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 Fax (802) 241-0343
Survey and Certification Reporting Line: (888) 700-5330
To Report Adult Abuse: (800) 564-1612

January 25, 2024

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 **January 2, 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,

PamelaMCotaRN
Pamela M. Cota, RN
Licensing Chief

Enclosure

STATEMENT OF DEFICIENCIES D PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	475036	A. BUILDING _____ B. WING _____	C 01/02/2024

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 unannounced, on-site investigation of complaints # 22534 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 CFR(s): 483.12(a)(1) §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 interviews and record review, the facility failed to ensure a resident's right to be free from physical abuse for 1 of 3 sampled residents. (Resident #2) Findings include: Resident #1 has resided at this facility since 5/19/22, with diagnoses that include Alzheimer's, severe vascular dementia, and an	F 600		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Amy N Bar — TITLE: Administrator — (X6) DATE: 1/22/24

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that r safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days .wing 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 agitation-induced psychotic disorder. Resident #2 has resided at the facility since 9/19/23 with diagnoses that include end-stage lewy body dementia and parkinsonism. Per record review, a witnessed resident to resident incident occurred between Resident #1 and Resident #2 on 12/9/23 at 5:47 AM. Resident #2 was standing in the doorway of his/her room, Resident #1 walked up to Resident #2 without speaking and hit her/his legs with her/his cane. Resident #2 attempted to move Resident #1 out of his way by grabbing his shirt; both residents fell to the ground. The investigative summary indicates Resident #2 could recall the incident and stated [Res. #1] whacked me three times on both legs [he/she] starts trouble with everyone." A review of statements by two witnesses dated 12/9/23 at 5:47 AM reveals that Resident #2 was standing in the doorway of their room when Resident #1 walked by and hit Resident #2 on his/her legs with his/her cane. Both witnesses attempted to intervene and re-direct but were unsuccessful, and the altercation continued, with both residents falling to the floor. A review of Resident #1's care plan indicates the following interventions initiated on 5/23/22 and reviewed on 12/5/23: utilize staff for one-on-one time if the resident is not easily directable, encourage residents to use his/her cane appropriately and not use it to hit others. Another intervention initiated on 11/9/23 and reviewed on 12/5/23 states, "When resident is walking the halls, she/he will be closely monitored to ensure the safety of all residents and allow staff to intervene if s/he swings her/his cane."	F 600	1. Resident #2 no longer resides in the facility. 2. Residents residing on the upstairs unit have the potential to be affected by the alleged deficient practice. 3. Resident #1 has had a medication review and changes made by the physician and a psychological evaluation. Resident #1 is discharging temporarily to an inpatient psychiatric hospital on 1/22/2024 4. Upon return from the hospital stay the interdisciplinary team will meet and collaborate with the psychiatric team to implement a plan of care that is effective to keep resident and others safe. 5. Education will be provided to staff regarding the plan's implementation upon resident #1's return. 6. Corrective action is complete as of 1/22/2024. **Tag F 600 POC accepted on 1/25/24 by D. Hoffman/P. Cota**	

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F 600	Continued From page 2 A progress note dated 12/13/2023 states that the resident is pacing the halls, swearing at staff, and taking food from another resident's plate; when a redirect was attempted, "[s/he] hit staff with a fist and then a cane." Another note dated 12/28/23 reveals "resident wandering into several resident rooms, shouting at other residents. Refusing to leave other resident's rooms when staff tried to re-direct, pulled glasses off a female resident's face. Hit a nurse with her/his cane who was attempting to re-direct." An interview was conducted with another resident on Res.#2's unit, Resident #3, on 1/2/24 at approximately 1:00 p.m. Res. #3 stated that s/he does not leave her/his room often as Resident # 1 will enter the room, rifle through her/his belongings, and often become aggressive, banging the cane on the floor and threatening to hit her/him. S/he feels safer in the room than in a common area. Per interview on 01/02/24 at 3:30 PM with the Assistant Director of Nursing (ADON) and the Director of Nursing, they confirmed that Resident #1 struck and pushed Resident #2 and struck out at the staff when they tried to intervene or redirect his/her behaviors. The DON confirmed that the facility was not keeping the residents free from physical abuse.	F 600		