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 21, 2025

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 recertification survey conducted on **December 18, 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, BS
Assistant Division Director
State Survey Agency Director

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 _____	12/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNION HOUSE NURSING HOME	3086 GLOVER STREET GLOVER, VT 05839

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E 000	Initial Comments The Division of Licensing and Protection conducted an emergency preparedness review during the annual recertification survey on 12/16 -12/18/24. There were no regulatory violations identified.	E 000		
F 000	INITIAL COMMENTS An unannounced, on-site re-certification survey was conducted by the Division of Licensing and Protection on 12/16/24 through 12/18/24 at Union House Nursing Home to determine compliance with 42 CFR Part 483 requirements for Long Term Care Facilities. The following regulatory violations were identified:	F 000		
F 607 SS=E	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(5)(ii)(iii) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, §483.12(b)(4) Establish coordination with the QAPI program required under §483.75. §483.12(b)(5) Ensure reporting of crimes occurring in federally-funded long-term care facilities in accordance with section 1150B of the Act. The policies and procedures must include	F 607	F 607 1. No residents were negatively affected by the alleged deficient practice. 2. Residents residing in the facility have the potential to be affected by the alleged deficient practice. 3. The facility administration is aware of the requirements to obtain national background checks and have done so for current staff.	2/1/25

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Shawn T. Hallisey | TITLE: Administrator | (X6) DATE: 1/17/2025

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 607	Continued From page 1 but are not limited to the following elements. §483.12(b)(5)(ii) Posting a conspicuous notice of employee rights, as defined at section 1150B(d)(3) of the Act. §483.12(b)(5)(iii) Prohibiting and preventing retaliation, as defined at section 1150B(d)(1) and (2) of the Act. This REQUIREMENT is not met as evidenced by: Based on interviews and record review the facility failed to create and implement a policy related to national background checks for their employees. The facility also did not complete national background checks for 19 of the 22 Licensed Nursing Assistants (LNAs) employed by the facility. Findings include: Record review of 5 LNA human resource files revealed there was no evidence of national background checks for 3 of the LNAs sampled. The facility provided an additional list of all LNAs employed at the facility and confirmed that only three of the 22 LNAs had evidence of national background checks. Per interview with the Clinical Lead Registered Nurse (RN) on 12/18/2024 at approximately 12:00 PM, s/he stated that the facility did not complete national background checks for their employed LNAs. Per record review, a memo from [Department of Aging and Independent Living] was sent out to nursing facilities on October 5, 2022, that states, "1. Prior to employing an individual and at least annually thereafter, a Facility must query the following entities regarding the prospective / current employee: ...Agency providing a national criminal background check ... To check whether	F 607	4. Audits will be conducted with new hires to ensure national background checks have been completed. 5. Reports of the audits will be reported to the QAA committee x 3 months at which time the committee will determine further frequency of the audits. 6. Corrective action completion date is 2/1/2025. **Tag F 607 POC accepted on 1/21/25 by T. Dougherty/P. Cota**	2/1/25

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F 607	Continued From page 2 the individual is barred from employment based on prior convictions in any state ...2. Under Vermont and federal laws and regulations, a Facility must decline to employ a prospective or current employee with: ...Criminal convictions for the abuse/exploitation/neglect of a vulnerable adult or child in any state ... In addition to the prohibitions mentioned above, Vermont laws prohibit long-term care facilities from employing individuals with "criminal convictions relating to bodily injury, theft or misuse of funds or property, and/or crimes inimical to the public welfare." Per review of the facility policy titled "Abuse Prevention Program" last revised 12/2016 states the following "As part of the resident abuse prevention, the administration will ... Conduct employee background checks ...Develop and implement policies and procedures to aid our facility in preventing abuse, neglect, or mistreatment of residents." The policy did not specify the requirement for national background checks. Per interview with the Clinical Lead RN on 12/18/2024 at 2:00 PM, s/he confirmed that s/he was not aware of the memo and that the abuse policy had not been updated to reflect requirement to complete at least one national background check for their employees. S/He also confirmed that the national background checks had not been done for the employees and they should have been.	F 607		
F 656 SS=E	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and	F 656		

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F 656	Continued From page 3 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 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.	F 656	F656 1. No residents were negatively affected by the alleged deficient practice and all residents have now had a skin check. 2. Residents residing in the facility who are at risk for alteration in skin integrity have the potential to be affected by the alleged deficient practice. 3. Education has been provided to nursing staff regarding the process for skin checks to be completed. 4. Weekly audits will be conducted by the Director of Nursing to ensure compliance with the plan. 5. 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. 6. Corrective action to be complete by 2/1/2025.	2/1/25

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F 656	Continued From page 4 §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure Care Plan interventions were implemented for three residents [Resident #27, Resident #39, and Resident #294] of 21 sampled residents. Findings include: 1. Per review of the medical record for Res. #27, the resident has a Care Plan focus that states "Resident is at risk for alteration in skin integrity related to immobility, urinary incontinence", a Care Plan goal that states "Resident will be free from alteration in skin integrity" and the Care Plan has interventions that include "Weekly skin check by Licensed Nurse." All of the aforementioned Care Plans were initiated on 6/27/24 and have not been revised. A review of nursing documentation titled "Assessments" for Resident #27 showed skin checks done on 6/22/24, 7/23/24 and 8/27/24, only 3 times in 24 weeks. 2. Per review of the medical record for Res. #39, the resident has a Care Plan focus that states "Resident is at risk for alteration in skin integrity related to incontinence, immobility", a Care Plan goal that states "Resident will be free from alteration in skin integrity" and the Care Plan has interventions that include "Weekly skin check by Licensed Nurse." All of the aforementioned Care Plans were initiated on 7/31/24 and have not been revised.	F 656	**Tag F 656 POC accepted on 1/21/25 by T. Dougherty/P. Cota**	

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F 656	Continued From page 5 A review of nursing documentation titled "Assessments" for Resident #39 showed a skin check done on 7/16/24, only once in 19 weeks. 3. Per review of the medical record for Res. #294, the resident has a Care Plan focus that states "Resident is at risk for alteration in skin integrity related to incontinence, immobility", a Care Plan goal that states "Resident will be free from alteration in skin integrity" and the Care Plan has interventions that include "Weekly skin check by Licensed Nurse." All of the aforementioned Care Plans were initiated on 7/23/24 and have not been revised. A review of nursing documentation titled "Assessments" for Resident #294 showed skin checks done on 7/11/24 and 12/10/24, only twice in 20 weeks. During an interview on 12/17/24 at 12:38 PM with a Licensed Practical Nurse and the Director of Nursing, both staff members confirmed interventions of "Weekly skin checks by a Licensed Nurse" to prevent alterations in skin integrity were not implemented for Residents #27, #39, and #294 per their plans of care.	F 656		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent	F 689	F689 1. Resident #39 and #11 care plans have been revised to reflect current interventions appropriate to address fall risk.	2/1/25

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F 689	Continued From page 6 accidents. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure that two residents [#39 & #11] of 21 sampled residents remained as free of accident hazards as possible regarding adequate supervision, implementing interventions to reduce hazards and risks, and assessing interventions for effectiveness. Findings include: 1.) Per record review, Res. #39 was admitted to the facility with diagnoses that include Alzheimer's disease, anxiety disorder, and muscle weakness. A Quarterly Fall Risk Assessment dated 10/20/24 identified the resident as a "High Risk" for falls, determining the resident was "disoriented", had a history of recent falls, with poor vision, poor safety judgement and attempted to get out bed and chairs "unsafely". Review of Res.#39's Care Plan identifies the resident as "is at risk for falls due to unsteady gait when tired, Alzheimer's disease, and history of falls". Record review reveals Resident #39 had sustained 4 falls in the past 2 months, including 2 falls on back-to-back days on 11/23 & 11/24/24. Further review revealed Res.#39 suffered a 5th fall on 12/5/24. Review of Progress Notes record the resident was "Combative at care, screaming, hitting, and pinching. This evening, [staff] was standing near the nurses' station, [Res.#39] was observed watching a Christmas movie and suddenly standing up from the wheelchair in a jumpy way and landing on [h/her] palms and	F 689	2. Residents at risk of experiencing falls have the potential to be affected by the alleged deficient practice. 3. Education to those responsible for updating care plans has been done to ensure care plans are updated with effective interventions to prevent accidents. 4. An initial audit was completed for residents who have experienced falls to ensure the care plan addresses appropriate interventions. 5. Audits will be conducted weekly by the Director of Nursing or designee to monitor the effectiveness of the plan. 6. Results of the audits will be reported to the QAA	2/1/25

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F 689	Continued From page 7 knees on the floor before staff were able to intervene. Resident was combative during assessment, screaming and trying to grab onto [staff]." In the days following the fall, Progress Notes [dated 12/7/24] record Res.#39 "continues to be combative with care, as well as with redirection," with interventions such as "Reapproach/reassurance" assessed as "ineffective." Per review of the facility's "Fall and Fall Risk, Managing" policy, under the policy's "Resident-Centered Approaches to Managing Falls and Fall Risk" section is "If falling recurs despite initial interventions, staff will implement additional or different interventions, or indicate why the current approach remains relevant." Additionally, under "Monitoring Subsequent Falls and Fall Risk" is "If the resident continues to fall, staff will re-evaluate the situation and whether it is appropriate to continue or change current interventions." [Policy version 1.2 (H5MAPL0313) revised 2018]. Per interview with the Director of Nursing [DON] on 12/17/24 at 12:38 PM, the DON confirmed the facility's policy is to review a resident's Care Plan after each fall and add additional interventions to prevent future falls. Per record review and confirmed during the DON interview, there were no new interventions added to Res. #39's Care Plan after the fall on 12/5/24 to prevent the resident from falling again. 2.) Per record review, Res.#11 was admitted to the facility with diagnoses that include: dementia, schizophrenia, anxiety, depression, and psychosis, as well as difficulty in walking, muscle weakness, muscle wasting, and	F 689	committee x 3 months at which time the committee will determine further frequency of the audits. 7. Corrective action to be complete by 2/1/2025. **Tag F 689 POC accepted on 1/21/25 by T. Dougherty/P. Cota**	2/1/25

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F 689	Continued From page 8 unsteadiness on [h/her] feet. Review of Res.#11's Care Plan identifies the resident as "at risk for falls due to: poor safety awareness due to Schizoaffective Disorder, Anxiety, Depression, and Psychosis, poor posture when ambulating, and using furniture to walk." Record review reveals Resident #11 had sustained 3 falls in the past 4 months, including a fall with bruising to their forehead. Further review revealed Res.#39 suffered a 4th fall on 12/5/24. Review of Progress Notes record the resident was "found sitting on [h/her] buttocks in [h/her] room, in between bathroom door and [h/her] wheelchair in front of [h/her]." Per interview with the Director of Nursing [DON] on 12/17/24 at 12:38 PM, the DON confirmed the facility's policy is to review a resident's Care Plan after each fall and add additional interventions to prevent future falls. Per record review and confirmed during the DON interview, there were no new interventions added to Res. #11's Care Plan after the fall on 12/5/24 to prevent the resident from falling again.	F 689		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control	F 880	F880 1. Resident #20 had no negative effects as a result of the alleged deficient practice. 2. Residents requiring dressing changes have the potential to be affected by the alleged deficient practice.	2/1/25

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F 880	Continued From page 9 program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct	F 880	3. Education has been provided to staff regarding proper infection prevention strategies to be used during dressing changes and competencies have been completed. 4. Weekly observation audits will be conducted by the Director of Nursing or designee to monitor effectiveness of the plan. 5. 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. 6. Corrective action to be completed by 2/1/2025. **Tag F 880 POC accepted on 1/21/25 by T. Dougherty/P. Cota**	2/1/25

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F 880	Continued From page 10 contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for one of 21 sampled residents (Resident #20). Findings include: Per observation on 12/17/24 at 1:37 PM Resident #20 unwrapped a gauze dressing covering a wound on their hand. The dressing was visibly soiled with blood. Resident #20 unwrapped the gauze until it was dangling from their hand and touching the floor of the dining area/TV room. At this point a staff Licensed Nursing Assistant [LNA] who was not wearing gloves began to redress the wound with the same gauze. Moments later a staff Registered Nurse [RN] came over to assist. The RN providing care to the resident was also not wearing gloves. Once Resident #20's hand	F 880		

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F 880	Continued From page 11 was fully wrapped the staff RN secured the gauze with the original tape which had been stuck to the arm of Resident #20's chair. In an interview with the facility's Director of Nursing [DON] on 12/18/24 at 1:36 PM the DON confirmed that the soiled dressings that had been in contact with the floor should not have been reused to dress the wounds on Resident #20.	F 880		