

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265873	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/19/2025
NAME OF PROVIDER OR SUPPLIER Union Nursing		STREET ADDRESS, CITY, STATE, ZIP CODE 1080 Marie Lane Union, MO 63084	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. (continued on next page)		

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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, facility staff failed to implement their abuse policy when they failed to complete a thorough investigation for an allegation of sexual abuse for one resident (Resident #1) out of one sampled resident, and did not ensure resident safety, when staff allowed Certified Nurse Aide (CNA) A who was alleged of the sexual abuse to continue to have contact with residents during the investigation. The facility census was 58. 1. Review of the facility's Abuse, Prevention and Prohibition policy, revised 2021, showed staff are directed as follows: -While a facility investigation is underway, steps will be taken to prevent further abuse;-When an employee is the alleged perpetrator of abuse or neglect, that employee shall immediately be barred from any further contact with residents through suspension, pending the outcomes of the facility investigation, prosecution or disciplinary action against the employee;-The administrator and/or the Director of Nursing (DON) will relay this suspension;-If sexual assault has been alleged, the physician will be contacted for an order to transfer to the emergency room for evaluation;-Every employee will be interviewed who was working on the specific hall/wing that the affected resident resides on;-If the allegation occurred on a specific shift, all staff for the identified shift only will complete a questionnaire and complete a statement if indicated. 2. Review of Resident #1's admission Minimum Data Set (MDS), a federally mandated assessment tool, dated 10/03/25, showed staff assessed the resident as cognitively intact, and diagnoses to include urinary tract infection (UTI), fractures and other multiple trauma. Review of the facility's initial investigation report, dated 10/22/25, showed the Director of Nursing (DON) documented the resident reported to staff and his/her family that he/she had been sexually abused the night before by CNA A. The report did not contain documentation the DON placed CNA A on suspension, did not contain documentation the physician was contacted, and did not contain a completed questionnaire or written statement from staff who worked the identified shift. Review of the facility's timekeeping records, dated 10/22/25 through 10/24/25, showed CNA A worked on 10/23/25 from 6:57 A.M. to 7:06 P.M. Review of the facility's completed investigation report summary, dated 10/24/25, showed staff documented the allegation was determined to be unsubstantiated. During an interview on 10/24/25 at 10:20 A.M., the DON said the administrator was out, and he/she investigated the resident's allegation. The DON said he/she did not suspend CNA A because CNA A had already left the building and was not scheduled to return to work until the next day. The DON said he/she interviewed CNA A and other staff that worked the shift, but did not ask any of the staff to complete a questionnaire or written statement. During an interview on 10/24/25 at 12:55 P.M., CNA B said he/she provided care to the resident on the night of 10/21/25, but he/she was not asked to complete a questionnaire or written statement regarding his/her interactions with the resident on 10/21/25. During an interview on 10/24/25 at 1:05 P.M., CNA A said he/she was contacted by the DON after he/she left work on the morning of 10/22/25 with questions about his/her interactions with the resident during the night shift on 10/21/25, but he/she was not asked to complete a questionnaire or written statement. CNA A said the DON did not notify him/her the resident had made a sexual allegation against him/her or informed him/her of a suspension from work, and he/she returned to the facility on [DATE] and worked for 12 hours on day shift. During an interview on 10/24/25 at 3:02 P.M., Licensed Practical Nurse (LPN) D said he/she was the charge nurse on the night of 10/21/25, the DON contacted him/her the morning of 10/22/25 with questions about CNA A's interactions with the resident during the night shift on 10/21/25, but he/she was not asked to complete a questionnaire or written statement. During an interview on 10/28/25 at 11:54 A.M., Certified Medication Technician (CMT) C said he/she worked on 10/21/25 from 6:15 A.M. until 12:21 A.M., but he/she was not interviewed or asked to complete a questionnaire or written statement regarding the resident's allegations. During an interview on 10/28/25 at 3:33 P.M., the resident's physician said he/she was at the facility on 10/23/25, but facility staff did not notify him/her of the resident's allegation of sexual abuse until 10/24/25 and he/she would expect staff to notify him/her when the incident occurred if the policy directed staff to do so. During an interview on 10/28/25 at 12:53 P.M., the administrator said in his/her absence from the facility, the DON was in charge and should have placed CNA A on suspension until he/she completed the investigation, the physician should have been notified shortly after the allegation was made, and all staff who worked the night shift on 10/21/25 should have been interviewed or asked to provide a statement. Complaint #2651547</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>Based on record review and interview, facility staff failed to contact local law enforcement and failed to report an allegation of sexual abuse for one resident (Resident #1) out of one sampled resident to the Department of Health and Senior Services (DHSS) within the two-hour required timeframe. The facility's census was 58.</p> <p>1. Review of the facility's Abuse, Prevention and Prohibition policy, revised 2021, showed staff are directed as follows: -Abuse includes verbal abuse, sexual abuse, physical abuse, and mental abuse including abuse facilitated or enabled using technology; -The person made aware of allegations of abuse or neglect OR the administrator will report the allegations of abuse and neglect to the mandated state agency and law enforcement; -The allegation will be reported no later than two hours after the allegation is made if the events that cause the allegation involve abuse or result in serious bodily injury.</p> <p>2. Review of Resident #1's admission Minimum Data Set (MDS), a federally mandated assessment tool, dated 10/03/25, showed staff assessed the resident as cognitively intact, and diagnoses to include urinary tract infection (UTI), fractures and other multiple trauma. Review of the facility's initial investigation report, dated 10/22/25, showed the Director of Nursing (DON) documented the resident reported to staff and his/her family that he/she had been sexually abused the night before by the male aide. The report did not contain documentation facility staff reported the allegation to DHSS within the two-hour timeframe after the resident and his/her family member reported the allegation of sexual abuse, and did not notify the local law enforcement. Review of the DHSS complaint/facility self-report database did not contain documentation of a facility report in regard to resident's allegation of sexual abuse to DHSS. During an interview on 10/24/25 at 10:20 A.M., the DON said the administrator was out, and he/she was responsible to report any abuse allegations to DHSS within two hours after the allegation is made. The DON said he/she did not report to DHSS or local law enforcement because after he/she spoke with the resident and family, he/she determined it was not a true allegation. During an interview on 10/28/25 at 12:53 P.M., the administrator said in his/her absence, the DON was responsible to report any allegations of abuse to DHSS within two hours after the allegation is made, and to local law enforcement. He/She said he/she was not sure why the DON did not report the allegation to DHSS.</p> <p>Complaint# 2651547</p>		