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	02/19/2026

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 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: Per observation on 02/10/2026 at 2:23 PM, of the medication storage room the following expired medications were noted: 2 bottles of Naproxen Sodium 220mg 50 caps expired 7/20252 bottles of Caltrate Bone Health Advance 60 tablet expired 12/20252 bottles of Cranberry 450mg 100 tablet expired 12/20252 bottles of Vitamin E 180mg/400IU 100 soft gels expired 12/20253 bottles of Vitamin D 10mcg/400IU 100tabsexpired 5/20254 bottles of CoQ10 100mg 30 soft gels expired 5/20251 bottle of Biotene Dry Mouth Rinse 16oz expired 11/20252 boxes of Antidiarrheal 2mg 24 caps expired 7/20251 box of Antidiarrheal 2mg 12 caps expired 10/20254 boxes of Acid Reducer 10mg 90 tabs expired 6/20252 bottles of Bisacodyl 5mg 100 tabs expired 4/2025 1 bottle of stool softener 100mg 100tabs expired 7/2025 Per interview on 02/20/2026 at approximately 2:45 PM, the Unit Manager confirmed that the above medications were expired.

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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F 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. 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.Findings include: 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. 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.

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 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: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.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. 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.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.

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. 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: 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. 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. 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. 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.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. 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 assistance receives the proper level of assistance for nail care for 1 of 2 sampled residents (Resident #10). Findings include: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.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.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.

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. 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:Per review of the facility policy Trauma-informed Care and culturally Competent Care revised 8/22, it states: Resident Care Planning, 2). Identify and decrease exposure to triggers that may re-traumatize the resident. 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. 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.The care plan does not identify triggers that may retraumatize the resident or interventions to mitigate them.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.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.