VERMONT

Department of Disabilities, Aging and Independent Living
Division of Licensing and Protection
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AGENCY OF HUMAN SERVICES

September 10, 2026

Mr. Travis Bergeron, Administrator
Union House Nursing Home
3086 Glover Street
Glover, VT 05839

Provider ID #: 475036

Dear Mr. Bergeron:

Enclosed is a copy of your acceptable plans of correction for the complaint investigation conducted on **August 31, 2026.** 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, BS
Assistant Division Director
State Survey Agency Director

Enclosure

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	475036	A. BUILDING B. WING	08/31/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Union House Nursing Home	3086 Glover Street , Glover, Vermont, 05839

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	INITIAL COMMENTS The Division of Licensing and Protection conducted an unannounced, onsite investigation of one complaint and 2 facility reported incidents, including reports #3152912, # 3105267, and # 3076022 on 8/19/26 with offsite investigation ensuing through 8/20/26 to determine compliance with 42 CFR Part 483 requirements for Long Term Care Facilities. During off-site review, Immediate jeopardy was identified at F689 related to accidents and supervision. The Licensing Chief notified the facility of the IJ level deficiency at the immediate jeopardy (IJ) level on 8/27/26. On 8/19/26, an onsite visit determined the facility had completed sufficient corrective actions to remove the immediate jeopardy on 8/14/26 by removing all motion detectors, revising care plans for fall prevention for residents to replace motion detectors, and educating staff. Non-compliance with the requirements at F689 remain. The facility is licensed for 44 beds and had a census of 42 at the time of the survey. An onsite extended survey was conducted on 8/31/26 due to the determination of substandard quality of care. The following regulatory deficiency was identified:	F0000		
F0689 SS = SQC-J	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents.	F0689	F 689 1. As noted, resident #1 has passed away. 2. Residents at risk of falls in the facility have the potential to be affected by the alleged deficient practice.	

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 reverse for further 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
Admin.	Administrator	9/8/26.

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F0689 SS = SQC-J	Continued from page 1 This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and record review, the facility failed to maintain a critical fall-prevention intervention for 1 of 3 sampled residents (Resident #1), who was at high risk due to severe cognitive impairment and repeated falls. Despite a care plan and motion detector alarm system, the device was unplugged and non-operational during the fatal fall. Leadership admitted that an active monitor could have prevented the incident, which resulted in death. Findings include: Per record review, Resident #1 had a Brief Interview for Mental Status (BIMS) of 4 (a cognitive assessment score demonstrating level of impairment), indicating severe cognitive impairment; diagnoses include Alzheimer's disease, dementia, muscle weakness, cognitive communication deficit, anxiety, depression, and difficulty in walking. Per review of a facility incident report, dated 8/2/26, Resident #1 experienced a witnessed fall in the doorway of his/her room on 8/2/26 at approximately 8:00 AM, was assessed for injury, then transported to the emergency department. Per review of a physician readmission assessment note, dated 8/4/26, after diagnostic imaging in the ER, Resident #1 was found to have sustained a head injury with right-sided intracranial hematoma (blood clot under the skull), subarachnoid hemorrhage (bleeding between the brain and the membrane that covers it), and a fracture to vertebrae C1 and C2 (the first 2 vertebrae of the spine). Resident #1 was admitted to the hospital for further management and after discussing care goals with the decision maker, s/he was transferred back to the facility on 8/4/26 on comfort care due to his/her poor overall prognosis. Resident #1 continued on comfort care until his/her death on 8/9/26. Per Resident # 1's death certificate, dated 8/10/26, the manner of death listed as complications of blunt force trauma to head and neck sustained in a fall from standing. Per review of the care plan, Resident #1 was at risk for falls and had several fall-prevention interventions in place, including a motion detector alarm system that the facility implemented on 7/3/25. Resident #1 had experienced 9 falls since the implementation of the monitoring system. Per interview with the Nursing Supervisor (NS) on 8/19/26 at 12:30 PM, she stated Resident #1 was at	F0689	3. The facility no longer uses motion alarms as a fall prevention strategy. 4. Other residents that were utilizing motion alarms as a fall prevention strategy have had alternative interventions put in place and education provided to staff. 5. Staff were also educated regarding the prohibition of utilizing alarms for fall prevention in the facility. 6. Audits will be completed by the Director of Nursing or designee 3 times weekly x1 month and then 3x weekly x3 months to ensure care plan interventions are effective and followed. 7. The results of the audits will be reported to the QAA committee by the Director of Nursing or designee x 3 months, at which time the committee will determine further action. 8. Corrective action complete 9/8/2026 **Tag F0689 POC accepted on 9/10/26 by R. Desrochers/S. Stem**	

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F0689 SS = SQC-J	Continued from page 2 a high risk for falls. She confirmed that Resident #1's motion detection monitor was in place and functioning as a fall-prevention intervention until the morning of 8/2/26, when the alarm box was found unplugged from the wall. Per review of the incident investigation report, dated 8/2/26, a Licensed Nursing Assistant (LNA) was asked to check the monitor alarm box after Resident #1's fall because it had not alerted them to the fact that s/he was out of bed. The LNA found the alarm box unplugged and reported this to the nurse. Per additional investigation documentation, dated 8/3/26, staff reported responding to Resident #1's alarm 4-5 times during the night and early morning hours of 8/1/26 – 8/2/26. Per interview with a LNA on 8/20/26 at 10:00 AM, she stated that the monitor had alarmed "maybe a couple of times" on the morning of 8/2/2026 before Resident #1 fell at 8:00 AM, but she was not sure of the times. She stated that responding to a motion detector alarm meant going into the resident's room and checking on them to make sure they were not at risk of falling. Per interview with a Registered Nurse (RN) on 8/19/26 at 2:25 PM, she stated that the dining/activities area was where the monitor system was plugged in and pointed at an outlet situated under a table where residents were sitting. She stated that one of the LNAs reported hearing the alarm that morning before Resident #1 fell at 8:00 AM. Per interview with the facility Administrator, the Administrator in Training (AIT), and the Regional Clinical Director (RCD) on 8/19/26 at 1:45 PM, they confirmed that the motion detection monitoring system was implemented as a fall prevention measure for Resident #1. They confirmed it was functioning correctly until the morning of 8/2/26 and that the alarm box was found unplugged and not working after Resident #1's fall. They confirmed staff had responded to the alarm during the night and early morning hours. The Administrator, AIT, and RCD confirmed it was possible that a functioning motion detection monitor could have prevented Resident #1's fall.	F0689		