

Division of Licensing and Protection
103 South Main Street, Ladd Hall
Waterbury, VT 05671-2306
<http://www.dail.vermont.gov>
Voice/TTY (802) 871-3317
To Report Adult Abuse: (800) 564-1612
Fax (802) 871-3318

August 29, 2013

Ms. Patricia Russell, Administrator
Union House Nursing Home
3086 Glover Street
Glover, VT 05839-9701

Dear Ms. Russell:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **August 7, 2013**. 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
Licensing Chief

PMC/tw

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

RECEIVED PRINTED: 08/14/2013
Division of FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 475036	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	AUG 28 13 Licensing and Protection	(X3) DATE SURVEY COMPLETED 08/07/2013
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NAME OF PROVIDER OR SUPPLIER UNION HOUSE NURSING HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 3086 GLOVER STREET GLOVER, VT 05839
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F 000 INITIAL COMMENTS

F 000

An unannounced on-site recertification survey was conducted by the Division of Licensing and Protection from 8/5/13 to 8/7/13. Based on information gathered, the following regulatory violations were cited.

F 225 483.13(c)(1)(ii)-(iii), (c)(2) - (4)
SS=D INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS

F 225

The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.

The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).

The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.

The results of all investigations must be reported to the administrator or his designated

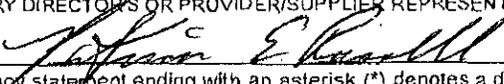
F225

A late report has been submitted for resident #6. There are no other allegations of abuse that have not been filed. All reports filed will be reviewed at Quality Assurance.
by DValiquette RN DNS

A mandatory inservice on abuse and abuse reporting to be held on August 28th, 2013 for all staff.
Person responsible: PRussell RN ADM and DValiquette RN DNS

F225 POC accepted 8/29/13
JHosmer RN / PML

8/23/13
PML
8/28/13
PML

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE Administrator	(X6) DATE 8/23/13
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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.

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F 225	<p>Continued From page 1</p> <p>representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p> <p>This REQUIREMENT is not met as evidenced by: Based on staff interview and record review the facility failed to report an allegation of abuse made by one of seventeen residents (Resident # 6). Findings include:</p> <p>Per review of documents written by the Director of Nursing Services (DNS) and review of written statements provided to the DNS in his/her internal investigation, Resident # 6 complained to the evening shift charge nurse on June 30, 2013 that the licensed nursing assistant (LNA) scrubbed his/her abdominal fold "too hard" and it hurt when s/he did it. The charge nurse spoke with the resident's significant other and with the resident that same evening. The LNA also apologized to the resident in the presence of the charge nurse. According to the DNS internal investigation report the issue appeared to be resolved. The DNS internal investigation document then states that Resident # 6 continued to verbalize to staff that the LNA had been "rough" washing him/her, and added that Resident # 6 was further complaining that the LNA was also "rough" pulling him/her up in bed and had hurt his/her back and neck. The DNS internal investigation document states that the registered nurse (RN) assisting the LNA with cares for resident # 6 that evening did not observe harsh clinical interventions. The RN</p>	F 225		

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F 225	<p>Continued From page 2</p> <p>wrote out his/her observation of this matter concurring with the DNS statement in the internal investigation. The RN wrote, "I did not feel the LNA was rough."</p> <p>Per review of the facility policy regarding reporting of abuse, the facility policy stipulates in section (5) "the investigation will be initiated within 24 hours of the report of abuse being made and completed within 5 working days from initiation to Licensing and Protection". The policy further states in section (8), "the administrator will submit their findings to Licensing and Protection within 5 working days from the incident, as it is not up to the facility administrator to make a final determination on whether or not the allegations of abuse are substantiated."</p> <p>During an interview with the DNS at 8:30 A.M. on August 7, 2013, the DNS confirmed that s/he did not submit a report to the Division of Licensing and Protection:</p>	F 225		
F 441 SS=F	<p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS</p> <p>The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and</p>	F 441		

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F 441	<p>Continued From page 3</p> <p>(3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and observation, the facility failed to assure that resident linens and clothing were properly handled and laundered so as to prevent the possible spread of infection and maintain a safe and sanitary environment. The practice affected all residents in the facility on all units dependent on laundry services. (Up to 42 residents per the Resident Roster) Findings include: Per 8/6/13 10:33 AM interview with the laundry services supervisor, s/he confirmed that water temperatures in the laundry facility have not been</p>	F 441	<p>F441</p> <p>Mixing valve was fixed on Thursday, August 8th by Blanchard Oil Service. Water temperatures have been checked and are in appropriate range for effective laundering per detergent manufacturer's label. Water temperatures will be checked weekly, log maintained and reported to Quality Assurance by Chris Toupin, Maintenance and Laundry Sprvr</p> <p>Laundry procedures regarding amounts/concentrations of detergents and bleach have been reviewed and updated to reflect proper ratios to be used. Random observations of laundry staff to be done weekly x 4, then monthly x3 with results reported to Quality Assurance by Chris Toupin, Maintenance and Laundry Sprvr and DValiquette RN DNS/Infection Control</p> <p>Personal protective equipment is available in laundry room and all laundry staff has been inserviced on use with verbal understanding of standard precautions and return demonstration for use of equipment by Chris Toupin and DValiquette RN DNS/Infection Control. Random observations of use of PPE by laundry staff and adherence to standard precautions to be monitored by Chris Toupin, Maintenance and Laundry Supervisor.</p>	<p>8/8/13 PL.</p> <p>8/8/13 PL.</p> <p>8/8/13 PL.</p>

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F 441	<p>Continued From page 4</p> <p>tested to verify that wash water temperatures meet the detergent manufacturer's recommendation for low temperature washing, or are above 160 degrees (per regulation), or that rinse water is treated with chlorine bleach to 125 ppm (parts per million) per regulation. According to the manufacturer's label on "Action Suds" (the facility's detergent), the detergent is most effective in water temperatures of 110-130 degrees Fahrenheit; the manufacturer's recommendation was verified by the Director of Nursing on 8/7/13 at 8:46 AM. On 8/6/13 during the 10:33 AM interview, the laundry service supervisor tested the water temperature in a running washing machine and the water temperature in a utility sink (on the same hot water line as the washers); the highest temperature achieved was 104 degrees Fahrenheit. On 8/6/13 at 11:58 AM, the supervisor reported that a mixing valve on the water supply line was "frozen" and prevented raising the water temperature any higher until it could be replaced.</p> <p>Per 8/6/13 10:33 AM interview with a laundry service aide, s/he reported that s/he added 4oz of bleach per 20 gallons of water, (determined as the washing machine capacity by the laundry supervisor) along with a scoop of "Action Suds" when washing white linens but did not add bleach to wash loads containing colored laundry even when there was soiling from body waste products observed. Per review of the Clorox bleach service bulletin (<http://www.clorox.com/pdf/5813_service_bulletins.pdf>), the amount of bleach used by the facility in the white loads was less than 100 ppm; there was no bleach in the dark colored loads.</p>	F 441	<p>Mandatory inservice for all staff on bloodborne pathogens/ isolation and standard precautions to be held on August 28, 2013. Person responsible: PRussell RN ADM and DValiquette RN DNS/Infection Control</p> <p>F441 POC accepted 8/29/13 JHsmer RN / POC</p>	<p>8/23/13 per.</p>

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F 441	<p>Continued From page 5</p> <p>Also during the 8/6/13 10:33 AM interview, the laundry aide reported that when handling soiled linens and clothing, s/he wore gloves and held the wash "away" from his/her body. The aide reported that s/he has not been provided and does not wear a gown/apron or protective eye wear (such as goggles) when rinsing soiled clothing in the utility sink or when placing items in the washing machines. S/he reported that sometimes soiled laundry touched his/her clothing. The aide reported that after handling the soiled laundry, s/he removed her gloves and then handled the clean linens, taking them out of the washing machines and then moved them in and out of the driers; s/he folded the clean wash while wearing the same clothing s/he wore when handling the soiled wash. Per 8/6/13 10:33 AM observation, there was no personal protective equipment in the laundry room; clean wash was observed to come in contact with the laundry aide's clothing as she folded and sorted the laundry.</p> <p>Per 8/7/13 8:46 AM interview with the Director of Nursing (DNS)/Infection control preventionist, facility standard precaution policies and procedures apply to all staff including the employees that work in the laundry. Per review of the facility policy for standard precautions and the laundry aide job description, gowns/aprons should be worn when there is potential for soiling clothing with blood/body fluids. Protection over the eyes should be worn during procedures that are likely to generate droplets of blood/body fluids. The policy also states that personal protective equipment (PPE) is provided to all associates. The type of protective barrier should be appropriate for the procedure being performed and the type of exposure anticipated.</p>	F 441		

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F9999 F9999	<p>Continued From page 6</p> <p>FINAL OBSERVATIONS</p> <p>3.17 Freedom from Restraints and Abuse f. The facility must ensure that all alleged violations involving mistreatment, neglect, exploitation, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and the licensing agency and Adult Protective Services in accordance with 33 V.S.A. Chapter 69. Based on staff interview and record review the facility failed to report an allegation of abuse made by one of seventeen residents in the stage 2 sample (Resident # 6). Findings include:</p> <p>Per review of documents written by the Director of Nursing Services (DNS) and review of written statements provided to the DNS in his/her internal investigation, Resident # 6 complained to the evening shift charge nurse on June 30, 2013 that the licensed nursing assistant (LNA) scrubbed his/her abdominal fold "too hard" and it hurt when s/he did it. The charge nurse spoke with the resident's significant other and with the resident that same evening. The LNA also apologized to the resident in the presence of the charge nurse. According to the DNS internal investigation report the issue appeared to be resolved. The DNS internal investigation document then states that Resident # 6 continued to verbalize to staff that the LNA had been "rough" washing him/her, and added that Resident # 6 was further complaining that the LNA was also "rough" pulling him/her up in bed and had hurt his/her back and neck. The DNS internal investigation document states that the registered nurse (RN) assisting the LNA with cares for resident # 6 that evening did not</p>	F9999 F9999	<p>F9999</p> <p>See plan of correction for F225</p>	<p>8/28/13 PL</p>

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F9999	<p>Continued From page 7</p> <p>observe harsh clinical interventions. The RN wrote out his/her observation of this matter concurring with the DNS statement in the internal investigation. The RN wrote, "I did not feel the LNA was rough."</p> <p>Per review of the facility policy regarding reporting of abuse, the facility policy stipulates in section (5) "the investigation will be initiated within 24 hours of the report of abuse being made and completed within 5 working days from initiation to Licensing and Protection". The policy further states in section (8), "the administrator will submit their findings to Licensing and Protection within 5 working days from the incident, as it is not up to the facility administrator to make a final determination on whether or not the allegations of abuse are substantiated."</p> <p>During an interview with the DNS at 8:30 A.M. on August 7, 2013, the DNS confirmed that s/he did not submit a report to the Division of Licensing and Protection.</p>	F9999		