VERMONT

Department of Disabilities, Aging and Independent Living
Division of Licensing and Protection
280 State Drive/HC 2 South
Waterbury, VT 05671-2060
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AGENCY OF HUMAN SERVICES

June 17, 2026

Mr. Bradford Ellis, Administrator
Vernon Green Nursing Home
61 Greenway Drive
Vernon, VT 05354

Provider ID #: 475008

RE: Complaint Survey Findings - Past Non-Compliance

Dear Mr. Ellis:

On **June 4, 2026**, the Division of Licensing and Protection, completed a complaint investigation at Vernon Green Nursing Home. As a result of that survey, the Division determined that at a point in time prior to the date of our visit you were not in substantial compliance with the federal regulations applicable to long-term care facilities.

Statement of Deficiencies Form CMS 2567

Enclosed is a statement of deficiency generated as a result of the survey. All references to regulatory requirements in the enclosure and in this letter are found in Title 42, Code of Federal Regulations. As the cited deficiencies were corrected at the time of our visit, no plan of correction is required. Please **sign page 1 and return a signed copy of the 2567 to this office.**

Informal Dispute Resolution (IDR) Opportunity

In accordance with 42 CFR §488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. To be given such an opportunity, you are required to send your written request, along with the specific deficiencies being disputed, including an explanation of why you are disputing those deficiencies, to Pamela Cota, RN, at the Division of Licensing and Protection. Contact information is listed below. Please include if you would prefer a virtual meeting or prefer to submit information in writing for review. This request must be sent during the same ten days you have for submitting your plan of correction. You must still submit a plan of correction for all deficiencies, including those you are disputing, by the due date. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action. Please note that the following are not allowable disputes in the IDR process: scope and severity of deficiencies, unless they are immediate jeopardy level or constitute substandard quality of care; remedies imposed by CMS; survey process or inconsistency issues; or concerns about the IDR process.

A facility cannot use the IDR process to claim past noncompliance.

Email (preferred): Pamela.Cota@vermont.gov
Mailing address: Division of Licensing and Protection, attn Pamela Cota
HC 2 South, 280 State Drive
Waterbury, VT 05671-2060

Phone: (802) 241-0480

Sincerely,



Pamela M. Cota, RN, BS
Assistant Division Director
State Survey Agency Director

Enclosure

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 475008	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 06/04/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Vernon Green Nursing Home	**61 Greenway Drive , Vernon, Vermont, 05354**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	INITIAL COMMENTS The Division of Licensing and Protection conducted an unannounced, onsite investigation of 1 complaint and 1 facility reported incident, including reports #3002021 and #2785238 on 6/3/2026, with offsite document review on 6/4/2026 to determine compliance with 42 CFR Part 483 requirements for Long Term Care Facilities. There were no regulatory deficiencies identified for the complaint. The following regulatory deficiencies were identified related to the facility reported incident:	F0000		
F0600 SS = D	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is NOT MET as evidenced by: 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	F0600	"Past Noncompliance - no plan of correction required"	

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 reverse for further 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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F0600 SS = D	Continued from page 1 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.	F0600		

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F0600 SS = D	Continued from page 2 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 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.	F0600		
F0729 SS = D	Nurse Aide Registry Verification, Retraining CFR(s): §483.35(d)(4)-(6) §483.35(d)(4) Registry verification. Before allowing an individual to serve as a nurse aide, a facility must receive registry verification that the individual has met competency evaluation requirements unless— (i) The individual is a full-time employee in a training and competency evaluation program approved by	F0729	"Past Noncompliance - no plan of correction required"	

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F0729 SS = D	Continued from page 3 the State; or (ii) The individual can prove that he or she has recently successfully completed a training and competency evaluation program or competency evaluation program approved by the State and has not yet been included in the registry. Facilities must follow up to ensure that such an individual actually becomes registered. §483.35(e)(5) Multi-State registry verification Before allowing an individual to serve as a nurse aide, a facility must seek information from every State registry established under sections 1819(e)(2)(A) or 1919(e)(2)(A) of the Act that the facility believes will include information on the individual. §483.35(e)(6) Required retraining. If, since an individual's most recent completion of a training and competency evaluation program, there has been a continuous period of 24 consecutive months during none of which the individual provided nursing or nursing-related services for monetary compensation, the individual must complete a new training and competency evaluation program or a new competency evaluation program. This REQUIREMENT is NOT MET as evidenced by: 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 1/13/2025. An employee information sheet states that she had a job change on 4/3/2025 to an LNA. NA #1 was granted a provisional nursing assistant license by the State Board of Nursing on 4/3/2025 with an expiration date of 6/12/2025. 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 6/12/2025 through	F0729		

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F0729 SS = D	Continued from page 4 2/22/2026 without the required license. During an interview on 6/3/2026 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 3/5/2026, prior to the onsite, this citation is designated as past non-compliance with the compliance date of 3/5/2026. 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.	F0729		