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

October 11, 2021

Mr. Brian Labelle, Administrator
Union House Nursing Home
3086 Glover Street
Glover, VT 05839-9701

Dear Mr. Labelle:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **September 1, 2021**. 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
Licensing Chief

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 09/01/2021

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
E 000	Initial Comments The Division of Licensing and Protection conducted an emergency preparedness survey on 9/1/21. There were no regulatory findings as a result.	E 000		
F 000	INITIAL COMMENTS The Division of Licensing and Protection conducted an unannounced onsite recertification survey 8/30/21 - 9/1/21. The following regulatory deficiencies were cited as a result:	F 000		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the	F 656	F656 1. Resident #20's care plan has been reviewed and a person-centered care plan has been developed to address the risk of falls. 2. Residents residing in the facility that are at risk to fall have the potential to be affected by the alleged deficient practice. 3. An audit has been completed to ensure that all residents residing in the facility that are risk to fall have a comprehensive person-centered care plan to address the risk of falls. 4. Education will be completed for nursing staff to ensure understanding of the need for a person-centered care plan to address the risk of falls.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

LNHA. ADMINISTRATOR 09/14/2021

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.

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 09/01/2021

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 656	Continued From page 1 findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to develop a comprehensive, person-centered care plan related to falls for one of 15 applicable residents (Resident #20). Findings include: 1. Per record review, Resident #20 was admitted on 1/15/2021 to the facility with diagnoses of Alzheimer's Disease, spinal stenosis (nerve pain in the spine), osteoarthritis (a joint disease that causes pain and decreased mobility), dizziness, and muscle weakness. Per progress notes, Resident #20 sustained falls on 1/30/2021, 2/15/2021, 2/19/2021, 3/10/2021, 4/1/2021, and 7/1/2021. The fall that occurred on 1/30/2021 resulted in Resident #20 being sent to the emergency room for evaluation due to post-fall pain and a decrease in mobility. The falls did not result in major injury. Per review of the Minimum Data Set (MDS; mandatory quarterly assessments of each resident), the 4/13/2021	F 656	5. Audits will be conducted weekly by the Director of Nursing or designee to ensure person-centered care plans are in place to address the risk of falls to monitor effectiveness of the plan. 6. The results of the audits will be reported to the QAA committee x3 months at which time the committee will determine further frequency of audits. 7. Corrective action will be completed by October 1, 2021. **TAG F 656 POC Accepted on 10/11/21 by R. Tremblay/P. Cota**	

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 09/01/2021

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 656	Continued From page 2 assessment documented that Resident #20 had sustained 2 falls since the previous assessment and the 7/8/2021 assessment documented 1 fall since the previous assessment. There is also ample documentation throughout the record regarding Resident #20's noncompliance with the use of their 4-wheeled rolling walker. One nursing note from 8/30/21 at 4:01 PM states, "has had multiple falls with pain and soreness. noncompliant with walker and ambulates frequently." Per review of Resident #20's care plan, there is no historical or current care plan related to falls or interventions to prevent falls. The only mention of falls in the care plan is within the care plan for pain. The problem reads, "Resident is at risk to experience pain due to diagnosis of spinal stenosis, lumbosacral region and falls with minor injuries." There are no interventions under this care plan problem related to the prevention of falls. An interdisciplinary team care plan conference summary note from 5/14/21 states, "s/p (status post) fall with hematoma" but no preventative interventions are listed. No other notes of this type mention any falls. Per interview on 9/1/2021 at approximately 11:00 AM, the Director of Nursing and the Clinical Coordinator confirmed that there is no evidence of a current or historical care plan related to fall prevention in Resident #20's record.	F 656		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be-	F 657	F657 1. Resident #41's care plan has been reviewed and revised to ensure appropriate interventions are in place to address the risk of falls. 2. Residents residing in the facility that are at risk for, and experience	

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 09/01/2021

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 657	Continued From page 3 (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility failed to reassess the effectiveness of the interventions, and review and revise 1 of 15 applicable resident's care plans to meet the resident's needs (Resident # 41). Findings include: The facility did not revise the care plan for Resident # 41 to address needs related to multiple falls. Per review of the clinical record, Resident # 41 had 6 falls between 8/30/20 - 7/23/21, and has a documented history of falls. Fall risk assessments done on 10/2/20, 12/21/20	F 657	falls have a potential to be affected by the alleged deficient practice. 3. An initial audit has been completed to ensure residents that have experienced falls have appropriate interventions in place to address the risk and that the care plan has been reviewed and revised as necessary. 4. Education will be provided to nursing staff to ensure understanding of the need for review and revision of the care plan with appropriate interventions to address falls. 5. An audit will be completed weekly by the Director of Nursing or designee 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 will be completed by October 1, 2021.	

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 09/01/2021

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 657	Continued From page 4 and 3/17/21 were all scored at 10 (high risk). A fall risk assessment done on 5/26/21 was scored at 16 (high risk). A fall risk assessment done on 6/30/21 was scored at 12 and another on 7/7/21 was scored as 21 (high risk). There is a falls care plan in place that was initiated on 4/5/18 and reviewed on 6/3/21. There is no evidence that new interventions were put into place after the repeated falls. Current interventions include staff to monitor closely especially when in room and to keep items in her reach. Per interview with the Director of Clinical Services (DCS) on 8/31/21 at 12:54 PM, h/she stated that the higher the fall risk assessment score, the higher the fall risk. The DCS also stated that the current interventions were inadequate. The DCS confirmed that Resident # 41's fall risk had increased and agreed that the care plan should have been and was not revised to reflect the changes.	F 657	**TAG F 657 POC Accepted on 10/11/21 by R. Tremblay/P. Cota**	
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used	F 758	F758 1. Resident #20 had no negative effects related to the alleged deficient practice. 2. Residents with medication orders have the potential to be affected by the alleged deficient practice. 3. An initial audit for all residents has been completed to ensure medications have indications and/or diagnosis for use documented.	

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 09/01/2021

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 758	Continued From page 5 psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure that ensure that residents are not given psychoactive drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record for one of 5 applicable residents (Resident #20).	F 758	4. Education will be provided to licensed nursing regarding the requirement to ensure a diagnosis or indication for use is documented with each medication. 5. Audits will be completed weekly by the Director of Nursing or designee to monitor effectiveness of the plan. 6. The 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 will be completed by October 1, 2021. **TAG F 758 POC Accepted on 10/11/21 by R. Tremblay/P. Cota**	

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 09/01/2021

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 758	Continued From page 6 Findings include: 1. Per record review, Resident #20 has orders for Escitalopram (an antidepressant medication) 10 milligrams by mouth at bedtime and Seroquel (an antipsychotic medication) 12.5 milligrams by mouth twice a day. Resident #20 was also prescribed Buspar (an anti-anxiety medication) 5 milligrams by mouth twice a day, which was discontinued on 8/3/2021. Per review of Resident #20's physician orders and medical record, there was no evidence found indicating which specific diagnoses, or symptoms related to diagnoses, the medications were prescribed to treat. Per interview on 9/1/2021 at approximately 11:30 AM, the Clinical Coordinator confirmed that they could not find evidence of which specific diagnoses or symptoms the medications had been prescribed to treat when ordered within the record.	F 758		