

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 475036	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/02/2024
NAME OF PROVIDER OR SUPPLIER Union House Nursing Home		STREET ADDRESS, CITY, STATE, ZIP CODE 3086 Glover Street Glover, VT 05839	

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)
<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>48017</p> <p>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)</p> <p>Findings include:</p> <p>Resident #1 has resided at this facility since 5/19/22, with diagnoses that include Alzheimer's, severe vascular dementia, and an agitation-induced psychotic disorder.</p> <p>Resident #2 has resided at the facility since 9/19/23 with diagnoses that include end-stage lewy body dementia and parkinsonism.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>(continued on next page)</p>

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>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.</p> <p>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.</p> <p>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.</p>		