

Division of Licensing and Protection
103 South Main Street
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

July 23, 2015

Mr. Dane Rank, Administrator
Thompson House Nursing Home
80 Maple Street
Brattleboro, VT 05301

Dear Mr. Rank:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **June 23, 2015**. 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



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

JUL 17 2015

PRINTED: 06/30/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 475050	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/23/2015
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NAME OF PROVIDER OR SUPPLIER THOMPSON HOUSE NURSING HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 80 MAPLE STREET BRATTLEBORO, VT 05301
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(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
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F 000 INITIAL COMMENTS

An announced on-site complaint investigation was conducted by the Division of Licensing and Protection on 6/22 and 6/23/15. There were regulatory findings.

F 224 483.13(c) PROHIBIT
SS=D MISTREATMENT/NEGLECT/MISAPPROPRIATN

The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.

This REQUIREMENT is not met as evidenced by:
Based on staff interview and resident review, the facility failed to ensure that 1 of 5 residents, Resident #1, was free from mistreatment. Findings include:

Per documentation in a nurse progress note, dated 6/3/15, Resident #1 "began yelling at 4AM and wanted to know if time to get up yet...as it got closer to 6AM [Resident #1] got angrier and yelled louder, started to yell 'help me'...Told [Resident #1] that needed to stop yelling or they would not be able to get [him/her] up. [Resident #1] didn't yell or ring for about 20 minutes and s/he was gotten up and it was explained that it was because s/he had stopped yelling." On 6/23/15, the Director of Nurses confirmed at 1:07 PM that the note could be viewed as inappropriate behavior by staff and be considered to violate the resident's dignity. S/he further

F 000

F 224

Resident #1's Interview with RN determined that documentation was not clear regarding the intent of the conversation, and that it was meant to indicate the re-approach that was necessary.

6/25/15

F 224

Policies regarding Abuse Reporting were reviewed and updated as necessary.

7/14/15

DNS provided education to staff member regarding definition of mistreatment and appropriate documentation language.

6/25/15

DNS or designee will review Abuse Prevention with 5 staff members per quarter to ensure understanding of policy.

Ongoing

Results will be reported at QA meetings. DNS to monitor for compliance.

Ongoing

F224 POC accepted 7/22/15 BBR/ARN/PMR

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

Administrative

(X6) DATE

7/14/15

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 224	Continued From page 1 stated that there would be counseling to the Registered Nurse that made the note.	F 224	F241	
F 241 SS=D	<p>483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY</p> <p>The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.</p> <p>This REQUIREMENT is not met as evidenced by: Based on staff interview and resident review, the facility failed to promote care in a manner that enhances the resident's dignity and respect for 1 of 5 residents, Resident #1. Findings include:</p> <p>Per documentation in a nurse progress note, dated 6/3/15, Resident #1 "began yelling at 4AM and wanted to know if time to get up yet...as it got closer to 6AM [Resident #1] got angrier and yelled louder, started to yell 'help me'...Told [Resident #1] that needed to stop yelling or they would not be able to get [him/her] up. [Resident #1] didn't yell or ring for about 20 minutes and s/he was gotten up and it was explained that it was because s/he had stopped yelling." On 6/23/15, the Director of Nurses confirmed at 1:07 PM that the note could be viewed as inappropriate behavior by staff and be considered to violate the resident's dignity. S/he further stated that there would be counseling to the Registered Nurse that made the note.</p>	F 241	<p>Resident #1's Interview with RN determined that documentation was not clear regarding the intent of the conversation, and that it was meant to indicate the re-approach that was necessary.</p> <p>Policies regarding Abuse Reporting were reviewed and updated as necessary.</p> <p>DNS provided education to staff member regarding definition of mistreatment and appropriate documentation language.</p> <p>DNS or designee will review Abuse Prevention with 5 staff members per quarter to ensure understanding of policy.</p> <p>Results will be reported at QA meetings. DNS to monitor for compliance.</p> <p><i>F241 POC accepted 7/22/15 B. BROWN/PML</i></p>	<p>6/25/15</p> <p>7/14/15</p> <p>6/25/15</p> <p>Ongoing</p> <p>Ongoing</p>
F 279 SS=D	<p>483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS</p> <p>A facility must use the results of the assessment</p>	F 279		

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F 279	<p>Continued From page 2</p> <p>to develop, review and revise the resident's comprehensive plan of care.</p> <p>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility failed to develop a care plan regarding behaviors for 1 of 5 residents, Resident #1. Findings include:</p> <p>During record review, it was noted that Resident #1 routinely exhibited behavior on the night shift as evidenced by calling out and wanting to get out of bed and being accusatory to staff and others. The resident has diagnoses that include dementia, depression, cochlear implant with hearing loss. Current care plan addresses anxiety related to illness and family concerns. The resident also has a care plan to address the use of psychotropic medications to include the use of Clonazepam 0.25mg by mouth every 8</p>	F 279	<p>F279</p> <p>Resident #1 Care Plan was updated. 6/22/15</p> <p>Residents with behavior care plans were reviewed to ensure resident updates are in place. 7/21/15</p> <p>Policies regarding care planning were reviewed and updated as necessary. 7/14/15</p> <p>DNS/SDC provided education to staff involved in care planning. 7/21/15</p> <p>DNS or designee will perform audits of 5 resident care plans per quarter to ensure that all identified needs are addressed Ongoing</p> <p>Results will be reported at QA meetings. DNS to monitor for compliance. Ongoing</p> <p><i>F279 POC accepted 7/27/15 BBW/RL/PMC</i></p>	

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F 279	Continued From page 3 hours as needed, which is in conjunction with Clonazepam 0.5mg by mouth at bedtime. The effects were minimal and the addition of Seroquel 25mg by mouth at bedtime was added with some noted effect. However, the care plan for Resident #1 does not reflect the current status of the resident's behavior, nor does the care plan contain specific measurable goals and interventions for staff to utilize that are individualized to the resident's behavioral issues and preferences. The Director of Nurses confirmed at 1:07 PM on 6/23/15 that there was no care plan to effectively reflect the current status of the resident's behavior.	F 279		

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER # 475050	MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	DATE SURVEY COMPLETE: 6/23/2015
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ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
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F 514	<p>483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE</p> <p>The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.</p> <p>The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.</p> <p>This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility failed to have complete medical records, in regards to physician progress notes for 1 of 5 residents, Resident #1. Findings include:</p> <p>During record review for Resident #1, it was found that physician progress notes for 4/10/2015, were not present. There were progress notes dated 2/27/15 and 6/19/15, but none for the required 60 day visit in April 2015. Per interview with the Director of Nursing (DON) on 6/23/15 at 1:00 PM, s/he stated that the physician, "had indeed visited and signed the orders on 4/10/15, but it doesn't look like they left any progress notes." The DON said that it is the practice of this physician to see the resident and then send the notes after the fact from his/her office. The DON confirmed at this time that the record was incomplete and the progress note was not present.</p> <p>*This is an "A" level citation.</p>
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The above isolated deficiencies pose no actual harm to the residents