dark substances and dust.Per interview with the kitchen manager on 1/14/2026 at 8:50 AM, s/he confirmed the dark substance and dust on the three vents had the potential to contaminate food preparation areas and the dishwashing stations. S/he did not know when the vents were last cleaned.Per interview, on 1/14/2026 at approximately 2:00 pm, the maintenance supervisor confirmed the kitchen vents needed to be cleaned.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. Based on interview and record review the facility failed to ensure care plans were revised timely for four residents (Residents #6, #14, #37, and #57) of 16 sampled residents. This is a repeat deficiency for this facility, with violations cited during the previous two recertification surveys, dated 10/30/24 and 12/4/23. Findings include:1.Per a record review, Resident #6 has diagnoses that include anemia, GERD (gastro esophageal reflux disease), non-pressure chronic ulcer of the left foot, and other malaise, all indications that present a risk for weight loss. Per a record review, Resident #6 weighed 123.6 pounds on 12/7/25. Resident #6's next recorded weight of 114.4 pounds was taken on 12/22/25. The weight loss of 9.2 pounds or 7.4% in a 15-day period between 12/7/25 and 12/22/25 is a significant weight loss, per MDS (Minimum Data Set) guidelines. According to CMS (Centers for Medicare & Medicaid Services) for long-term care residents, a significant weight loss is defined as a loss of 5% or more of body weight in the last 30 days or 10% or more of body weight in the last 180 days (6 months). Per a record review, Resident #6 has a care plan approach dated 10/30/24 which states, I am at risk for weight changes and altered fluid status D/T [due to] my variable meal intake r/t [related to] my physical limitations, as well as my cognitive/mood state. Resident #6 has a care plan approach dated 10/30/24, which states that she/he should be monitored for sudden weight loss. Per a record review, the facility dietician noted the weight loss in a progress note dated 12/29/25 at 3:15pm, WEIGHT WARNING: Value: 114.4 [pounds] Vital Date: 2025-12-22 11:01:00. -3.0% change from last weight [7.4%, 9.2] -7.5% change [8.5%, 10.6]. Resident #6's care plan was not updated to reflect any interventions for the weight loss. Per an interview with the DON (Director of Nursing) on 1/13/26 at 1 pm, the DON stated that there should have been a progress note from the dietitian during the month of 12/25 addressing Resident #6's significant weight loss. Per an interview with the dietician on 1/14/26 at 11:59 am, the dietician stated that she/he was aware of the weight loss incurred by Resident #6. The dietitian stated that in a discussion s/he had with Resident #6 about the current weight loss, the resident stated to the dietitian that s/he did not want an additional intervention and would like to wait and see if their weight increased. During the interview on 1/14/26 at 11:59 am, the dietitian stated, I should have written a note about that, shouldn't I. 2.Per a record review, Resident #37 has diagnoses that include unspecified dementia of unspecified severity with other behavioral disturbance, repeated falls, history of falling, weakness, and unsteadiness on feet. Per a record review, Resident #37 has a care plan problem dated 3/31/25 that states, I am at risk for falling R/T [related to] my decreased safety awareness. Per a record review, Resident #37 sustained 8 documented falls between 9/29/25 and 12/27/25. Per a record review, Resident #37 sustained a fall on 9/29/25. A nursing progress note dated 9/29/25 at 8:31 pm states, Resident sitting on floor next to wc [wheelchair] in former single room across the hall from current trip [triple] occupancy room. Appears to have lowered [him/her-self] to the ground. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #37 sustained a fall on 10/17/25. A nursing progress note dated 10/17 pm at 5:47 pm states, Unwitnessed, found on floor in bathroom of old room across hallway from current room; Unwitnessed fall. Resident #37 sustained a fall on 11/8/25. A nursing progress note dated 11/8/25 at 11:52 pm states, Resident found on floor next to bed. Unwitnessed fall; holding head with goose egg/presumed hematoma to left of apex of head; I hit my head. I was trying to get into bed. I have a headache. Resident #37 sustained a fall on 11/22/25. Per a nursing progress note dated 11/22/25 at 11:30 pm, At 6:15p Lna [licensed nursing assistant] reported that [Resident #37] was on the floor on his head. Upon getting to hallway [s/he] was in front of [his/her] w/c on knees and forehead resting on [his/her] hat. Resident #37 sustained a fall on 12/7/25. Per a nursing progress note dated 12/7/25 at 4:35 pm, [Resident #37 fell forward out of w/c, redness to right knee. Denies pain. Witness and [s/he] did not hit [his/her] head. Staff assisted up to w/c and then [s/he] went to bed. Resident #37 sustained a fall on 12/26/25. Per a nursing progress note dated 12/26/25 at 2:53 am states, Resident seen sitting on the floor just outside of room - resident is naked with [his/her] brief to [his/her] thigh - resident assessed - incontinent of bowel and bladder - denies hitting head - just my pride very apologetic. Resident #37 sustained two falls on 12/27/25. A nursing progress note dated 12/27/25 at 1:01 pm states, Observed by staff walking out of another patients room when [s/he] lost [his/her] balance and fell. Patient did not hit [his/her] head, no injuries noted. A nursing progress note dated 12/27/25 at 8:38 pm states, PT attempting to get OOB [out of bed] at approx. [approximately] 2020 [8:20 pm] and rolled out of bed and onto floor before staff could assist. Did not hit head and no injuries noted. There were no new interventions documented in Resident 37's care plan subsequent to any of the above-mentioned falls. Per an interview with the DON (Director of Nursing) on 1/14/26 at 9:06 am, s/he confirmed that Resident #37's care plan should have been updated subsequent to each fall. 3.Per record review, Resident #14 has a Care Plan which identifies the resident as at risk for falls related to decreased cognition, poor safety awareness, requiring encouragement to sit or rest. The four interventions listed in Resident #14's Care Plan to prevent future falls are all dated 12/5/2025. Review of Progress Notes for Resident #14 dated 1/4/26 reveal at 9:20 AM the resident was Sleeping in chair, leaning forward and fell to the floor hitting their right frontal head on floor. The resident sustained a quarter sized bump on right lateral forehead - ice applied. Further review of Resident #14's Care Plan revealed no updates to prevent future falls for the resident. Further review of Progress Notes for Resident #14 reveals 2 days later the resident fell again. Progress Notes record on 1/6/26 At 4:30 this morning [Resident #14's] bed alarm could be heard. When staff went to check, [Resident #14] was sitting on the floor next to [h/her] bed. A quarter size abrasion is noted to the left side of [h/her] forehead. Further review of Resident #14's Care Plan again revealed no updates added to prevent future falls for the resident. An interview was conducted with the DON [Director of Nursing] on 1/14/26 at 9:06 AM. The DON confirmed Resident #14's care plan was not updated to prevent future falls after falls on (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1/4/26 and 1/6/26. 4.Per review of Resident #57's medical record, they have a BIMS [Brief Interview of Mental Status] score of 99 as of 11/25/25 which indicates severe cognitive impairment. The resident was dependent on staff for ADLs [Activities of Daily Living] and hygiene. Resident #57 had medical diagnoses of dementia, history of TIA [Transient Ischemic Attack] and cerebral infarction, and MDD [Major Depressive Disorder]. Per review of a progress note dated 11/16/25 at 5:54 AM it states, Called to [Resident]'s room, observed eyes closed skin warm and dry to touch, right side of [his/her] face drooping, nonresponsive, 107/88 99.8 92 18 o2 oxygen saturation] sat 95%. no mottling or edema, observed, [s/he] is moving around, picking [his/her] legs up, picking [his/her] nose. Per review of a progress note dated 11/16/25 it states, [Resident #57] noted with facial droop. Resident is nonverbal but nurse suspects resident might have had a stroke. POA [Power of Attorney] was notified, does not wish to have resident transferred to hospital. Request to have comfort measures in place. Per review of a physician progress note dated 11/26/25 at 6:30 PM (occurred on 11/17/25 this is LATE entry) it states, [Resident #57] was noted by staff yesterday to have left-sided facial droop and to be nonverbal. They had high suspicion of a cerebrovascular infarction at that time. They reach out to [his/her family representative] who is her DPOA and [s/he] did not want [him/her] transferred to the hospital at that time and preferred that [s/he] be started on comfort measures and to remain here at [facility]. Due to advanced dementia [Resident #57]'s quality of life had been declining over recent years and [his/her family representative] felt that any transfer to the hospital would be more traumatic than beneficial and would not have wanted any major interventions done if a condition was found. Per review of the facility's Care Planning-Interdisciplinary Team policy [last revised 11/28/23] it states, Policy: Our facility's Care Planning/Interdisciplinary Team is responsible for the development of an individualized comprehensive care plan for each resident.3.The care plan is based on the resident's comprehensive assessment and is developed by a [sic] interdisciplinary team which includes, but is not necessarily limited to the following personnel: a. attending physician; registered Nurse who has a responsibility for the resident; c. Dietary Manager/Dietician d. Social Services Worker responsible for resident; e. Activity Director/Coordinator; f. Therapists (speech, occupational . recreational, etc.), as applicable; consultants (as appropriate); h. Director of Nursing (as applicable);i. Charge Nurse responsible for resident care; j. Nursing Assistants responsible for the resident's care; and k. others as appropriate or necessary to meet the needs of the resident. Per review of Resident #57's care plan, there is no information regarding the resident being placed on comfort care. An interview was conducted with the DON [Director of Nursing] on 01/13/26 at 3:59 PM. The DON confirmed that care plan was not updated to reflect comfort care stating, I don't see it there.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. Based on observation, interview and record review the facility failed to ensure appropriate infection prevention and control related to disinfecting a shared electric shaver that is used for multiple residents. Findings include:Per observations in the B-Wing shared shower room on 1/14/2026 at 9:16 AM an electric razor was noted on the shelf by the bathtub; this electric shaver did not have a resident name on it. At the time of the observation, the Registered Nurse confirmed that the shaver was used for multiple residents when they needed a shave. During an interview with 2 Licensed Nursing Assistants (LNAs) on 1/14/2026 at approximately 11:30 AM when asked who the electric shaver belonged to, they stated that it is used for residents who need a quick shave after their bath. The LNAs were asked about the cleaning method used between residents and they stated that they use an alcohol pad to clean it. Per review of the facility Infection Control Policy issued 3/16/2020 states that equipment or items in the patient environment likely to have been contaminated with infectious body fluids must be handled in a manner to prevent transmission of infectious agents . Also, equipment or items in the patient environment likely to have been contaminated with infectious body fluids must be handled in a manner to prevent transmission of infectious agents (e.g., wear gloves for direct contact properly sterilize equipment before use on another patient). Per interview on 1/14/2026 at 1:17 PM with the Director of Nursing, she had not been aware that staff were using this specific shaver, nor had she been aware that they were using the shaver for multiple residents. The Director of Nursing confirmed that the use of an alcohol pad was not an appropriate or effective way to clean the shaver between use.

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F 0923 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have enough outside ventilation via a window or mechanical ventilation, or both. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview the facility failed to ensure there was adequate mechanical ventilation on the memory care unit to prevent excessive buildup of mildew and urine odors. Findings include:During the initial tour of the licensed memory care unit (B-Wing) on 1/12/2026 at 11:28 AM a strong odor of mildew was noted on entrance to the unit. After walking by room [ROOM NUMBER] the mildew odor mixed with the smell of urine was present down the entire hall. The damp, mildew, urine smells remained throughout the length ogf the survey. During a walkthrough of B-Wing with the Director of Maintenance on 1/14/2026 at 10:16 AM he was asked about the dampness and musty smell in the air, he stated that some residents are incontinent and will try to go to the bathroom in all different places such as on the rug. The facility has carpet extractors that will clean the urine out of the rugs. When a resident is incontinent on the rug, staff try cleaning it right away and also try to get it done in the evening time when everyone isn't walking around. When questioned if the rugs have enough time to dry, he expressed that it is difficult to get them to dry in the wintertime as they cannot open windows or run the HVAC (heating, ventilation, and air conditioning) as frequently as in the summer because it makes it too cold for the residents. He confirmed that the dampness and the odors have been an ongoing issue. When asked if he keeps a log of how often he runs the ventilation system he stated that no he did not.

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure residents were free from abuse for one of three sampled residents (Res #54). This is a repeat deficiency for this facility, with violations cited during the previous two recertification surveys, dated 10/30/24 and 12/4/23. Findings include:Per review of the facility's Resident Abuse, Neglect, Exploitation, and Misappropriation of resident property policy [last revised 9/23/24] it states, Policy: It is the established priority of [facility] to provide its residents with a living environment free from any instance of abuse, neglect, exploitation and misappropriation of resident property.To that end, a policy has been established to deter the prospect of resident [abuse, neglect, exploitation and misappropriation] that governs staff screening and training, preventative and protective measure, and procedures for identification, investigation and reporting [abuse, neglect, exploitation, misappropriation].[Facility] will maintain a living and work environment that minimizes the likelihood of resident [abuse, neglect, exploitation, misappropriation].Per record review, Resident #54 has a BIMS [Brief Interview of Mental Status] score of 1 as of 1/8/26 indicating the resident is cognitively impaired. Resident #54 has medical diagnoses of dementia, Alzheimer's Disease, and depression. The resident is dependent on staff for ADLs [Activities of Daily Living] and hygiene.Per review of the facility's internal investigation it states, Two staff members [LNA [Licensed Nursing Assistant]#3 and LNA#4], LNAs reported that night shift LNA staff received in report that [Resident #54] had required 2 showers due to bowel movements and became aggressive with the second shower and the [LNA#1][had sprayed [him/her] in the face with cold water. [LNA #2] had assisted [LNA #1] with the shower as [Resident #54] became aggressive. Both staff were laughing about the incident. The incident occurred on 11/13/25 during the evening shift.Per review of a witness statement from LNA#3 it states, [LNA#3] when she arrived at work [LNA#1] and [LNA#2] were behind the desk laughing about something. [LNA#1] was giving her report and said that [Resident #54] ad two blowouts and needed two showers. During the second shower [Resident #54] was agitated and pulling on the hose and pipes and [LNA#1] said she was so frustrated she just sprayed [Resident #54] with freezing water. [LNA#2] had to help because [Resident #54] was trying to rip the hose out of [LNA#1]'s hands and started pulling on the pipes. Both [LNA#12 and LNA#2] were laughing about this. [Resident #54] wanted to apologize to someone, [s/he] did not know who.Per review of the follow-up investigation it states, The allegation was reported to APS [Adult Protective Services], the [NAME] Board of Nursing and the [NAME] County Sheriff's Department. As of this date there are no outcomes [Resident #54] was assessed by the DON [Director of Nursing] and the social services director at different times throughout the day. [S/he has no recollection of the incident and his mood and behavior is at baseline .4. Corrective Action(s) Taken: [Resident #54] was assessed and has no recollection of the incident. [His/Her] mood and behavior are at baseline. Behavior is being monitored by staff and emotional support provided to both [Resident #54] and [his/her] [family representative]. [LNA#1] was suspended immediately pending investigation, and subsequently terminated from employment. [LNA#2] was suspended immediately pending investigation, and subsequently terminated from employment. MD [Medical Director] has been notified. Education regarding abuse and neglect is being done with staff. Social services and behavioral services will remain involved for ongoing support and management.3. Conclusion There is enough evidence to support that this allegation is substantiated.Per review of an addendum to final the report dated 11/19/25 it states, [Resident #54] was noted to have 5 bruises on [his/her] left forearm in healing stages. These are likely related to staff's attempt to prevent [him/her] from grabbing the water hose in the shower by holding onto [his/her] arm during the previously reported incident. [Resident #54] has no pain and is in good spirits at this time. [S/he] does not recall how the bruising occurred. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Appropriate notifications have been made, will monitor bruising.On 1/13/26 at 1:30 PM an interview was conducted with the DON. She confirmed the abuse occurred, stating, Yes, I substantiated it. She confirmed that the abuse should not have occurred.

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. Based on interview and record review the facility failed to ensure discharge notices were sent to the Long-Term Care Ombudsman for one of two sampled residents (Resident #58). Findings include:Per review of Resident #58's medical record, Resident #58 has a BIMS [Brief Interview of Mental Status] score of 15 as of 12/29/25, indicating they did not have any cognitive impairment. Resident #58 has medical diagnoses of non-ST elevated myocardial infarction (a heart attack that partially obstructs the coronary artery) and unspecified dementia. Resident #58 was independent with ADLs [Activities of Daily Living] and hygiene.Per review of a social services progress note dated 12/17/25 at 12:46 PM states, .[Resident #58] who will be returning home on Saturday, 12-20-25 with services. [S/he] also has a friend who will help [him/her] and a place called [facility] that assists [him/her] with transportation needs. Both [Resident #58 and family representative] are aware that they should schedule a follow-up appointment with [his/her] PCP [primary care provider]. An administration note on 12/20/25 at 5:52 PM states, PT [Patient] discharged . Per review of the facility's Documentation of Transfers and Discharges policy [last revised 12/23/16] states, 1.All documentation concerning the transfer or discharge of a resident must be recorded in the resident's medical record. There is no mention of sending any transfer or discharge notices to the Long-Term Care ombudsman.An interview was conducted with social services on 1/13/26 at 1:42 PM. Social services confirmed she did not inform the ombudsman of the resident's discharge, stating, I didn't know I had to do that.

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities Based on interview and record review the facility failed to ensure PASARR screenings were completed for two of five sampled residents (Residents #5 and #48). Findings include: Per review of the medical records for Resident # 5 and Resident # 48, the records did not contain a PASARR (a Preadmission Screening and Resident Review). This is a federal requirement ensuring people with serious mental illness or intellectual/developmental disabilities are not wrongly placed in Medicaid-certified nursing facilities, instead directing them to the most appropriate, least restrictive setting with needed specialized services. A level 1 screening is conducted to identify conditions that require specialized services.Per interview with the Director of Social Services at 11:16 AM on 1/14/2026, she confirmed that all residents should have a Level 1 PASARR screening completed before they are admitted to the facility. She also stated that for a new admission to the facility, from the community, she will conduct the PASARR interview which starts with a Level 1 interview. She confirmed that PASARR documents are not in Resident #5 and Resident #109s' charts.

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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** Based on observation interview and record review the facility failed to ensure professional standards were maintained regarding delegation of nursing duties for one of four sampled residents (Resident #5). This is a repeat deficiency for this facility, with violations cited during the previous two recertification surveys, dated 10/30/24 and 12/4/23.Findings include: Review of Prescribed Orders for Resident #5 include Lidocaine External Patch 4 % (Lidocaine patch is a topical anesthetic used to stop pain,) Apply to left and right hip topically at bedtime on 12 hours. off 12 hours. and remove per schedule.Review of the Medication Administration Record [MAR] for Resident #5 for Jan. 12, 2026, reveals licensed nursing staff initialing as completed the application of Lidocaine patches to the left and right hip of Resident #5 at 8:00 PM on Jan. 12, 2026.An interview was conducted with the Staff Nurse for Resident #5 on Jan. 13 at 9:11 AM. The Staff Nurse stated the LNAs [Licensed Nursing Assistants] take off the lidocaine patches. I have no concern signing off [on the MAR regarding removing the Lidocaine patches] before I check [to see if LNAs removed the two patches.] The Staff Nurse stated that no LNA had reported removing the lidocaine patches to h/her. The Staff Nurse then marked the electronic MAR order for the removal of the two lidocaine patches as completed at 7:59 AM on Jan. 13, 2026. Per observation on 1/13/26 at 9:14 AM the Staff Nurse then entered Resident #5's room to administer the resident their oral medications and did not check Resident #5 to remove the left and right Lidocaine patches before or after administering the medications and leaving the room. Per review of the National Guidelines for Nursing Delegation [Effective Date: 04/01/2019 Written by: American Nurses Association - National Council State Boards of Nursing -Jointly Adopted by: ANA Board of Directors / NCSBN Board of Directors],delegation rights include:The activity falls within the delegate's job description or is included as part of the established written policies and procedures of the nursing practice setting.The licensed nurse along with the employer and the delegate is responsible for ensuring that the delegate possesses the appropriate skills and knowledge to perform the activity.The licensed nurse is responsible for monitoring the delegated activity, following up with the delegate at the completion of the activity,The licensed nurse should ensure appropriate documentation of the activity is completed. Per record review, review of the facility's Job description: Licensed Nurse Assistant reveals no mention of assisting with medication administration.Review of 5 sampled LNA's training and competencies revealed no training regarding medication administration or assisting with medication administration for any of the 5 LNAs. An interview was conducted with the facility's Administrator on 1/13/26 at 12:24 PM. The facility's Administrator reported there are no Licensed Nursing Assistants in the facility that are certified/trained to assist with medication administration, including removal of lidocaine patches. Review of the [NAME] State Board of Nursing LNA [Licensed Nursing Assistant] Scope of Practice Statement includes An LNA may not perform activities which exceed the scope defined by the level of licensure. This means that LNAs may not perform, even if directed to do so, an activity not appropriate to their level of licensure or otherwise prohibited by law.[References/Citations: 26 V.S.A. S 1592. Definitions: Administrative Rules 2.8 (c) [NAME] Board of Nursing Position Statement: The Role of the Nurse in Delegating Nursing Interventions-Date of Initial acceptance: January 2011, Revised (Date) _ January 12, 2015, July 9, 2018].An interview was conducted with the facility's Director of Nursing [DON] on 1/13/26 at 1:30 PM. The DON confirmed that there are no Licensed Nursing Assistants in the facility that are certified/trained to assist with medication administration. The DON further confirmed it is out of the scope of practice for the Staff Nurse to delegate a task to staff member unqualified and lacking the certification to perform the task, and out of the scope of practice for an LNA who is not certified as required to perform the delegated task. The DON confirmed that participating in medication administration, as in removal of a prescribed medication patch, was both out of an LNA's scope of practice and the LNA's job description. The DON further confirmed (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	thatthe facility's Medication Administration/Medication Errors Policy and Procedure [Document ID: VACH-PP-1-6-623, Reissued 11/29/23] includes Medications shall be administered in a safe and timely manner and as prescribed, in accordance with good nursing principles and practices and only by persons legally authorized to do so. The DON confirmed that the Staff Nurse delegating the medication patch removal to an LNA and then signing off on the Medication Administration Record that a Physician's Order was completed without verification was a violation of facility policy and not according to accepted professional standards.

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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. Based on interview and record review the facility failed to ensure residents were free from accidents and hazards for two of 11 sampled residents (Residents #14 and #37). This is a repeat deficiency for this facility, with violations cited during the previous two recertification surveys, dated 10/30/24 and 12/4/23. Findings include: 1.Per record review, Resident #14 has a Care Plan which identifies the resident as at risk for falls related to decreased cognition, poor safety awareness, requiring encouragement to sit or rest. The four interventions listed in Resident #14's Care Plan to prevent future falls are all dated 12/5/2025. Review of Progress Notes for Resident #14 dated 1/4/26 reveal at 9:20 AM the resident was Sleeping in chair, leaning forward and fell to the floor hitting their right frontal head on floor. The resident sustained a quarter sized bump on right lateral forehead - ice applied. Further review of Resident #14's Care Plan revealed no new intervention added to prevent future falls for the resident. Further review of Progress Notes for Resident #14 reveals 2 days later the resident fell again. Progress Notes record on 1/6/26 At 4:30 this morning [Resident #14's] bed alarm could be heard. When staff went to check, [Resident #14] was sitting on the floor next to [h/her] bed. A quarter size abrasion is noted to the left side of [h/her] forehead. Further review of Resident #14's Care Plan again revealed no new intervention added to prevent future falls for the resident. An interview was conducted with the DON [Director of Nursing] on 1/14/26 at 9:06 AM. The DON confirmed there were no new interventions implemented to prevent future falls for Resident #14 after falls on 1/4/26 and 1/6/26. 2.Per a record review, Resident #37 has diagnoses that include unspecified dementia of unspecified severity with other behavioral disturbance, repeated falls, history of falling, weakness, and unsteadiness on feet. Per a record review, Resident #37 has a care plan problem dated 3/31/25 that states, I am at risk for falling R/T my decreased safety awareness. Per a record review, Resident #37 sustained 8 documented falls between 9/29/25 and 12/27/25. Per a record review, Resident #37 sustained a fall on 9/29/25. A nursing progress note dated 9/29/25 at 8:31 pm states, resident sitting on floor next to wc [wheelchair] in former single room across the hall from current trip [triple] occupancy room. Appears to have lowered [him/her-self] to the ground. Resident #37 sustained a fall on 10/17/25. A nursing progress note dated 10/17 pm at 5:47 pm states, unwitnessed, found on floor in bathroom of old room across hallway from current room; Unwitnessed fall. Resident #37 sustained a fall on 11/8/25. A nursing progress note dated 11/8/25 at 11:52 pm states, Resident found on floor next to bed. Unwitnessed fall; holding head with goose egg/presumed hematoma to left of apex of head; I hit my head. I was trying to get into bed. I have a headache. Resident #37 sustained a fall on 11/22/25. Per a nursing progress note dated 11/22/25 at 11:30 pm, At 6:15p Lna [licensed nursing assistant] reported that [Resident #37] was on the floor on his head. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Upon getting to hallway [s/he] was in front of [his/her] w/c on knees and forehead resting on [his/her] hat. Resident #37 sustained a fall on 12/7/25. Per a nursing progress note dated 12/7/25 at 4:35 pm, [Resident #37 fell forward out of w/c, redness to right knee. Denies pain. Witness and [s/he] did not hit [his/her] head. Staff assisted up to w/c and then [s/he] went to bed. Resident #37 sustained a fall on 12/26/25. Per a nursing progress note dated 12/26/25 at 2:53 am states, resident seen sitting on the floor just outside of room - resident is naked with [his/her] brief to [his/her] thigh - resident assessed - incontinent of bowel and bladder - denies hitting head - just my pride very apologetic. Resident #37 sustained two falls on 12/27/25. A nursing progress note dated 12/27/25 at 1:01 pm states, Observed by staff walking out of another patients room when [he/she] lost [his/her] balance and fell. Patient did not hit [his/her] head, no injuries noted. A nursing progress note dated 12/27/25 at 8:38 pm states, PT attempting to get OOB at approx [approximately] 2020 [8:20 pm] and rolled out of bed and onto floor before staff could assist. Did not hit head and no injuries noted. Per a record review, there were no documented interventions implemented in Resident #37's care plan subsequent to any of the above listed falls. Per an interview with the DON (Director of Nursing) on 1/14/26 at 9:06 am, s/he confirmed that there should have been new interventions attempted after each fall.

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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. Based on interview and record review the facility failed to ensure interventions were implemented after a significant weight loss for one of two sampled residents (Res #6).This is a repeat deficiency for this facility, with the violation cited during the previous recertification survey, dated 10/30/24. Findings include:Per a record review, Resident #6 has diagnoses that include anemia, GERD (gastro esophageal reflux disease), non-pressure chronic ulcer of the left foot, and other malaise, all indications that present a risk for weight loss.Per a record review, Resident #6 weighed 123.6 pounds on 12/7/25. Resident #6's next recorded weight of 114.4 pounds. was taken on 12/22/25. The weight loss of 9.2 pounds. or 7.4% in a 15-day period between 12/7/25 and 12/22/25 is a significant weight loss, per MDS (Minimum Data Set) guidelines. According to CMS (Centers for Medicare & Medicaid Services) for long-term care residents, a significant weight loss is defined as a loss of 5% or more of body weight in the last 30 days or 10% or more of body weight in the last 180 days (6 months).Per a record review, Resident #6 has a care plan approach dated 10/30/24 which states, I am at risk for weight changes and altered fluid status D/T my variable meal intake r/t my physical limitations, as well as my cognitive/mood state. Resident #6 has a care plan approach dated 10/30/24, which states that s/he should be monitored for sudden weight loss. Resident #6 has a care plan approach dated 10/30/24 that states Weigh me per my physician's orders and chart. Report any significant weight changes to my MD/Family.Per a record review, the facility dietician noted the weight loss in a progress note dated 12/29/25 at 3:15pm, WEIGHT WARNING: Value: 114.4 [pounds] Vital Date: 2025-12-22 11:01:00. -3.0% change from last weight [7.4%, 9.2] -7.5% change [8.5%, 10.6]. Resident #6's care plan was not updated to reflect any interventions for the weight loss. Resident's #6's record does not reflect notification of the MD or family with regard to the significant weight loss.Per an interview with the DON (Director of Nursing) on 1/13/26 at 1pm, the DON stated that there should have been a progress note from the dietitian during the month of 12/25 addressing Resident #6's significant weight loss.Per an interview with the dietician on 1/14/26 at 11:59am, the dietician stated that s/he was aware of the weight loss incurred by Resident #6. In a discussion with Resident #6 about the current weight loss, the resident stated to the dietitian that s/he did not want an additional intervention and would like to wait and see if their weight increased. During the interview on 1/14/26 at 11:59am, the dietitian stated, I should have written a note about that, shouldn't I.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. Based on observation and interview the facility failed to ensure the facility was free from medication errors greater than 5% with 2 errors in 32 opportunities [6.25%]. Findings include: Review of the facility's Medication Administration/Medication Errors Policy and Procedure [Document ID: VACH-PP-1-6-623, Reissued 11/29/23] reveals Medications shall be administered in a safe and timely manner and as prescribed, in accordance with good nursing principles and practices .1). Review of Prescribed Orders for Resident #5 include Lidocaine External Patch 4 % (Lidocaine patch is a topical anesthetic used to stop pain,) Apply to left and right hip topically at bedtime- on 12 hours, off 12 hours and remove per schedule.Review of the Medication Administration Record [MAR] for Resident #5 for Jan. 12, 2026, reveals licensed nursing staff initialed as completed the application of Lidocaine patches to the left and right hip of Resident #5 at 8:00 PM on Jan. 12, 2026.Per interview with the Staff Nurse for Resident #5 on Jan. 13 at 9:11 AM, the Staff Nurse stated I have no concern signing off [on removing the Lidocaine patches] before I check [to see if the two patches are present.] The Staff Nurse stated that no LNA had reported removing the lidocaine patches to her. The Staff Nurse then marked the electronic MAR order for the removal of the two lidocaine patches as completed at 7:59 AM on Jan. 13, 2026. Per observation on 1/13/26 at 9:14 AM the Staff Nurse then entered Resident #5's room to administer the resident their oral medications and did not check Resident #5 to remove the left and right Lidocaine patches before or after administering the medications and leaving the room.2). Review of Physician Orders for Resident #44 include Lidocaine External Patch 4 % Apply to midback topically at bedtime for pain. Further orders include Remove Lidocaine patch every AM (mid back).Review of the Medication Administration Record [MAR] for Resident #44 for Jan. 12, 2026, reveals licensed nursing staff initialed as completed the application of Lidocaine patches to the mid back of Resident #44 at 8:00 PM on Jan. 12, 2026.Per observation on 1/13/26 at 9:24 AM the Staff Nurse then entered Resident #44's room to administer the resident their oral medications. During the medication administration, the Staff Nurse attempted to remove the lidocaine patch but was unable to locate it. The Staff Nurse was then observed initialing Resident #44's MAR as having completed the order to remove the lidocaine patch, without actually confirming the patch was ever present. An interview was conducted with the facility's Director of Nursing [DON] on 1/13/26 at 1:30 PM. The DON confirmed that neither order for Resident #5 or Resident #44's lidocaine patches were completed as ordered. The DON further confirmed the Staff RN was in error when documenting on the MAR that the removal of the patches were completed as ordered.