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

March 22, 2024

Mr. Shawn Hallisey, Administrator
Union House Nursing Home
3086 Glover Street
Glover, VT 05839-9701

Dear Mr. Hallisey:

Enclosed is a copy of your acceptable plans of correction for the complaint investigation conducted on **February 28, 2024.** Please post this document in a prominent place in your facility.

We may 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,

Pamela M Cota RN

Pamela M. Cota, RN
Licensing Chief

Enclosure

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	475036	A. BUILDING ______ B. WING ______	C 02/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNION HOUSE NURSING HOME	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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The Division of Licensing and Protection conducted an onsite, unannounced complaint investigation of intake #22513 and a facility-reported incident #22763, on 2/28/24 to determine compliance with 42 CFR Part 483 requirements for Long Term Care Facilities. The following deficiency was identified as a result of this investigation.	F 000		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the	F 609	F609 1. No residents were negatively affected by the alleged deficient practice. 2. Residents involved in reportable events have the potential to be affected by the alleged deficient practice. 3. Facility administration is aware of the reporting requirements to the Division of Licensing and Protection and inadvertently entered the incorrect email address to make the report. 4. The correct email address to make reports to the state agency has been verified and is posted and available for staff required to make reports to the State Agency.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Shawn T. Hallisey — TITLE: Administrator — (X6) DATE: 3/22/24

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.

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

PRINTED: 03/11/2024
FORM APPROVED
OMB NO. 0938-0391

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UNION HOUSE NURSING HOME	**3086 GLOVER STREET GLOVER, VT 05839**

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F 609	Continued From page 1 incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure a timely report of an incident of suspected resident-to-resident abuse for 2 of 2 residents (Resident#1 and Resident #2). Findings include: Review of a nursing progress note from 1/8/24 revealed that Resident #1 had approached Resident #5 and started to pull on Resident #5's wheelchair, when s/he told Resident #1 to stop, Resident #1 became angry and slapped Resident #5 on the right arm. A review of the facility's internal investigation file related to this incident on 1/8/24 revealed confirmation from Adult Protective Services (APS) that a report for this incident had been made to that agency however, there was no documentation or confirmation to support that a report had also been made to the State Agency (SA) which is a requirement. An interview on 2/20/24 with the Director of Nursing (DON) revealed that s/he believed s/he had reported the incident to APS and to the SA via an email sent through the facility fax machine. However, when this surveyor reviewed the ASPEN Complaint Tracking System (ACTS) on 2/20/24 during a previous facility-report complaint investigation, the report was not found, indicating that the suspected abuse report related to the incident on 1/8/24 had not been submitted to the SA. On 2/20/24 it was noted that the email address in	F 609	5. Audits will be done as needed with reportable events to monitor effectiveness of the plan. 6. Results of the audits will be reported to the QAA committee x3 months at which time the committee will determine further frequency of the audits. 7. Corrective action is complete as of 3/22/2024. **Tag F 609 POC accepted on 3/22/24 by N. Baker/P. Cota**	