VERMONT

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 Reporting Line (888) 700-5330
To Report Adult Abuse: (800) 564-1612

September 15, 2022

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

RE: Complaint Survey Findings - Past Non-Compliance

Dear Mr. Labelle:

On **August 31, 2022**, the Division of Licensing and Protection, completed a complaint investigation at Union House 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

In accordance with §488.331, you have one opportunity to question cited deficiencies through an informal dispute process. To be given such an opportunity, you are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies to Suzanne Leavitt RN, MS, Assistant Division Director, Division of Licensing and Protection. **This written request must be received by this office by September 27, 2022.**

Sincerely,

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 08/31/2022

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 unannounced onsite investigation of 2 Facility Reported Incidents (FRI) on 8/31/2022, the following regulatory violations were cited as a result:	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States.	F 550		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
LNHA	ADMINISTRATOR	09/19/2022.

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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F 550	Continued From page 1 §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on staff interviews and record review, the facility failed to protect and promote the rights of 1 of 2 applicable residents (Residents #2). The facility failed to treat Resident #2 with respect and dignity and in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life. Findings include: Per record review, Resident #2 was admitted to the facility with diagnoses that include but are not limited to Alzheimer's Disease. Per review of the facility's internal investigation along with written witness and alleged perpetrator statements, a Licensed Nurse Aide (LNA) behaved in a way that was abusive, disrespectful and demeaning to the resident. On 7/7/22 at approximately 11:00pm LNA #1 said to LNA #2, "stay here I want to show you something". LNA #1 then took a spray bottle filled with water and sprayed it into the face of a sleeping resident, (Resident #2) waking him up. LNA #1 then said to the resident "the roof must be leaking again". When LNA #2 asked LNA #1	F 550	Past noncompliance: no plan of correction required.	

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F 550	Continued From page 2 why would they do something like that, LNA #1 laughed and said, "it was funny seeing him get upset". On 7/12/22 the facility investigative summary report, substantiated the allegation of abuse and violating a resident's rights and per interview on 8/31/22, this was confirmed by the Acting Director of Nursing. Based on corrective actions completed prior to the onsite, this citation is designated as past non-compliance. The following actions were completed by the facility: 1. Following the incident, the Interdisciplinary Team Members (IDT) met to discuss the incident and plans were made to re-educate all staff regarding abuse and resident rights. 2. The Licensed Nurse Aide (LNA) involved, was immediately suspended, and then terminated on 7/12/22. 3. Education regarding abuse prohibition and abuse reporting was provided to all staff on 7/11/2022. Additionally, this training involved a staff questionnaire regarding staff actions if they were to witness abuse, who to report abuse to, if they had ever observed abuse taking place within the facility and whether the facility had trained staff regarding resident rights and abuse. 4. An analysis of the incident will be discussed again by the quality team (QAPI) during the scheduled October 2022 meeting.	F 550		
F 600 SS=D	Free from Abuse and Neglect CFR(s): 483.12(a)(1)	F 600		

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F 600	Continued From page 3 §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 staff interviews and record review, the facility failed to ensure 1 of 2 applicable residents (Residents #2) were free from physical abuse. Findings include: Per record review, review of the facility's internal investigation along with written witness and alleged perpetrator statements, a facility Licensed Nurse Aide (LNA) physically abused Resident #2. On 7/7/22 at approximately 11:00pm LNA #1 said to LNA #2, "stay here I want to show you something". LNA #1 then took a spray bottle filled with water and sprayed it into the face of a sleeping resident, (Resident #2) waking him up. LNA #1 then said to the resident "the roof must be leaking again". When LNA #2 asked LNA #1 why would they do something like that, LNA #1 laughed and said, "it was funny seeing him get upset".	F 600	Past noncompliance: no plan of correction required.	

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F 600	Continued From page 4 Using the "Reasonable Person Concept", a reasonable person in a similar situation would feel mental anguish due to feeling humiliated and/or dehumanized by being treated as not having emotions, feelings or sensations and being objectified for the amusement of LNA #1. On 7/12/22 the facility investigative summary report, substantiated the allegation of abuse and violation of resident rights and per interview on 8/31/22, this was confirmed by the Acting Director of Nursing. Based on corrective actions completed prior to the onsite, this citation is designated as past non-compliance. The following actions were completed by the facility: 1. Following the incident, the Interdisciplinary Team Members (IDT) met to discuss the incident and plans were made to re-educate all staff regarding abuse and resident rights. 2. The Licensed Nurse Aide (LNA) involved, was immediately suspended, and then terminated on 7/12/22. 3. Education regarding abuse prohibition and abuse reporting was provided to all staff on 7/11/2022. Additionally, this training involved a staff questionnaire regarding staff actions if they were to witness abuse, who to report abuse to, if they had ever observed abuse taking place within the facility and whether the facility had trained staff regarding resident rights and abuse. 4. An analysis of the incident will be discussed again by the quality team (QAPI) during the	F 600		

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F 600	Continued From page 5 scheduled October 2022 meeting.	F 600		