

## **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 http://www.dail.vermont.gov

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 28, 2023

Ms. Amy Braun, Administrator Union House Nursing Home 3086 Glover Street Glover, VT 05839-9701

Provider #: 475036

Dear Ms. Braun:

Enclosed is a copy of your acceptable plans of correction for the Life Safety Code survey conducted on **October 13, 2023**. Please post this document in a prominent place in your facility.

We will follow up to verify that substantial compliance has been achieved and maintained. If we find that your facility has failed to achieve or maintain substantial compliance, remedies may be imposed.

Sincerely,

tammy wehneyer

Tammy Wehmeyer Administrative Services Manager

Enclosure

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

PRINTED: 11/02/2023 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  475036			(X2) MULTIPLE CONSTRUCTION  A. BUILDING 01  B. WING			(X3) DATE SURVEY COMPLETED  - 10/13/2023	
		475036					
NAME OF PROVIDER OR SUPPLIER  UNION HOUSE NURSING HOME				STREET ADDRESS, CITY, STATE, ZIP CODE 3086 GLOVER STREET GLOVER, VT 05839			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
K 000	INITIAL COMMENTS		K 000				
K 341 SS=D	on 10/13/23. Entry a conducted with the C	Life Safety Code inspection nd exit interviews were linical Director and the The following violations	K	341			
	components approve accordance with NFP and NFPA 72, Nation provide effective warr building. In areas not detection is installed unit. In new occupant at notification applian and supervising static Fire alarm system will paths are monitored 18.3.4.1, 19.3.4.1, 9.6	s installed with systems and d for the purpose in A 70, National Electric Code, al Fire Alarm Code to ning of fire in any part of the continuously occupied, at each fire alarm control by, detection is also installed ce circuit power extenders, on transmitting equipment. Fing or other transmission for integrity.			<ol> <li>No residents had any negative ef related to the alleged deficient practice.</li> <li>Residents residing in the facility have the potential to be affected to the alleged deficient practice.</li> <li>Johnson Controls has been notified to address the fact that some of the smoke detectors are not wired into the Fire Alarm Control Panel.</li> <li>Johnson controls has reviewed the electrical blueprints of the facility and has received back a signed copy of the quote that they provided to the facility. existing fire panel to wire all smoke detectors to. The project completion date will by by</li> </ol>	oby ed dee o	
	by: At the time of inspect determined that Smo do not provide activa Panel. In an additional detection is available appliances are in use	ke alarm(s) in the basement tion to the Fire Alarm Control al basement location, no CO where combustible fuel			1/14/2024  5.A CO detector has been placed in the area where combustible fuel appliances are in use (clothes dryers).  Tag K 341 POC accepted on 12/28 M. Steele/T. Wehmeyer	/23 by	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Amy Braun

Amy Braun Administrator

12/14/2023

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.

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PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETED IN COMPLE	(X3) DATE SURVEY COMPLETED	
NAME OF PROVIDER OR SUPPLIER  UNION HOUSE NURSING HOME  (X4) ID PREFIX TAG  REGULATORY OR LSC IDENTIFYING INFORMATION)  STREET ADDRESS, CITY, STATE, ZIP CODE  3086 GLOVER STREET  GLOVER, VT 05839  (X5)  PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLE ACTION SHOULD BE DATE OF COMPLETE OF	3/2023	
PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  PREFIX TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  DEFICIENCY)		
K 341 Continued From page 1 K 341	(X5) COMPLETION DATE	
and Maintenance Director at 1:00PM on 10/13/2023.		