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

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 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. 29776 Based upon interview and record review, the facility failed to ensure one resident [Res. #35] of 21 sampled residents remained free from physical abuse. Findings include: Per record review of Progress Notes for Res. #35 dated 7/22/24 Other resident was in [h/her] room when [Res.#35] tried to enter the room. [Res.#35] asked the person to leave [h/her] room and they got agitated and would not let [h/her] in [h/her] own room. They took [Res.35's] glasses off and threw them across the room, poured a soda on [h/her] head and then was moving [h/her] wheelchair from side to side until [s/he] ultimately fell out of the wheelchair. [Res.#35] did call for help and staff arrived as soon as heard [h/her]. Per review of the facility's investigation of the incident, the investigation concluded the allegation was verified by evidence collected during the investigation and was witnessed by staff. Per review of corrective actions taken by the facility after the incident, the residents were immediately separated after the incident and assessed for injuries. Close supervision was provided. Care plans for both residents were updated. Family, physician, and authorities were notified, the incident was reported to the State Agency and investigated in the appropriate time frame. The perpetrator was psychologically evaluated and medications were adjusted. Res. #35 was moved off the perpetrator's unit, and Social Services and Behavioral Health Services were involved in care and treatment for both residents post incident. Review of Res.#35's medical record reveals no negative physical or psychological outcomes from the incident. The facility conducted a Behavior Analysis Report regarding the perpetrator's behaviors before and after the incident. Behaviors that were monitored included grabbing others, hitting others, pushing others, cursing at others, screaming at others, threatening others, and rejection of care. The facility monitored the number of behaviors, when they occurred, the intervention[s] provided, and whether the interventions were effective. Per review of the Behavior Analysis Report, interventions implemented to halt the behavior during the incident on 7/21/24 and new interventions implemented to prevent future incidents were documented and noted effective. Per interview with staff Licensed Practical Nurse [LPN] on 10/30/24 at 8:34 AM, the LPN confirmed the perpetrator's past behaviors and improvement post incident. The facility completed corrective actions after identifying this deficient practice, prior to the survey entrance; therefore, this deficiency is considered past noncompliance.

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