

## **AGENCY OF HUMAN SERVICES**

## DEPARTMENT OF DISABILITIES, AGING AND INDEPENDENT LIVING

Division of Licensing and Protection

HC 2 South, 280 State Drive
Waterbury VT 05671-2060
<a href="http://www.dail.vermont.gov">http://www.dail.vermont.gov</a>
Survey and Certification Voice/TTY (802) 241-0480
Survey and Certification Fax (802) 241-0343
Survey and Certification Reporting Line (888) 700-5330
To Report Adult Abuse: (800) 564-1612

December 26, 2024

Mr. Bradford Ellis, Administrator Vernon Green Nursing Home 61 Greenway Drive Vernon, VT 05354-9474

Provider ID #: 475008

Dear Mr. Ellis:

On **December 23, 2024**, we conducted a revisit to the survey of **October 30, 2024**, to verify that your facility had achieved substantial compliance. Based on our revisit, we found that your facility is in substantial compliance with participation requirements found in Title 42, Code of Federal Regulations as of **December 15, 2024**.

If you have any questions concerning this letter, please contact me at (802) 241-0480.

Sincerely,

Pamela M. Cota, RN, BS Assistant Division Director

Pamela MCotaRN

State Survey Agency Director

## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/26/2024 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED  R 12/23/2024	
		475008	B. WING				
NAME OF PROVIDER OR SUPPLIER				STREET ADDRESS	S, CITY, STATE, ZIP CODE	1 12/	23/2024
VERNON GREEN NURSING HOME				61 GREENWAY DRIVE			
VERNOR GREEN NORMONO NOME				VERNON, VT 05354			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG	(EAC	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)		(X5) COMPLETION DATE
{E 000}	Initial Comments		{E 0	00}			
{F 000}	during the annual rec	ency preparedness review ertification survey on 10/30/2024. There were no dentified.	{F 0	00}			
	at the facility on the d	ounced, onsite revisit survey late indicated in the upper his form. The violation(s)					
LABORATORY	DIRECTOR'S OR PROVIDER/S	SUPPLIER REPRESENTATIVE'S SIGNATUR	 !F		TITLE		(X6) DATE

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.