VERMONT

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

December 8, 2025

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 **November 26, 2025.** 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
Pamela M. Cota, RN, BS
Assistant Division Director
State Survey Agency Director

Enclosure

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 475036	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 11/26/2025

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 two facility reported incidents #166589 and #2579072, on11/25/25, with offsite review through 11/26/25, to determine compliance with 42 CFR Part 483 requirements for Long Term Care Facilities. The following regulatory deficiency was identified:	F0000	F600 1. Resident #1 had no negative effects related to the alleged deficient practice and no longer resides in the facility. 2. Residents within close proximity to resident #2 have the potential to be affected by the alleged deficient practice. 3. The plan of care was reviewed and revised following this incident in August 2025. The IDT team continues to review and revise as needed to ensure behavior needs are met and interventions are sufficient to protect other residents. 4. Staff were made aware of changes identified to the plan of care for resident #2 to ensure behavioral needs are met.	
F0600 SS = D	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is NOT MET as evidenced by: Based on interview and record review, the facility failed to protect the resident's right to be free from physical abuse by a resident for 1 of 4 residents in the sample, (Resident #1). Findings include: Per record review, Resident #2 has diagnoses that include schizophrenia, major depressive disorder, and anxiety disorder. Per review of Resident #2's care plan, s/he has a care plan focus that reads, "Resident has potential for behavior [related to] schizophrenia, and major depressive disorder, and has [history] of aggression towards others," initiated on 8/12/15. Per an email dated 11/26/25 from the Director of Nursing	F0600		

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F0600 SS = D	Continued from page 1 (DON), Resident #2 was involved in a resident-to-resident altercation on 8/12/24, in which Resident #2 had hit his/her roommate. Per record review, a facility reported incident (FRI) was submitted to the State Agency on 8/1/25, with an allegation of physical abuse related to a resident-to-resident altercation that occurred on 8/1/25 between Resident #1 and Resident #2. The submission revealed that Resident #2 was observed sitting in the dining area when Resident #1 walked out of his/her room and walked by Resident #2. Resident #2 was calling Resident #1 names and struck Resident #1 in the chest multiple times. A 5-day investigation summary, submitted to the state on 8/7/25 includes a documented interview between the facility and Resident #2, where Resident #2 admitted to striking Resident #1. S/He admitted that s/he does not like Resident #1 because s/he walks around in his/her briefs. The 5-day investigation summary verified that physical abuse occurred to Resident #1. Per interview with the Director of Nursing (DON) on 11/25/25 at approximately 9:40 AM, she stated that this incident did occur as reported in the FRI submitted on 8/1/25.	F0600	5. Education is received by staff related to Dementia and behaviors upon hire, at least annually, and as needed throughout the year. 6. The Director of Nursing currently meets with resident #2 on a weekly basis to evaluate the resident's mood and behavior and to ensure current interventions are sufficient. 7. Resident #2 has not been involved in further aggressive incidents with other residents since this event. 8. The Director of Nursing will report to the QAA committee the findings related to the meetings held with this resident x3 at which time the committee will determine further frequency of reporting required. 9. Corrective action is in place as of 12/4/2025 and will continue. **Tag F 600 POC accepted on 12/7/25 by J. Schneckenburger/S. Stem**	