

Division of Licensing and Protection

HC 2 South, 280 State Drive

Waterbury, VT 05671-2060

<http://www.dail.vermont.gov>

Survey and Certification Voice/TTY (802) 241-0480

Survey and Certification Fax (802) 241-0343

Survey and Certification Reporting Line: (888) 700-5330

To Report Adult Abuse: (800) 564-1612

July 21, 2016

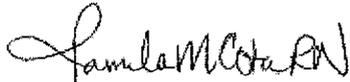
Mr. Dane Rank, Administrator  
Thompson House Nursing Home  
80 Maple Street  
Brattleboro, VT 05301

Dear Mr. Rank:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on June 28, 2016. 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 21 2016 PRINTED: 07/07/2016  
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  06/28/2016
NAME OF PROVIDER OR SUPPLIER  THOMPSON HOUSE NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 80 MAPLE STREET BRATTLEBORO, VT. 05301		
(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	
F 000	INITIAL COMMENTS  An unannounced on-site recertification survey was conducted by the Division of Licensing and Protection on 6/27 and 6/28/16. There were regulatory findings.	F 000			
F 168 SS=C	483.10(g)(2) RIGHT TO INFO FROM/CONTACT ADVOCATE AGENCIES  A resident has the right to receive information from agencies acting as client advocates, and be afforded the opportunity to contact these agencies.  This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to provide accurate information for contacting advocate agencies (the licensing agency). Findings include:  Per observation on 6/27/16 at 5:17 AM of the facility's first and second floor postings of Resident's Rights, the number and address posted for the Division of Licensing and Protection (DLP), was noted to be incorrect. Per interview with the Administrator on 6/27/16 at approximately 9 AM, s/he stated that s/he had recently changed the address and phone number to reflect the current phone number and address of DLP. S/he stated that s/he would make sure the postings were correct following his/her conversation with the surveyors. Per observation on 6/28/16 at 8:25 AM of the first and second floor postings of Resident's Rights, the number and address posted for DLP continued to be incorrect and further confirmation from the administrator that the	F 168	All postings were reviewed and updated by the Administrator to reflect current addresses and contact numbers  Administrator or designee will Review postings quarterly to ensure ongoing compliance Results to be reported in QA Meetings quarterly.  <i>Filed for accepted 7/21/16 BBORTON/pmc</i>	06/28/16  07/04/16 and ongoing	

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



TITLE

Administrator

(X6) DATE

7/13/16

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 168	Continued From page 1 phone numbers listed on the facility postings were non-working numbers and that a resident would not be able to contact the Division of Licensing and Protection with the current numbers posted.	F 168			
F 176 SS=D	483.10(n) RESIDENT SELF-ADMINISTER DRUGS IF DEEMED SAFE  An individual resident may self-administer drugs if the interdisciplinary team, as defined by §483.20(d)(2)(ii), has determined that this practice is safe.  This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility failed to assess 1 of 14 residents, (Resident #12), for the ability to self-administer medication. Findings include:  Per facility policy titled Medication Administration Self-Administration by Resident dated 10/07 identifies "Residents who desire to self administer medications are permitted to do so with a prescriber's order and if the nursing center's interdisciplinary team has determined that the practice would be safe. A self-administration of medication evaluation of the Resident's ability review is to be conducted. The evaluation should be completed for any resident who wishes to self-administer medications and should be repeated on a regular basis (no less than annually)".  Per medical record review, Resident #12, has a physician's order dated 10/15/16 that identifies Resident #12 may have inhaler at the bedside for	F 176	Res# 12 self-administration assessment completed  DNS reviewed all residents on self administration for self-administration assessments.. DNS or designee will audit resident records quarterly and present in QA Meetings to ensure that all residents with orders for self- medication administration are assessed confirming safe practice and ability prior to giving medication to resident.  Res# 12 Ventolin inhaler kept at bedside in original packaging with # of doses 123 remaining noted on box dated 06/28/16.  Nurse assigned to resident will monitor q shift number of doses administered by resident by count q shift and record on the MAR.	06/28/16   07/14/16 and ongoing   07/04/16	

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F 176	<p>Continued From page 2</p> <p>personal use. Medication Administration Record identifies Ventolin 90 Micro Grams, 1 puff every 4-6 hours as needed for shortness of breath, may keep at bedside.</p> <p>Per interview with the Registered Nurse (RN)/Charge Nurse, observation of the packaging of the inhaler (packaging is located in the medication cart), identifies that the inhaler has 200 metered doses. There is no documentation identifying on the Medication Administration Record (MAR) or on the packaging when the inhaler was provided to the resident. The inhaler itself identifies that there are 123 inhalations remaining in the inhaler. Seventy-seven (77) doses have been self administered. The MAR dated 6/1/16 through 6/30/16, does not identify that any Ventolin Inhaler medications have been administered for the month. RN confirms that the nurses do not check the inhaler at the bedside and are not aware of when the resident self-administers the inhaler.</p> <p>Per interview with the Registered Nurse/Charge Nurse and the MDS (Minimum Data Set) Coordinator, confirmation was obtained that there has not been any evaluations for self-administer of medications for Resident #12, therefore the team has not determined that Resident #12 is safe to self-administer the medication.</p> <p>Facility policy titled Medication Storage/Bedside Medication Storage dated 10/07, identifies that 4b. "medications provided to the resident for bedside storage are kept in the containers dispensed by the provider pharmacy. 48. The</p>	F 176	<p>DNS or designee will audit MAR quarterly to ensure proper administration by resident and monitor doses used.</p> <p><i>F176 POC accepted 7/21/16 BB&amp;AK/RN/MLC</i></p>	07/14/15 and ongoing	

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F 176	Continued From page 3 nurse will oversee storage security and accountability of bedside medication."	F 176			
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN  The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.  This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility failed to implement the plan of care for one (1) of fourteen (14) residents in the sample, Resident #32. Findings include: Per record review, Resident #32 had an unwitnessed fall on 6/15/16 and the facility failed to implement the plan of care regarding falls. The care plan indicated that the facility was to follow fall protocol and per the facility's Fall Protocol it states that an unwitnessed fall is to be treated as if the resident struck their head and neuro vital signs (NVS) are to be obtained every hour for four (4) hours, and then every shift for four (4) shifts. Further review of the record failed to provide evidence that NVS were obtained for Resident #32 after the fall and the Licensed Practical Nurse confirmed at 12:47 PM on 6/28/16 that there is no evidence that the staff had done NVS. During interview with the Director of Nursing at 3:33 PM on 6/28/16, s/he stated that there was no evidence that the facility Fall Protocol had been followed and confirmed that the care plan had not been followed.	F 282	Policy and protocol regarding falls reviewed for accuracy and regulatory compliance.  DNS/SDC provided education to all Nursing staff on the importance of care planning and neuro vital signs following a fall.  DNS or designee will review all fall documentation on an ongoing basis to ensure continued compliance.  <i>F282 Pol accepted 7/21/16 BB/ACRN/AM</i>	07/04/16	07/15/16
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS	F 329		07/15/16 and ongoing	

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F 329	Continued From page 4  Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.  Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.  This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to insure that 1 of 6 residents (Resident #12), had appropriate monitoring for the use of oxygen and the self-administration of an inhaler kept at the bedside. The findings include the following:  1. Per observation on 6/27/16, while in Resident #12's room (as s/he is lying in bed), the oxygen	F 329	All MAR's reviewed by DNS for O2 documentation omissions and errors.  DNS spoke with Res# 12 regarding changing Oxygen levels on concentrator and the importance of having it set within parameters of physicians order. Asked resident to notify Nurse if short of breath. Resident agreed.  Nurse assigned to resident will monitor flow meter to assure that the concentrator is set within the limits ordered by the physician, and record the rate q shift in the MAR. Any discrepancy in O2 levels outside of physician parameters will be reported to the DNS.  Nurse assigned to resident #12 will record the O2 stats per shift on the MAR.  DNS or designee to audit MAR quarterly to ensure	7/14/16	07/04/16
				07/04/16 and ongoing	
				7/14/16	

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F 329	<p>Continued From page 5</p> <p>concentrator flow meter was set to deliver oxygen at 6 liters per minute (l/m). The surveyor asked the resident why the oxygen flow meter was set so high and s/he responded that s/he was having difficulty breathing and needs it high so s/he can breath. S/he voices "I have Chronic Obstructive Lung Disease" (COPD). Per observation on 6/28/16 at 8 AM in the presence of the Director of Nurses (DNS), the oxygen concentrator flow meter was set at 4.5 l/m. The DNS confirms that the flow is to be set at 4 l/m unless the resident is ambulating.</p> <p>Per review of the physician's orders dated 2/1/16 through 2/29/16 order is for Oxygen at 4 l/m increase with activity. Treatment Administration Record identifies Oxygen at 4 l/m increase with activity PRN. All three shifts (11-7, 7-3 &amp; 3-11), document that the oxygen is being provided at 4 l/m. There is no evidence in the medical record identifying that the oxygen flow has been increased above 4 l/m.</p> <p>Per discussion with the resident on 6/29/16 s/he confirms that s/he adjusts the flow as s/he feels s/he needs more or less oxygen.</p> <p>Per discussion with the RN/Charge Nurse, confirmation is made that the staff do not check the liter flow of the concentrator for Resident #12.</p> <p>2. Per observation in the room of Resident #12, a Ventolin Inhaler was found at the bedside for the resident's personal use. Per medical record review, Resident #12, has a physician's order dated 10/15/16, may have inhaler at the bedside for personal use. Medication Administration</p>	F 329	<p>compliance, results will be reported in QA Meetings</p> <p><i>F329 acc accepted 7/21/16 BBA/MP/PMC</i></p>	Ongoing	

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F 329	Continued From page 6 Record identifies Ventolin 90 Micro Grams, 1 puff every 4-6 hours as needed for shortness of breath, may keep at bedside.  Per interview with the Registered Nurse (RN)/Charge Nurse, observation of the packaging of the inhaler (packaging is located in the medication cart), identifies that the inhaler has 200 metered doses. There is no documentation identifying on the Medication Administration Record (MAR) or on the packaging when the inhaler was provided to the resident. The inhaler itself identifies that there are 123 inhalations remaining in the inhaler. Seventy-seven (77) doses have been self administered. The MAR dated 6/1/16 through 6/30/16, does not identify that any Ventolin Inhaler medications have been administered for the month. RN confirms that the nurses do not check the inhaler at the bedside and are not aware of when the resident self-administers the inhaler.  Facility policy titled Medication Storage/Bedside Medication Storage dated 10/07, identifies that 4b. "medications provided to the resident for bedside storage are kept in the containers dispensed by the provider pharmacy. 48. The nurse will oversee storage security and accountability of bedside medication."	F 329			
F 356 SS=B	483.30(e) POSTED NURSE STAFFING INFORMATION  The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked	F 356	Administrator found weekend Weekend staffing postings behind front desk, in mailbox, and posted them. Administrator and staffing coordinator audited facility		

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F 356	<p>Continued From page 7</p> <p>by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift:</p> <ul style="list-style-type: none"> <li>- Registered nurses.</li> <li>- Licensed practical nurses or licensed vocational nurses (as defined under State law).</li> <li>- Certified nurse aides.</li> </ul> <p>o Resident census.</p> <p>The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows:</p> <ul style="list-style-type: none"> <li>o Clear and readable format.</li> <li>o In a prominent place readily accessible to residents and visitors.</li> </ul> <p>The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard.</p> <p>The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation and staff interview, the facility failed to post daily census and staffing as per regulation. Findings include:</p> <p>Upon arrival at the facility on 6/27/16 at 5:00 AM, observation of the census and staffing posting presented that it was dated 6/24/16 and it listed a census of 39 and that the night shift had 1 Registered Nurse (RN) for 8 hours, 1 Licensed Nursing Assistant (LNA) for 6.5 hours and 2 LNA</p>	F 356	<p>staffing postings for the previous quarter, ensuring their presence and accuracy.</p> <p>Weekend staffing postings will be completed by Friday of the previous week, and given to the Charge Nurse who will be responsible for updating and posting them on a daily basis, over the weekend.</p> <p>Administrator or designee will audit postings on a daily basis from 07/20/16 to 08/09/16, and weekly thereafter to ensure continued compliance. Any non-compliance with policy will be reported in QA Meetings quarterly.</p> <p><i>F356 POC accepted 7/21/16 BBorden P/LAW</i></p>	07/04/16	07/20/16
					07/20/16 and ongoing

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F 356	Continued From page 8 for 8 hours. Upon arrival the staffing consisted of 1 RN, 1 Licensed Practical Nurse and 2 LNA. One of the first floor LNAs was asked to review the posting and stated that it was incorrect for the date of survey. Confirmation was obtained from the RN at 5:15 AM that the daily posting was not correct and that it appears that the staffing and census had not been posted for the past weekend.	F 356			
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY  The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions  This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to ensure that food prep areas, sinks, and equipment were clean; and food temperatures were monitored and maintained under sanitary conditions. Findings include:  1. During the initial tour of the facility kitchen on 6/27/16 at 5:51 AM, the inside of the warming oven had scattered food particles and a sheet pan with a dried brown substance resembling grease; and the outside of the oven and the oven handles were soiled with a sticky substance	F 371	1. The warming oven was cleaned and sanitized. 2. The stovetop burners, handles, and other surfaces were cleaned and sanitized. 3. All kitchen trash cans were taken apart, cleaned, and replaced. 4. Both handsinks were cleaned and sanitized. 5. The mixer base was scrubbed to remove flour. 6. All stainless steel pans and items below the prep table and cleaned. 7. The roast beef was discarded. 8. The food temperature log was updated, policy for completion reviewed with staff, and moved to be posted on the cooks line.	07/06/16	

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F 371	Continued From page 9 resembling grease. The day cook removed the soiled pan and s/he confirmed that the pan and oven were not clean at that time. Per observation at 5:55 AM, the kitchen had a gas stove with four burners, each burner had a caked, black substance and dried food particles. At this time, the day cook confirmed that the stove was not clean. Per observation at 6:00 AM, the tops of the trash cans were soiled with scattered food particles and the kitchen had two sinks used for hand washing each of which had particles resembling food and grease. The industrial mixer was noted to have a dry, caked, white substance on the base. There was a bottom shelf under one of the food prep areas which contained clean, stainless dishes and trays, where food particles were noted along the entire shelf. Per observation at 6:03 AM, eleven separately contained desserts and a tub of watermelon were noted on a counter near the sink in the dishwashing area. Per interview with the cook at this time, s/he stated that the food was left over from Sunday (6/26/16) and was not thrown out. Per observation at 6:10 AM, the food prep refrigerator was noted to have cooked roast beef on one of the shelves labeled with a date of 6/21/16. Per interview at 6:10 AM with the cook, s/he stated that per facility policy, food was not to be kept more than 3 days. S/he confirmed that the roast beef was outdated and should be thrown away.  2. During a second tour of the facility kitchen on 6/28/16 at 9:30 AM with the Food Services Manager (FSM), the gas stove burners had a caked, black substance with food particles; the tops of the trash cans were soiled with scattered food and particles; the mixer had a dry, caked,	F 371	All cleaning issues (items #1 - #6) will be added to the sanitation audit and will be completed monthly. These audits will be presented monthly to the Administrator, and in aggregate, quarterly, in the QA Meetings by the Food Service Director or his Designee.  All food in kitchen was visualized and verified for being dated within parameters defined by food service policy.  Policies for labeling and maximum time for food retention were reviewed with all cooks and other staff involved. Food labeling and retention will be inspected on a weekly basis, by FSD from 07/18/16 through 08/19/16, and monthly thereafter during the sanitation audit. Results will be presented to the Administrator and to the Interdisciplinary	07/18/15	06/28/16

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>475050</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>06/28/2016</b>
NAME OF PROVIDER OR SUPPLIER  <b>THOMPSON HOUSE NURSING HOME</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>80 MAPLE STREET BRATTLEBORO, VT 05301</b>		
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F 371	Continued From page 10 white substance on the base; the bottom shelf containing clean, stainless dishes and trays had food particles along the shelf; and both of the sinks used for hand washing had particles resembling food and grease. Per interview on 6/28/16 at 9:30 AM with the Food Services Manager, s/he confirmed these observations.  3. Per review on 6/28/16 at 10:46 AM of the facility Food Temperature Log Book, the temperature tracking sheets from 1/28/16 to the present date (6/28/16), did not have any temperatures recorded for the dinner meal service. Per interview on 6/28/16 at 11:01 AM with the FSM, s/he confirmed that the dinner temperatures were not recorded and that there was no way to be certain that the temperatures were done prior to the service of the dinner meals from 1/28/16 to the present date.	F 371	team in the QA Meetings quarterly.  <i>F371 POC accepted 7/21/16 BBORTLRN/AMU</i>	07/18/16	
F 431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS  The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.  Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.	F 431	Expired OTC medications were destroyed, Ativan vial was returned to Parhamerica.  Pharmacist Karen Shorter and Acting Pharmacy Director Toni Spencer notified of expired medication in emergency supply.  DNS or designee will audit medication refrigerators for expired medications monthly and report findings in QA Meetings quarterly.	06/28/16  07/14/16  07/14/16 and ongoing	

*F431 POC accepted 7/21/16 BBORTLRN/AMU*

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F 431	<p>Continued From page 11</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and staff interview the facility failed to insure that medication used for the residents were not expired in 2 of 2 medication storage rooms. Findings include:</p> <p>During completion of the medication storage task on 06/27/2016 at 1:20 PM it was observed that there was a multi-use emergency Ativan vial in the medication refrigerator that had expired 7/2015. The Director of Nurses (DON) confirmed at the time of the observation that the Ativan had expired. During review of the second floor medication refrigerator in the medication storage room at 1:44 PM, a 15 milliliter container of Refresh tears expired 5/16 and 6 Compro suppositories had expired on 11/2015. This observation was confirmed by the Unit Nurse at</p>	F 431		

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F 431	Continued From page 12 the time of the observation.	F 431		