VERMONT

**Department of Disabilities, Aging and Independent Living**
**Division of Licensing and Protection**
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*AGENCY OF HUMAN SERVICES*

April 2, 2026

Mr. Travis Bergeron, Administrator
Union House Nursing Home
3086 Glover Street
Glover, VT 05839

Provider ID #: 475036

Dear Mr. Bergeron:

Enclosed is a copy of your acceptable plans of correction for the recertification survey conducted on **February 19, 2026.** 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, BS
Assistant Division Director
State Survey Agency Director

Enclosure

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 475036 | (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING | (X3) DATE SURVEY COMPLETED 02/19/2026 |
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| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| E0000 | Initial Comments<br><br>During a re-certification survey conducted from 2/9/26 through 2/12/26 by the Division of Licensing and Protection, an Emergency Preparedness survey was performed to determine compliance with 42 CFR Part 483.73 Emergency Preparedness Requirements for Long-Term Care Facilities, the following regulatory violations were identified: | E0000 | | |
| E0020<br>SS = F | Policies for Evac. and Primary/Alt. Comm.<br><br>CFR(s): 483.73(b)(3)<br><br>§403.748(b)(3), §416.54(b)(2), §418.113(b)(6)(ii), §441.184(b)(3), §460.84(b)(3), §482.15(b)(3), §483.73(b)(3), §483.475(b)(3), §485.68(b)(1), §485.542(b)(3), §485.625(b)(3), §485.727(b)(1), §485.920(b)(2), §491.12(b)(1), §494.62(b)(2)<br><br>[(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years [annually for LTC facilities]. At a minimum, the policies and procedures must address the following:]<br><br>[(3) or (1), (2), (6)] Safe evacuation from the [facility], which includes consideration of care and treatment needs of evacuees; staff responsibilities; transportation; identification of evacuation location(s); and primary and alternate means of communication with external sources of assistance.<br><br>*[For RNHCIs at §403.748(b)(3) and ASCs at §416.54(b)(2) and REHs at §485.542(b)(3):]<br><br>Safe evacuation from the [RNHCI or ASC or REHs] which includes the following: | E0020 | E0020<br><br>1. No residents were negatively impacted by the alleged deficient practice.<br>2. Residents residing in the facility have the potential to be negatively impacted by the alleged deficient practice.<br>3. The facility's Emergency Preparedness Plan has been reviewed and revised as needed to address the identified areas of concern.<br>4. Education has been provided to staff regarding the evacuation procedures listed in the plan and responsible duties during an emergency. | |

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 reverse for further 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.

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
|---|---|---|
| Craig B. Young | Administrator | 3/30/26 |

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| E0020 SS = F | Continued from page 1<br>(i) Consideration of care needs of evacuees.<br><br>(ii) Staff responsibilities.<br><br>(iii) Transportation.<br><br>(iv) Identification of evacuation location(s).<br><br>(v) Primary and alternate means of communication with external sources of assistance.<br><br>* [For CORFs at §485.68(b)(1), Clinics, Rehabilitation Agencies, OPT/Speech at §485.727(b)(1), and ESRD Facilities at §494.62(b)(2):]<br><br>Safe evacuation from the [CORF; Clinics, Rehabilitation Agencies, and Public Health Agencies as Providers of Outpatient Physical Therapy and Speech-Language Pathology Services; and ESRD Facilities], which includes staff responsibilities, and needs of the patients.<br><br>* [For RHCs/FQHCs at §491.12(b)(1):] Safe evacuation from the RHC/FQHC, which includes appropriate placement of exit signs; staff responsibilities and needs of the patients.<br><br>This REQUIREMENT is NOT MET as evidenced by:<br><br>Based on observation, Interview, and policy review, the facility failed to develop an adequate Emergency Preparedness Plan that included procedures for the safe evacuation of residents with cognitive and mobility issues from the facility. Findings include:<br><br>Per observation on 2/9/26 at approximately 10:30 AM, the facility's only elevator was noted to be out of order.<br><br>Per Interview on 2/9/26 at approximately 10:35 AM, the facility's administrator confirmed that the facility has one elevator, and it has been out of order for 3 or 4 weeks. The part had been ordered, and they were waiting for it to arrive and be installed. The administrator explained that the staff were utilizing the stairs to deliver food and linens.<br><br>Per review of the Facility Risk Assessment, last updated "9/25/25", it revealed on page 3 under the category 2.1 Acuity, Subcategory "Special Treatments | E0020 | 5. Audits will be conducted monthly by the administrator or designee by interviews and observations of staff to ensure staff retain knowledge of evacuation procedures and responsibilities.<br>6. Monthly audits will be conducted x3 months and the results will be reported to the QAA committee X3 months at which time the committee will determine if further action is needed.<br>7. Corrective action completed 3/30/2026.<br><br>**Tag E0020 POC accepted on 4/2/26 by G. Prefontaine/S. Stem** | |

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| E0020 SS = F | Continued from page 2<br>and Conditions" lists Mental Health, special treatments to include Dementia, the number/average or Range of Residents is 28. On page 4 under the category "Assistance with Activities of Daily Living, under the "Mobility" category revealed the facility had 4 Independent residents, 18 residents who need assistive devices to ambulate (walk), 17 residents who are in a chair most of the time, and 3 residents who are bedfast (in bed) all or most of the time. Further review of the Facility Risk Assessment, page 7 under the category "Staffing Plan", 3.2 "Based on [The Facility's] population and their needs for care and support, below is the facilities general approach to staffing to ensure that we have sufficient staff to meet the number, diagnosis, acuity and needs of the residents at any given time as required by State and Federal Regulations.", page 8 revealed staffing ratios for the night shift (11 pm - 7 am) is 1 RN [registered nurse] or LPN [licensed practical nurse] for both units and 2 LNAs [licensed nurse's aides] (one assigned to each unit). Page 9 revealed under "Night Staff", "LNA's are assigned to one of two units (Downstairs and Upstairs_ and both LNAs work together to provide patient care to the residents with the on-duty nurse." And "The one assigned nurse cares for all residents and assists the LNA's in answering lights, providing direct care as needed.....".<br><br>During observation, interview and record review throughout the days of survey, the resident population on the second floor consisted of 18 residents; 12 residents diagnosed with dementia, 3 residents diagnosed with cognitive deficits, and 1 resident diagnosed with Parkinson's disease. Of these 18 residents, 9 require assistance to navigate the stairs with staff assistance, and 9 residents are unable to be transferred using the stairs and require full staff assistance via another method. In addition to the 18 residents on the second floor, there are 26 residents on the first floor of which 12 have dementia, and 18 of the 26 require more than 1 staff assistance for transfers. Review of staff schedules revealed that there are 3 staff (1 nurse and 2 LNA's (Licensed Nursing Assistants) scheduled for the 11 PM to 7 AM shift.<br><br>Per review of the facility's Emergency Plan Section V-Emergency Response and Procedures, It reveals that residents in high-risk areas should be evacuated using wheelchairs, blanket drag, body carry, chair carry (stair chair), or mattresses. The plan does not define what a "high-risk area" is, it does not include the | E0020 | | |

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| E0020 SS = F | Continued from page 3<br>plan for which staff are responsible for evacuating residents, nor does it include which staff are responsible for triaging residents or the triage process. There is also no documentation that staff have been trained in these procedures.<br><br>Per review of the EP manuals on each nursing unit, neither had been updated since 2023. The contact information for key personnel was not up to date in either of the 2 copies of the EPP and it was not consistent with the EP binder provided to the survey team on 2/9/26.<br><br>Per interview on 2/8/26 at approximately 8:20 AM with a Staff Nurse, she stated she does not have knowledge of the stair-chair and has not been trained on it. She expressed concern about the ability to evacuate residents and stated she has asked for training but has not received any.<br><br>Per interview on 2/10/26 at approximately 1:40 PM with the Nursing Supervisor, she stated she has utilized the stair chair to get residents down the stairs for appointments, and 4 other staff were trained by the EMS Chief; however, she does not believe there are documented competencies of these demonstrations.<br><br>Per interview on 2/11/26 at 4:10 PM, an LNA stated she has watched EMS use the stair chair a few times in the last few months but has not used it herself and does not consider these observations to be training. She stated she is not confident that she'd be able to safely use the stair chair to evacuate residents.<br><br>Per interview on 2/11/26 at approximately 4:20 PM, an LPN confirmed she has not had any training on the stair chair or the evacuation process. She stated that she is worried that she is too small to evacuate residents. She stated that she is concerned about not knowing the process and she has asked for more training to no avail. | E0020 | | |
| E0037 SS = F | EP Training Program<br><br>CFR(s): 483.73(d)(1)<br><br>§403.748(d)(1), §416.54(d)(1), §418.113(d)(1), §441.184(d)(1), §460.84(d)(1), §482.15(d)(1), §483.73(d)(1), §483.475(d)(1), §484.102(d)(1), | E0037 | E0037<br>1. The facility would like to note that there was an evacuation of the lower floor of the facility in July of 2025 that was performed | |

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| E0037 SS = F | Continued from page 4<br>§485.68(d)(1), §485.542(d)(1), §485.625(d)(1), §485.727(d)(1), §485.920(d)(1), §486.360(d)(1), §491.12(d)(1).<br><br>"[For RNCHIs at §403.748, ASCs at §416.54, Hospitals at §482.15, ICF/IIDs at §483.475, HHAs at §484.102, REHs at §485.542, "Organizations" under §485.727, OPOs at §486.360, RHC/FQHCs at §491.12:]<br><br>(1) Training program. The [facility] must do all of the following:<br><br>(i) Initial training in emergency preparedness policies and procedures to all new and existing staff, Individuals providing services under arrangement, and volunteers, consistent with their expected roles.<br><br>(ii) Provide emergency preparedness training at least every 2 years.<br><br>(iii) Maintain documentation of all emergency preparedness training.<br><br>(iv) Demonstrate staff knowledge of emergency procedures.<br><br>(v) If the emergency preparedness policies and procedures are significantly updated, the [facility] must conduct training on the updated policies and procedures.<br><br>"[For Hospices at §418.113(d):] (1) Training. The hospice must do all of the following:<br><br>(I) Initial training in emergency preparedness policies and procedures to all new and existing hospice employees, and individuals providing services under arrangement, consistent with their expected roles.<br><br>(ii) Demonstrate staff knowledge of emergency procedures.<br><br>(iii) Provide emergency preparedness training at least every 2 years.<br><br>(iv) Periodically review and rehearse its emergency preparedness plan with hospice employees (including nonemployee staff), with special emphasis placed on carrying out the procedures necessary to protect patients and others.<br><br>(v) Maintain documentation of all emergency | E0037 | successfully and without any negative outcomes.<br>2. No residents were negatively impacted by the alleged deficient practice.<br>3. Residents residing in the facility have the potential to be affected by the alleged deficient practice.<br>4. Competency training has been completed for staff in the use of evacuation procedures and new staff coming in are trained prior to working independently on the floor.<br>5. Audits will be conducted at least monthly by the Administrator or designee to ensure ongoing competence with evacuation procedures.<br>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.<br>7. Corrective action completed 3/30/2026.<br><br>**Tag E0037 POC accepted on 4/2/26 by G. Prefontaine/S. Stem** | |

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| E0037 SS = F | Continued from page 5<br>preparedness training.<br><br>(vi) If the emergency preparedness policies and procedures are significantly updated, the hospice must conduct training on the updated policies and<br><br>procedures.<br><br>*[For PRTFs at §441.184(d):] (1) Training program. The PRTF must do all of the following:<br><br>(I) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles.<br><br>(ii) After Initial training, provide emergency preparedness training every 2 years.<br><br>(iii) Demonstrate staff knowledge of emergency procedures.<br><br>(iv) Maintain documentation of all emergency preparedness training.<br><br>(v) If the emergency preparedness policies and procedures are significantly updated, the PRTF must conduct training on the updated policies and procedures.<br><br>*[For PACE at §460.84(d):] (1) The PACE organization must do all of the following:<br><br>(i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing on-site services under arrangement, contractors, participants, and volunteers, consistent with their expected roles.<br><br>(ii) Provide emergency preparedness training at least every 2 years.<br><br>(iii) Demonstrate staff knowledge of emergency procedures, including informing participants of what to do, where to go, and whom to contact in case of an emergency.<br><br>(iv) Maintain documentation of all training.<br><br>(v) If the emergency preparedness policies and procedures are significantly updated, the PACE must conduct training on the updated policies and | E0037 | | |

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| E0037 SS = F | Continued from page 6<br>procedures.<br><br>*[For LTC Facilities at §483.73(d):](1) Training Program. The LTC facility must do all of the following:<br><br>(I) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected role.<br><br>(ii) Provide emergency preparedness training at least annually.<br><br>(iii) Maintain documentation of all emergency preparedness training.<br><br>(iv) Demonstrate staff knowledge of emergency procedures.<br><br>*[For CORFs at §485.68(d):](1)Training. The CORF must do all of the following:<br><br>(i) Provide Initial training In emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles.<br><br>(ii) Provide emergency preparedness training at least every 2 years.<br><br>(Iii) Maintain documentation of the training.<br><br>(Iv) Demonstrate staff knowledge of emergency procedures. All new personnel must be oriented and assigned specific responsibilities regarding the CORF's emergency plan within 2 weeks of their first workday. The training program must Include Instruction in the location and use of alarm systems and signals and firefighting equipment.<br><br>(v) If the emergency preparedness policies and procedures are significantly updated, the CORF must conduct training on the updated policies and procedures.<br><br>*[For CAHs at §485.625(d):](1) Training program. The CAH must do all of the following:<br><br>(i) Initial training in emergency preparedness policies and procedures, including prompt reporting and extinguishing of fires, protection, and where | E0037 | | |

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| E0037 SS = F | Continued from page 7<br>necessary, evacuation of patients, personnel, and guests, fire prevention, and cooperation with firefighting and disaster authorities, to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles.<br><br>(ii) Provide emergency preparedness training at least every 2 years.<br><br>(iii) Maintain documentation of the training.<br><br>(iv) Demonstrate staff knowledge of emergency procedures.<br><br>(v) If the emergency preparedness policies and procedures are significantly updated, the CAH must conduct training on the updated policies and procedures.<br><br>*[For CMHCs at §485.920(d):] (1) Training. The CMHC must provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles, and maintain documentation of the training. The CMHC must demonstrate staff knowledge of emergency procedures. Thereafter, the CMHC must provide emergency preparedness training at least every 2 years.<br><br>This REQUIREMENT Is NOT MET as evidenced by:<br><br>Based on interview and record/policy review, the facility failed to provide initial and annual Emergency Preparedness training for 2 of 6 staff reviewed; and failed to provide Emergency Preparedness training specific to the facility's risk assessment policies and procedures as well as the communication plan for 6 of 6 staff reviewed. Findings include:<br><br>Review of the Facility Risk Assessment reveals the following: page 10. "In addition, all managers will be educated and demonstrate competency in the following areas: .....11. fire/disaster/emergency preparedness and .....All LNA 's must have no less than 12 hours of continuing education per year based on their performance review. Annual in-service is based on date of employment rather than calendar year." Page 12 under the same category reveals, "They will also receive education in the following: .....e. Emergency preparedness".<br><br>Per review of the facility's Emergency Preparedness | E0037 | | |

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| E0037 SS = F | Continued from page 8<br>Plan (EPP), under "Section V - Emergency Response and Procedures" on page 4 states, "8. .....Move resident's using wheelchairs, blanket drag, body cany, chair carry, mattresses." The Plan does not include adequate information and/or training on how to evacuate residents using these policies and procedures.<br><br>Per Interview on 2/8/26 at approximately 8:20 AM with a staff nurse, she stated she does not have knowledge of the stair chair she states she was not trained on it, she expressed concern about the ability to evacuate residents and stated she has asked for training but has not received any.<br><br>Per interview on 2/10/26 at approximately 1:40 PM with the nursing supervisor, she stated she has utilized the stair chair to get residents down the stairs for appointments, and 4 other staff were trained by the EMS Chief; however, she does not believe there are documented competencies of these demonstrations.<br><br>Per interview on 2/11/26 at approximately 3:30 PM with the second-floor unit nurse, she confirmed that she has not had training on blanket drags, or the chair.<br><br>During an interview on 2/11/26 at 4:10 PM, an LNA stated she has watched EMS use the chair a few times in the last few months but has not used it herself and does not consider these observations to be training. She stated she Is not confident that she'd be able to safely use the stair chair to evacuate residents.<br><br>Per interview on 2/11/26 at approximately 4:20 PM with an LPN, who stated she works as a charge nurse per diem, confirmed that she has not had any training on the stair chair or facility evacuation process. She stated that she is concerned about not knowing the process and she has asked for more training to no avail.<br><br>Review of staff training records revealed two of six sampled staff had no EP (Emergency Preparedness) training and there was no evidence that six of six sampled staff had training specifically to the facility's protocols and procedures for evacuation. The training did not include how to evacuate residents using the blanket drag, body carry, chair carry, or mattresses. The evacuation training provided to staff states that staff should follow procedures and protocols for evacuation and have regular drills. There | E0037 | | |

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| E0037 SS = F | Continued from page 9<br>is no evidence of competencies for any staff, or documentation that staff have demonstrated their knowledge of emergency procedures. | E0037 | | |
| F0000 | INITIAL COMMENTS<br><br>The Division of Licensing and Protection conducted an unannounced, onsite recertification survey and investigation of 1 facility reported incident, including report #2739462 on 2/9/26 through 2/12/26 to determine compliance with 42 CFR Part 483 requirements for Long Term Care Facilities. No deficiencies were cited as a result of the facility reported incident. Deficiencies were cited as a result of the recertification survey. Findings include: | F0000 | | |
| F0550 SS = D | Resident Rights/Exercise of Rights<br><br>CFR(s): 483.10(a)(1)(2)(b)(1)(2)<br><br>§483.10(a) Resident Rights.<br><br>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.<br><br>§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.<br><br>§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.<br><br>§483.10(b) Exercise of Rights.<br><br>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.<br><br>§483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without | F0550 | F0550<br><br>1. The elevator in the facility is now operational.<br>2. Resident #1 had been residing on the first floor after hospitalization when the elevator was down and despite this, resident #1 insisted on moving back to the upstairs unit.<br>3. Residents residing on the upstairs unit have the potential to be negatively affected by the alleged deficient practice.<br>4. Going forward, if the elevator becomes inoperable again, the facility will offer residence on the downstairs unit if availability allows for those that are unable to access the stairs. | |

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| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Union House Nursing Home | 3086 Glover Street , Glover, Vermont, 05839 |

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| F0550 SS = D | Continued from page 10<br>interference, coercion, discrimination, or reprisal from the facility.<br><br>§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.<br><br>This REQUIREMENT is NOT MET as evidenced by:<br><br>Based on observation, interview and record review, the facility failed to protect a resident's right to a dignified existence by failing to provide access to the first floor of the building in a manner that provided safety and comfort for 1 applicable resident in the sample (Resident #1). Findings include:<br><br>On 2/9/26 at 12:22 PM and 2/11/26 at 12:30 PM, Resident #1 was observed eating lunch in his/her room.<br><br>During an Interview with Resident #1, on 2/11/26 at 3:58 PM, s/he indicated that s/he recently went to the hospital, and the facility staff used a stair-chair to transport her/him down the stairs to the ambulance. S/He expressed a fear of being dropped on the stairs while being carried down the stairs in the stair-chair. Resident #1 indicated s/he enjoyed taking the elevator to the 1st floor to meet with social services. Over the past few weeks, s/he was unable to access the 1st floor because the elevator was out of service. Resident #1 reported missing the first-floor visits. S/he stated that fear of the chair prevented him/her from visiting the first floor; and s/he preferred to stay in his/her room.<br><br>Per the care plan, revised 12/21/25, Resident #1 has a diagnosis of Schizophrenia and is exhibiting self-isolating behaviors. Per the care plan, reviewed on 12/29/25, Resident #1 Is wheelchair-dependent for mobility, requires assistance from one person to transfer into the wheelchair, and resides on the second floor of a two-story structure.<br><br>Per the interview on 12/11/26, at 1:25 PM, the Unit Manager stated that the facility was not honoring the rights of Resident #1 because they failed to provide an alternate way for him/her to access the first floor other than the stair-chair which caused Resident #1 to be fearful. She agreed that Resident #1 benefited from the ability to leave the second floor, as s/he rarely participated in activities outside of his/her room. | F0550 | 5. If there is not availability on the first floor the facility will offer to relocate the resident to a sister facility temporarily until either a room is available on the first floor, the elevator is repaired, or the resident feels comfortable utilizing alternative means to come down the stairs.<br>6. Facility administration is aware of the requirements for residents' rights.<br>7. Audits will be done as needed by the administrator or designee if there is a situation where residents are unable to access the first floor when they choose to.<br>8. Reports will be made to the QAA committee X3 months at which time the committee will determine if further action is needed.<br>9. Corrective action completed 3/13/2026.<br><br>**Tag F0550 POC accepted on 4/2/26 by G. Prefontaine/S. Stem** | |
| F0582 | Medicaid/Medicare Coverage/Liability Notice | F0582 | | |

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| F0582 SS = D | Continued from page 11<br><br>CFR(s): 483.10(g)(17)(18)(i)-(v)<br><br>§483.10(g)(17) The facility must--<br><br>(i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of-<br><br>(A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged;<br><br>(B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and<br><br>(ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section.<br><br>§483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate.<br><br>(i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible.<br><br>(ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change.<br><br>(iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements.<br><br>(iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility. | F0582 | F0582<br><br>1. No residents were negatively affected by the alleged deficient practice.<br>2. Residents receiving services under their Medicare benefit have the potential to be affected by the alleged deficient practice.<br>3. Staff responsible for notification are aware of the requirements for a 48-hour notice prior to benefits ending.<br>4. Audits will be conducted weekly during Utilization Review Meeting by the MDS Coordinator to ensure compliance with the requirements.<br>5. Results of the audits will be reported at the QAA committee x3 months, at which time the committee will determine if further action is needed.<br>6. Corrective action completed 3/30/2026.<br><br>**Tag F0582 POC accepted on 4/2/26 by G. Prefontaine/S. Stem** | |

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| F0582 SS = D | Continued from page 12<br>(v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations.<br><br>This REQUIREMENT is NOT MET as evidenced by:<br><br>Based on interview and record review the facility failed to provide the Notice of Medicare Non-Coverage at least two days before the end of a Medicare covered Part A stay or when all of Part B therapies were ending for 1 of 3 residents reviewed (Resident #32). Findings include:<br><br>Per review of Resident # 32's BNP notice, it revealed the resident's services ended on 10/19/25 and the letter was dated 10/20/25 which did not provide the resident with the required 48-hours.<br><br>Per Interview on 2/11/26 at 1:44 PM, The MDS coordinator confirmed that Resident #32 was not notified that their services were ending on 10/19/25 until 10/20/25, which is less than the required 48-hour notification.<br><br>Per interview on 2/12/26 at approximately 9:25 AM, the Social Services Director stated Resident #32 had been informed in September of 2025 that their benefits would end on 10/19/25 based on a letter the facility had received from the insurance company.<br><br>Per interview on 2/12/26 at approximately 9:50 AM, the Social Services Director confirmed that neither Resident #32 nor their family were informed at least 48-hours prior to the services ending and she was aware that this was a federal requirement. | F0582 | | |
| F0677 SS = D | ADL Care Provided for Dependent Residents<br><br>CFR(s): 483.24(a)(2)<br><br>§483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene;<br><br>This REQUIREMENT is NOT MET as evidenced by:<br><br>Based on observation, interview, and record review, the facility failed to ensure that a resident who is unable to carry out activities of daily living [ADLs] without | F0677 | F0677<br><br>1. Resident #10's nails have been trimmed.<br>2. Residents requiring assistance with adl's have the potential to be affected by the alleged deficient practice. | |

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| F0677 SS = D | Continued from page 13<br>assistance receives the proper level of assistance for nail care for 1 of 2 sampled residents (Resident #10). Findings include:<br><br>Per review of the facilities policy titled "Fingernails/Toenails, Care of" with a revision date of 2/18, it states that nail care is "daily cleaning and regular trimming." It also identifies that personal protective equipment like gloves should be used as needed.<br><br>Per observation and interview on 2/9/26 at 5:07 PM, Resident #10's fingernails were observed to be long on both hands. Resident #10 was asked if their fingernails were at their desired length and they stated that their fingernails were poking into their skin when they closed their fist and that they wanted their nails shorter. Resident #10 also stated that they were able to peel one of their long fingernails off.<br><br>Per interview with a Registered Nurse (RN) on 2/11/26 at 3:46 PM, she stated that the Resident #10's fingernails had been cut. When asked to observe Resident #10's feet, the RN assisted Resident #10 with taking off his/her shoes. Resident #10 stated that his/her toe's hurt as the nurse checked his/her toenails. Resident #10's toenails were observed to be long and thick. The RN confirmed that the toenails needed to be trimmed and were thick. | F0677 | 3. In-services have been provided to staff regarding the policy and procedure for nail care.<br>4. Audits will be conducted weekly x3 months by the Director of Nursing or designee to ensure compliance with the requirements.<br>5. Results of the audits will be reported to the QAA committee x3 months, at which time the committee will determine if further action is needed.<br>6. Corrective action completed 3/30/2026.<br><br>**Tag F0677 POC accepted on 4/2/26 by G. Prefontaine/S. Stem** | |
| F0699 SS = D | Trauma informed Care<br><br>CFR(s): 483.25(m)<br><br>§483.25(m) Trauma-Informed care<br><br>The facility must ensure that residents who are trauma survivors receive culturally competent, trauma-informed care in accordance with professional standards of practice and accounting for residents' experiences and preferences in order to eliminate or mitigate triggers that may cause re-traumatization of the resident.<br><br>This REQUIREMENT is NOT MET as evidenced by:<br><br>Based on interview and record review the facility failed to provide culturally competent and trauma-informed care by failing to ensure a care plan identified triggers of past trauma and provided interventions for those triggers for 1 applicable resident in the sample (Resident #8). Findings include:<br><br>Per review of the facility policy "Trauma-informed Care and culturally Competent Care" revised 8/22, it states: | F0699 | F0699<br><br>1. The care plan for resident #8 has been updated to reflect trauma triggers and interventions for those triggers.<br>2. Residents with a history of trauma have the potential to be affected by the alleged deficient practice. | |

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| F0699 SS = D | Continued from page 14<br>"Resident Care Planning, 2). Identify and decrease exposure to triggers that may re-traumatize the resident".<br><br>Per record review, Resident #8 has a diagnosis of post-traumatic stress disorder. His/her care plan with a review date of 01/08/26, lists several traumatic events. The care plan goal reveals that the resident will feel safe in her living environment and not exhibit any negative psychosocial impact related to experiencing trauma triggers.<br><br>Per a document titled "Primary Care PTSD Screen", dated 4/17/25, it shows that Resident #8's family provided information on traumas that had affected him/her. The resident was startled easily and was afraid of stairs due to past falls.<br><br>The care plan does not identify triggers that may retraumatize the resident or interventions to mitigate them.<br><br>Per interview with an LNA on 2/12/26 at 10:45 AM, she stated that she was not aware of Resident #8's triggers.<br><br>Per interview with the Director of Nursing (DON) on 2/12/26 at 11:04 AM, she confirmed that the care plan did not include identification of triggers or interventions to prevent re-traumatization of Resident #8. | F0699 | 3. Education has been provided to staff responsible for ensuring resident care plans identify triggers and interventions specific to the triggers.<br>4. An initial audit of other residents with a history of trauma has been completed and revisions to the care plan have been made as needed.<br>5. Audits will be done monthly by the Director of Nursing or designee x3 months to ensure ongoing compliance with the requirements.<br>6. The results of the audits will be reported to the QAA committee x3 months at which time the committee will determine if further action is needed.<br>7. Corrective action completed 3/30/3026.<br><br>**Tag F0699 POC accepted on 4/2/26 by G. Prefontaine/S. Stem** | |
| F0761 SS = F | Label/Store Drugs and Biologicals<br><br>CFR(s): 483.45(g)(h)(1)(2)<br><br>§483.45(g) Labeling of Drugs and Biologicals<br><br>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.<br><br>§483.45(h) Storage of Drugs and Biologicals<br><br>§483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. | F0761 | F0761<br><br>1. No residents were negatively affected by the alleged | |

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| F0761 SS = F | Continued from page 15<br><br>§483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.<br><br>This REQUIREMENT is NOT MET as evidenced by:<br><br>Based on observations and interviews the facility failed to ensure that drugs and biologicals in the medication storage room were within their expiration date. Findings include:<br><br>Per observation on 02/10/2026 at 2:23 PM, of the medication storage room the following expired medications were noted:<br><br>2 bottles of Naproxen Sodium 220mg 50 caps expired 7/2025<br><br>2 bottles of Caltrate Bone Health Advance 60 tablet expired 12/2025<br><br>2 bottles of Cranberry 450mg 100 tablet expired 12/2025<br><br>2 bottles of Vitamin E 180mg/400IU 100 soft gels expired 12/2025<br><br>3 bottles of Vitamin D 10mcg/400IU 100tabsexpired 5/2025<br><br>4 bottles of CoQ10 100mg 30 soft gels expired 5/2025<br><br>1 bottle of Biotene Dry Mouth Rinse 16oz expired 11/2025<br><br>2 boxes of Antidiarrheal 2mg 24 caps expired 7/2025<br><br>1 box of Antidiarrheal 2mg 12 caps expired 10/2025<br><br>4 boxes of Acid Reducer 10mg 90 tabs expired 6/2025<br><br>2 bottles of Bisacodyl 5mg 100 tabs expired 4/2025<br><br>1 bottle of stool softener 100mg 100tabs expired 7/2025<br><br>Per interview on 02/20/2026 at approximately 2:45 PM, the Unit Manager confirmed that the above medications were expired. | F0761 | deficient practice and all identified expired medication was discarded.<br>2. Residents receiving medication in the facility have the potential to be affected by the alleged deficient practice.<br>3. Education has been provided to staff responsible for monitoring the medication in the medication storage room to check for expired medications when restocking.<br>4. Audits will be conducted weekly x3 months by the Director of Nursing or designee to ensure continued compliance with the requirements.<br>5. Results of the audits will be reported to the QAA committee x3 months, at which time the committee will determine if further action is needed.<br>6. Corrective action completed 3/30/2026.<br><br>**Tag F0761 POC accepted on 4/2/26 by G. Prefontaine/S. Stem** | |

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| F0761 ~~F0947~~ SS = E | Required In-Service Training for Nurse Aides<br><br>CFR(s): 483.95(g)(1)-(4)<br><br>§483.95(g) Required in-service training for nurse aides.<br><br>In-service training must-<br><br>§483.95(g)(1) Be sufficient to ensure the continuing competence of nurse aides, but must be no less than 12 hours per year.<br><br>§483.95(g)(2) Include dementia management training and resident abuse prevention training.<br><br>§483.95(g)(3) Address areas of weakness as determined in nurse aides' performance reviews and facility assessment at § 483.71 and may address the special needs of residents as determined by the facility staff.<br><br>§483.95(g)(4) For nurse aides providing services to individuals with cognitive impairments, also address the care of the cognitively impaired.<br><br>This REQUIREMENT is NOT MET as evidenced by:<br><br>Based on record review and interview, the facility failed to ensure 1 of 6 Licensed Nursing Assistants (LNA) had completed the mandatory 12 hours of annual training, and 2 of 6 LNAs had completed dementia training.<br><br>Findings include:<br><br>Per review of employee Human Resources files for permanent and contracted staff, the facility had no evidence of the required 12 hours of annual training for LNA #4, hired on 9/8/20/23. LNA #3 with a date of hire of 12/3/1991 and LNA #5 with a date of hire of 4/16/2018 did not have evidence of dementia training.<br><br>Per interview on 2/2/26 at approximately 3:30 PM, the RN Nursing Supervisor was unable to provide any evidence that LNA #4 had completed their required 12-hour annual training, and LNA #3 and LNA #5 had received the mandatory dementia training. The RN Nursing Supervisor confirmed that the employee files reviewed contained the only documentation the facility had for staff training. | F0761 F0947 | | |

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| F0947 SS = E | | F0947 | F0947<br>1. No residents were negatively affected by the alleged deficient practice.<br>2. Residents residing in the facility have the potential to be affected by the alleged deficient practice.<br>3. Required education has been completed for LNA #3, #4, and #5.<br>4. An audit of all other LNA's has been completed to ensure required education is completed.<br>5. Audits will be conducted monthly by the Human Resources Director based on dates of hire to ensure required training is completed.<br>6. Results of the audits will be reported to the QAA committee x3 months, at which time the committee will determine if further action is needed.<br>7. Corrective action completed 3/30/2026.<br><br>**Tag F0947 POC accepted on 4/2/26 by G. Prefontaine/S. Stem** | |