

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

November 12, 2014

Mr. Dane Rank, Administrator
Thompson House Nursing Home
80 Maple Street
Brattleboro, VT 05302-6551

Dear Mr. Rank:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **October 29, 2014**. 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

PRINTED: 11/03/2014
FORM APPROVED

RECEIVED 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 _____	Division of NOV 7 14 Licensing and Protection	(X3) DATE SURVEY COMPLETED R 10/29/2014
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NAME OF PROVIDER OR SUPPLIER THOMPSON HOUSE NURSING HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 80 MAPLE STREET BRATTLEBORO, VT 05302
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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 unannounced onsite second follow-up survey was conducted by the Division of Licensing and Protection on 10/28/14 and 10/29/14. While the facility was found to be in substantial compliance, the following issues were identified that require corrections.

{F 280} 483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP
SS=B

The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.

A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.

This REQUIREMENT is not met as evidenced by:
Based on staff interview and record review, the facility failed to review and revise care plans for 2 of 7 residents in the sample, Resident #2 and #3, involving skin care treatments and psychotropic

{F 000}

F 280

Resident #3
Care Plan updated to remove psychotropic care plan and add Monitor for changes in Mood Care Plan.

10/29/14

{F 280}

Resident #2
Care Plan updated to reflect current status and treatment for skin integrity.

10/29/14

MDS Coordinator will review entire care plans with IDT every week for scheduled care plan meetings.

10/30/14 and Ongoing

Policies regarding care planning were reviewed and updated as necessary.

11/7/14

DNS/SDC provided education to staff involved in care planning.

11/10/14

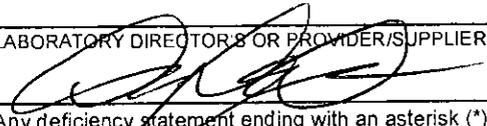
DNS or designee will perform audits of 5 resident care plans per quarter to ensure that all identified needs are addressed

Ongoing

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

Ongoing

F280 POC accepted 11/12/14 BBorker/AMC

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE Administrator	(X6) DATE 11/6/14
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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.

SCANNED

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{F 280}	<p>Continued From page 1 medication usage. Findings include:</p> <p>1. On 10/29/14 per interview with the Registered Nurse (RN) MDS/Clinical Coordinator at 12:20 PM, s/he stated that unless there is a concern about the resident, the care plan is not read or reviewed at the care plan meeting. During the care plan meeting only the care plan that has been discussed regarding a concern is reviewed. If there are no concerns then the date is crossed out and a new date is written to indicate when the care plan next needs to be reviewed. At 3:40 PM per interview with the Director of Nursing (DON), who stated h/she sometimes attends as the representative from the nursing department, acknowledged that during care plan meetings, the care plans go to the meeting, but if there is nothing to change on them, then the date is crossed off and the new review date is added, but there is no reviewing of each individual care plan and it is only done if there is a change.</p> <p>2. During review of care plans for Resident #3, there was a care plan dated 12/09/2013 and listed as an active problem for the potential for adverse side effects related to psychotropic drug use. Review of the medications for Resident #3 presents that the resident is not on psychotropic medications. The care plan was updated 4/2013 (unable to verify the day in April) to represent that the psychotropic had been discontinued. The care plan remained as an active care plan during care plan reviews for 6/4/13, 9/3/13, 12/2/13, 3/1/14, 6/1/14 and 9/1/14 even though the resident was not on psychotropic medications. This was confirmed on 10/29/14 per interview with Registered Nurse (RN), MDS/Clinical Coordinator at 12:20PM. Further confirmation that during the care plan meeting only the care</p>	{F 280}		

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{F 280}	<p>Continued From page 2</p> <p>plan that has been discussed regarding a concern is reviewed. If there are no concerns then the date is crossed out and a new date is written to indicate when the next care plan needs to be reviewed.</p> <p>3. During review of care plans for Resident #2, on 10/29/14, they presented with a care plan dated 12/12/12 with last date of review as 9/1/14, for Potential for skin breakdown related to needs assistance with Activities of Daily Living (ADL ' S) and mobility. On 7/8/14 there was an update to include Mepitel to right heel and change every 3 days and as needed (prn). Per interview with the Minimum Data Set (MDS) Coordinator at 12:26 PM h/she stated that the area was resolved on 10/20/14 and that the care plan had not been revised to reflect that change. Per interview with the Licensed Practical Nurse (LPN) at 12:50 PM h/she stated that the current treatment being used was skin prep for protection, as the areas are resolved. Asked the LPN where that information would be documented and h/she replied the Treatment Administration Record (TAR). Review of the TAR record did not accurately reflect the current treatment and this was confirmed by the LPN and the MDS coordinator at 12:55 PM. The care plan for Resident #2 also did not reflect the current status of Stage 2 ulceration on the inner right buttocks, near the coccyx, that had resolved on 10/20/14. This was confirmed by the MDS coordinator at time of discovery.</p> <p>See also F520.</p>	{F 280}		
{F 520} SS=B	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS	{F 520}		

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{F 520}	Continued From page 3 A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility failed to develop and implement appropriate plans of action to correct identified quality deficiencies. Findings include: During review of care plans for Resident #3, there was a care plan dated 12/09/2013 and listed as an active problem for the potential for adverse side effects related to psychotropic drug use. Review of the medications for Resident #3 presents that the resident is not on psychotropic	{F 520}	F 520 Resident #3 Care Plan updated to remove psychotropic care plan and add Monitor for changes in Mood Care Plan. Resident #2 Care Plan updated to reflect current status and treatment for skin integrity. MDS Coordinator will review entire care plans with IDT every week for scheduled care plan meetings. Audits will be performed routinely for active action plans and reported to the DNS or designee for follow up. DNS and Administrator will review audits and action plans monthly to determine if revisions or modifications are necessary. Results will be reported quarterly at QA meetings. Administrator to monitor for compliance. <i>F520 for accepted 11/12/14 BB/ARU/PMC</i>	10/29/14 10/29/14 10/30/14 and Ongoing Ongoing Ongoing Ongoing	

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{F 520}	Continued From page 4 medications. The care plan was updated 4/2013 (unable to verify the day in April) to represent that the psychotropic had been discontinued. The care plan remained as an active care plan during care plan reviews for 6/4/13, 9/3/13, 12/2/13, 3/1/14, 6/1/14 and 9/1/14 even though the resident was not on psychotropic medications. This was confirmed on 10/29/14 per interview with Registered Nurse (RN), MDS/Clinical Coordinator at 12:20 PM. Further confirmation that during the care plan meeting only the care plan that has been discussed regarding a concern is reviewed. If there are no concerns then the date is crossed out and a new date is written to indicate when the next care plan needs to be reviewed. H/she further confirmed during the interview that unless there is a concern, the care plan is not read or reviewed at the care plan meeting. At 3:00 PM per interview with social services, h/she stated that the care plan meetings are conducted in his/her office and h/she guides the meeting. Representatives from therapy, if the resident is receiving therapy, someone from dietary, social services and nursing attend the meetings. Activities review with him/her prior to the meeting and h/she represents them. Family and resident are invited and will sometimes attend. H/she stated that they meet at least quarterly. H/she further stated that the process is to go around the room and ask if there are any concerns and asks what they can improve on. At 3:40 PM per interview with the Director of Nursing (DON), who stated h/she sometimes attends as the representative from the nursing department, confirmed who would attend as previously stated by social services. She acknowledged that during care plan meetings, the care plans go to the meeting, but if there is nothing to change on them, then the date is crossed off and the new	{F 520}		

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	{F 520} Continued From page 5 review date is added, but there is no reviewing of each individual care plan and it is only done if there is a change. See also F280.	{F 520}		