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

August 10, 2023

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

Dear Ms. Braun:

Enclosed is a copy of your acceptable plans of correction for the complaint investigation conducted on **July 21, 2023.** 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 |
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| | 475036 | A. BUILDING ______ B. WING ______ | C 07/21/2023 |

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

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| F 000 | INITIAL COMMENTS<br><br>The Division of Licensing and Protection conducted an unannounced, on-site investigation of complaint #22013 and facility reported incidents #21986 and #21898 on 7/19/2023, with additional offsite investigation that ensued until 7/21/23, to determine if the facility was in compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. The following regulatory violations were identified as a result: | F 000 | | |
| F 600 SS=D | Free from Abuse and Neglect<br>CFR(s): 483.12(a)(1)<br><br>§483.12 Freedom from Abuse, Neglect, and Exploitation<br>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.<br><br>§483.12(a) The facility must-<br><br>§483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion;<br>This REQUIREMENT is not met as evidenced by:<br>Based on interview and record review, the facility failed to ensure a resident's right to be free from physical, verbal, and mental abuse for 2 of 2 sampled residents (Residents #1 and #3).<br>Findings include:<br><br>1. Per record review, Resident #1, has been residing at the facility since 2017 and has | F 600 | F 600<br><br>1. Residents #1 and 3 have had no lasting effects related to the alleged deficient practice and have no recollection of the events.<br>2. The identified employee contract was immediately terminated, and he/she did not work in the facility following this event.<br>3. Resident #4 care plan has been updated to reflect line of site supervision when out of the room.<br>4. Residents residing in the facility have the potential to be affected by the alleged deficient practice. | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Amy [signature] TITLE: Administrator (X6) DATE: 8/10/2023

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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| F 600 | Continued From page 1<br>diagnoses to include dementia, parkinsonism, post-traumatic stress disorder, and congestive heart failure. This resident's care plan reveals interventions related to dementia care and behaviors such as frequent and sometimes loud chanting,<br><br>Review of an 05/23/23 facility investigation summary report reveals that a licensed nursing assistant (LNA) reported to a nurse downstairs in the facility at approximately 4:55 PM on 05/18/2023 that, ' ... a [travel LNA] was working on the upstairs unit ... and asked me to help get [Resident #1] into the bathroom so s/he could give [the resident] a bath, so I did. I left the bathroom and [the travel LNA] called me back in as [Resident #1] was sliding out of the chair and s/he needed assistance to get him/her back into the chair. We slid [the resident] back into the chair and lowered the chair down to the lowest position and ... [Resident #1] was making a lot of noise and [the travel LNA] told [Resident #1] to shut up and s/he got a face towel and put it in [the resident's] mouth. That is when I went and told the nurse downstairs."<br><br>The written statement from the AP reveals s/he admittedly put his/her hand over Resident #1's mouth and whispered in his/her ear to 'quiet down.' The investigative summary completed by the facility concluded that per the AP's own admission, it is determined that the AP acted in a physically inappropriate manner toward Resident #1 to quiet his chanting and crying. The employee's contract was terminated, and s/he never worked in the facility again after this incident<br><br>Per further review of the facility investigative | F 600 | 5. Education has been provided regarding abuse prevention.<br>6. Staff interviews and observation audits are in place and will continue to be completed by the Director of Nursing or designee weekly to monitor the effectiveness of the plan.<br>7. 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.<br>8. Corrective action will be completed by 8/18/2023.<br><br>**Tag F 600 POC accepted on 8/10/23 by S. Stem/P. Cota** | |

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| F 600 | Continued From page 2<br>summary and interview with the Director of Nursing (DNS) at 11:00 AM on 07/18/23, s/he states s/he was notified immediately of the incident and went directly to the facility after receiving the phone call to interview staff and report to the required authorities. The DNS asked the alleged perpetrator (AP) to come to the DNS office where the facility Administrator and DNS asked the AP to describe what actions the AP took while attempting to bathe Resident #1. Per the DNS the AP stated s/he was giving the resident a bath and, '... [the resident] was chanting and crying very loud.' The DNS states s/he, ' ... asked if there was anything else that happened ... there is an allegation that you put a washcloth in [the resident's] mouth to quiet [him/her] down. [The AP] responded, [the resident] was chanting and crying very loud.' The AP was immediately suspended pending a full investigation.<br><br>Psychosocial assessments were completed on 05/18/23 and 05/23/23. The assessments concluded there was no change from this resident's baseline physical or mental status related to this incident. Due to dementia this resident has no recollection of the event at this time, nor did s/he recollect it directly after it occurred per record review. However, to use the reasonable person concept, one would expect a person who has been physically and verbally abused to feel mental anguish.<br><br>At 4:30 PM on 07/18/23 the Director of Nursing (DON) and Administrator confirmed Resident #1 suffered physical, mental, and verbal abuse.<br><br>2. Review of a facility investigation summary, dated 6/28/23, reveals that on 6/21/23 Resident | F 600 | | |

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| F 600 | Continued From page 3<br>#4 ran his/her wheelchair into Resident #3, knocking Resident #3 to the floor. Prior to the incident, Resident #3 was in the dining room cleaning up Resident #4's meal while Resident #4 was away from the table. A progress note, dated 6/22/23, stated that upon returning to the table, Resident #4 yelled at Resident #3 'Leave my stuff alone. I told you about messing with my stuff. I am going to run you over.' An incident report, dated 6/21/23, reveals that Resident #3 had 3 red marks across the top of his/her foot upon assessment following the event. A 6/22/23 progress note reveals that when asked about the event, Resident #4 had conveyed that s/he was upset and would 'do it again.'<br><br>On 7/18/23 at 4:00 PM, the Unit Supervisor stated that Resident #4 has a history of aggressive behaviors and has had prior altercations with Resident #3. Review of a facility investigation summary dated 5/8/23 reveals that on 5/7/23 Resident #3 was attempting to clean up a spill at Resident #4's table. Resident #4 had become upset that Resident #3 was in his/her personal space and commented that s/he would run over Resident #3 if s/he didn't get out of the way.<br><br>An incident report 6/21/23 describes Resident #4's actions on 6/21/23 as intentional during the incident with Resident #3. At approximately 5 PM on 7/18/23, the DON confirmed that Resident #4 was physically abusive with Resident #3 during the events on 6/21/23. | F 600 | | |
| F 609 SS=D | Reporting of Alleged Violations<br>CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4)<br><br>§483.12(c) In response to allegations of abuse, | F 609 | | |

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| F 609 | Continued From page 4<br>neglect, exploitation, or mistreatment, the facility must:<br><br>§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.<br><br>§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 incident, and if the alleged violation is verified appropriate corrective action must be taken.<br>This REQUIREMENT is not met as evidenced by:<br>Based on interviews and record review, the facility failed to implement policies and procedures for ensuring the reporting of an alleged violation of neglect to the state survey and certification agency for one applicable resident (Resident #2); and failed to ensure that employees immediately report an injury of unknown source to the facility administrator and state survey and certification agency for one applicable resident (Resident #3). Findings | F 609 | F609<br><br>1. Neither resident identified in the deficiency statement resides in the facility any longer.<br>2. Residents identified as having potential abuse/neglect allegations have the potential to be affected by the alleged deficient practice.<br>3. Reports have since been made to the licensing agency regarding the identified allegations of potential abuse/neglect and investigations completed.<br>4. Facility administration is aware of the requirement to report allegations of abuse/neglect and injuries of unknown origin to the licensing agency.<br>5. Education has been provided to staff regarding the reporting requirements. | |

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| F 609 | Continued From page 5<br>include:<br><br>Facility policy titled Abuse, Neglect, Exploitation or Misappropriation - Reporting and Investigating, last revised 9/2022, states: "If resident abuse, neglect, exploitation, misappropriation of resident property or injury of unknown source is suspected, the suspicion must be reported immediately to the administrator and to other officials according to state law."<br><br>1. A review of a facility investigation, dated 4/17/23, reveals that facility staff reported to the previous Administrator an allegation of neglect in regard to Licensed Nurse #2 not administering pain medications to Resident #2, who was actively dying and suffering. The investigation note reveals that Licensed Nurse #2 was terminated because of this event. There is no evidence that this allegation was reported to the state survey and certification agency.<br><br>On 7/18/23 at approximately 5:00 PM, the Administrator and Director of Nursing (DON) confirmed that this event had not been reported to the state survey and certification agency.<br><br>2. Per review of Resident #3's medical record, the following 7/3/23 nurse progress was discovered: "AM LNA [Licensed Nursing Aide] called nurse to bedside, as resident has a new bruise noted to the left side of his back. Moderate in size and dark purple in color. LNA said she did not previously see this bruise this week." There are no other notes in Resident #3's medical record that reveal this injury was reported to the DON or Administrator, or that this injury was investigated.<br><br>On 7/18/23 at approximately 5:00 PM, the DON | F 609 | 6. Audits that include staff and resident interviews as well as record review have been implemented and will continue to be completed by the Director of Nursing or designee weekly to monitor effectiveness of the plan.<br>7. Results of these interviews and audits will be reported to the QAA committee x3 months at which time the committee will determine further frequency of the audits.<br>8. Corrective action to be completed by 8/18/2023.<br><br>**Tag F 609 POC accepted on 8/10/23 by S. Stem/P. Cota** | |

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| F 609 | Continued From page 6<br>indicated that s/he was unaware of Resident #3's bruise or any investigation into an injury of unknown origin for Resident #3. On 7/19/23 at 11:23 AM, the DON revealed that the nurse only wrote a progress note about this and this nurse did not report it to his/her supervisor or the DON. S/He confirmed that s/he should have been made aware of this injury. | F 609 | | |
| F 684<br>SS=E | Quality of Care<br>CFR(s): 483.25<br><br>§ 483.25 Quality of care<br>Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices.<br>This REQUIREMENT is not met as evidenced by:<br>Based on interviews and record review, the facility failed to ensure that residents received medication in accordance with physician orders and facility policy for 5 of 17 sampled residents (Residents #5, #6, #7, #8, and #9). Findings include:<br><br>A medication administration audit was performed by the Director of Nursing (DON) for all 17 residents residing on the upstairs unit for 7/14/23 through 7/16/26. The audit revealed that 5 of the 17 residents had a significant number of refusals documented during the 7 AM- 7 PM shift. Review of the nursing schedule reveals that Licensed Practical Nurse (LPN) #1 worked the 7 AM- 7 PM shift on the upstairs unit on 7/14/23, 7/15/23, and | F 684 | F684<br><br>1. The identified residents in the deficiency statement show no signs of negative effects as a result of the alleged deficient practice.<br>2. The physician has been made aware of the findings cited in the deficiency statement.<br>3. Residents residing in the facility that have medications ordered have the potential to be affected by the alleged deficient practice.<br>4. The identified nurse was a travel nurse, and the contract has since expired. Therefore, the nurse no longer works in the facility. | |

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| F 684 | Continued From page 7<br>7/16/23. This was confirmed on 7/20/23 at approximately 12:30 PM by the DON.<br><br>Review of Resident #5's medication administration records (MAR) between 7/14/23 and 7/16/23 revealed the following medications documented as refused:<br>7/14/23- 2 doses of divalproex 125 mg sprinkle cap for dementia with behaviors;<br>7/14/23- 1 dose Quetiapine Fumarate 12.5 mg for dementia with behaviors<br>7/14/23- 1 dose Spironolact 25mg for edema<br>7/14/23- 1 dose Montelukast 10 mg for emphysema<br>7/14/23- 2 doses Pancrease 4200-14200 UNIT with meals for exocrine pancreatic insufficiency<br>7/14/23- 2 doses Lactase Enzyme 3000 UNIT with meals for disorders of diaphragm<br><br>Review of Resident #6's medication administration records (MAR) between 7/14/23 and 7/16/23 revealed the following medications documented as refused:<br>7/15/23- 1 dose Tamsulosin 0.8 mg for prostate cancer<br>7/15/23- 1 dose Baclofen 10 mg for osteoarthritis pain<br>7/15/23- 1 dose Lisinopril 20 mg for hypertension<br>7/15/23- 1 dose Acetaminophen extra strength 1000mg for peripheral vascular disease pain<br>7/15/23- 1 dose Citalopram 10 mg for depression<br>7/15/23- 1 dose Quetiapine Fumarate 50 mg for dementia with behaviors<br>7/15/23- 1 dose Calcium 600 mg and D 200IU for supplement<br>7/15/23- 1 dose Timolol maleate solution 0.25% for glaucoma<br>7/15/23- 1 dose Polyth Glyc Pow 17 mg for constipation | F 684 | 5. The policy for medication administration and protocol for refusals has been reviewed and education provided to licensed nurses regarding the requirements for documentation, reapproach, and notifications with medication refusals.<br>6. Audits will be conducted by the Director of Nursing 3 times weekly x1 month and weekly x3 months thereafter to monitor effectiveness of the plan.<br>7. 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.<br>8. Corrective action will be completed by 8/18/2023.<br><br>**Tag F 684 POC accepted on 8/10/23 by S. Stem/P. Cota** | |

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| F 684 | Continued From page 8<br>7/16/23- 1 dose Tamsulosin 0.8 mg for prostate cancer<br>7/16/23- 1 dose Tamsulosin 0.8 mg for prostate cancer<br>7/16/23- 1 dose Lisinopril 20 mg for hypertension<br>7/16/23- 1 dose Acetaminophen extra strength 1000mg for peripheral vascular<br>7/16/23- 1 dose Citalopram 10 mg for depression<br>7/16/23- 1 dose Quetiapine Fumarate 50 mg for dementia with behaviors<br>7/16/23- 1 dose Calcium 600 mg and D 200IU for supplement<br>7/16/23- 1 dose Timolol maleate solution 0.25% for glaucoma<br>7/16/23- 1 dose Polyth Glyc Pow 17 mg for constipation<br><br>Review of Resident #7's medication administration records (MAR) between 7/14/23 and 7/16/23 revealed the following medications documented as refused:<br>7/15/23- 1 does Senna 8.6 mg for constipation<br>7/15/23- 2 doses quetiapine 12.5 mg for dementia with agitation<br>7/15/23- 2 doses Acetaminophen extra strength 500 mg for polyneuropathy pain<br>7/15/23- 1 drop in each eye- artificial tears solution<br>7/15/23- 1 dose gabapentin 100 mg for neuropathic pain<br>7/15/23- 2 doses furosemide 20 mg for polyneuropathy<br><br>Review of Resident #8's medication administration records (MAR) between 7/14/23 and 7/16/23 revealed the following medications documented as refused:<br>7/15/23- 1 does metoprol 25 mg for high blood pressure | F 684 | | |

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| F 684 | Continued From page 9<br>7/15/23- 1 dose omeprazole 20 mg for gastro-intestinal protection<br>7/15/23- 1 dose quetiapine 150 mg extended release for schizoaffective disorder<br>7/15/23- 1 dose glipizide extended release for diabetes<br>7/15/23- 1 dose multi vitamin with minerals for supplement<br>7/15/23- 1 dose amlodipine 5 mg for hypertension<br>7/15/23- 1 dose aspirin 81 mg for heart health<br>7/15/23- 1 dose probiotic for antibiotic use<br>7/15/23- 1 dose novolog flex pen (sliding scale based on blood sugar) for diabetes<br>7/15/23- 2 doses furosemide 40 mg for heart failure<br>7/15/23- 1 dose Levemir flex pen 60 units for diabetes<br>7/15/23- 1 dose prednisone 10 mg for skin blisters<br>7/16/23- 1 dose metoprol 25 mg for high blood pressure<br>7/16/23- 1 dose omeprazole 20 mg for gastro-intestinal protection<br>7/16/23- 1 dose quetiapine 150 mg extended release for schizoaffective disorder<br>7/16/23- 1 dose glipizide extended release for diabetes<br>7/16/23- 1 dose multi vitamin with minerals for supplement<br>7/16/23- 1 dose amlodipine 5 mg for hypertension<br>7/16/23- 1 dose aspirin 81 mg for heart health<br>7/16/23- 1 dose probiotic for antibiotic use<br>7/16/23- 1 dose novolog flex pen (sliding scale based on blood sugar) for diabetes<br>7/16/23- 1 dose furosemide 40 mg for heart failure<br>7/16/23- 1 dose Levemir flex pen 60 units for diabetes<br>7/16/23- 1 dose prednisone 10 mg for skin | F 684 | | |

| 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 07/21/2023 |

| 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 684 | Continued From page 10<br>blisters<br><br>Review of Resident #9's medication administration records (MAR) between 7/14/23 and 7/16/23 revealed the following medications documented as refused:<br>7/14/23- 1 dose furosemide 40 mg for hypertension<br>7/14/23- 1 dose trazodone 50 mg for chronic post-traumatic stress disorder<br><br>7/21/23 at 1:20 PM, the DON stated that there was no evidence in Resident #5, #6, #7, #9, or #9's medical record that additional attempts were made for medication administration, a nursing supervisor was notified of the residents' refusal, or that the provider was notified of their medication refusal. S/He stated LPN #1 usually works downstairs because s/he doesn't work well with residents that have behaviors and the upstairs unit has a lot of residents with behaviors. S/He confirmed that the above medications documented as refused on the MAR by LPN #1. S/He stated that there should have been documentation of the refusal in the nursing notes, more than just marking it as refused on the MAR, and the provider should have been notified of the refusals. | F 684 | | |