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	05/07/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Union House Nursing Home	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)
F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Protect each resident from the wrongful use of the resident's belongings or money. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure that four of four sampled residents (Res.#1, Res.#2, Res.#3, and Res.#4) were free from misappropriation of property related to medication. Findings include:Per record review of the facility's Identifying Exploitation, Theft, and Misappropriation of Resident Property policy [last revised April 2021] states, 4.Misappropriation of resident property means the deliberate misplacement, exploitation, or wrongful, temporary or permanent use of a resident's belongings or money without the resident's consent. 5. Examples of misappropriation of resident property include .f. drug diversion (taking the resident's medication) .Per review of an initial incident report from the facility to the state agency on 11/10/25, the facility investigated the allegation of drug diversion by LPN [Licensed Practical Nurse] #1 for Residents #1, #2, and #3 regarding discrepancies in controlled substance documentation and medication counts in addition to medication tampering. Per review of the facility's final 5 day summary submitted to the state agency on 11/17/25, it was discovered that LPN #1, who started working at the facility on 11/4/25, had diverted the following controlled substances, Oxycodone (20 tablets), Tramadol (1 tablet), and Lorazepam (1 tablet), from Residents #1, #2, #3, and #4 between 11/7/25 and 11/8/25. Errors were identified with medication counts matching the medication administration records and the controlled substance log. It was also determined that multiple medication cards were tampered with, revealing narcotic medications replaced with non-narcotic medications.Per record review of a document from the State of [NAME] Secretary of State Office of Professional Regulation (OPR) Board of Nursing in the facility incident file states, 54. After further investigation, [LPN #3 and RN#2] discovered that [Resident #3] Oxycodone cards had been tampered with by replacing the narcotic with non-narcotic medications, including Hydroxyzine [a medication used for anxiety], Prednisone [a steroid], Meclizine [a medication used to treat nausea and vomiting], and Metoprolol [a medication used to treat high blood pressure], which were all medications available from the medication cart. 55. [RN#2] later told OPR Investigator that Prednisone and Metoprolol were contraindicated with medications that some of the residents were prescribed and that, if medication tampering had not been discovered, it could have caused great harm to the residents.60. [RN#1] was able to determine by the different colors and sized of the tablets contained in [Resident #1]'s medication card that seven of the oxycodone tablets had been replaced with what appeared to be Spironolactone, which is a potassium sparing diuretic.62. In total the Nursing Home discovered that approximately twenty Oxycodone tablets were unaccounted for the after [LPN#1]'s shifts on November 7, and 8, 2025, either because they had been recorded by [LPN#1] as being dispensed without also recording their administration or because the tablets were discovered to be missing from the medicationAn interview was conducted with the DON [Director of Nursing] on 5/6/26 at 11:37 AM. The DON confirmed that the medications for Resident #1, Resident #2, Resident #3, and Resident #4 had been diverted by LPN #1. The DON confirmed this incident should not have occurred.

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)
F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. Per interview and record review, the facility failed to ensure one of four sampled employees received medication administration competency prior to administering medications. Findings include:Per record review of Licensed Practical Nurse (LPN) #1's training log, there was no documentation that LPN #1 received a medication administration competency prior to starting her position. She worked for four days starting on 11/4/25 to 11/8/25 with no medication administration competency. The employee was terminated on 11/8/25 for medication diversion of Oxycodone (a medication used for moderate to severe pain), Tramadol (a medication used to treat pain), and Lorazepam (a medication used to treat anxiety). See F602 for more information.Per email notification from the Director of Nursing on 5/7/26, she confirmed that the facility did not have documentation related to medication administration for LPN #1 in writing, I could not find her med pass competency .