

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

FEB - 2 2010

PRINTED: 01/20/2010  
FORM APPROVED  
OMB NO. 0938-0391

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>01/07/2010</b>
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NAME OF PROVIDER OR SUPPLIER  <b>THOMPSON HOUSE NURSING HOME</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>80 MAPLE STREET BRATTLEBORO, VT 05302</b>
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F 000	INITIAL COMMENTS	F 000		
F 272 SS=D	<p>An unannounced recertification survey was conducted from 1/4/10 to 1/7/10, as authorized by the Federal Centers for Medicare and Medicaid Services. The following regulatory violations were found.</p> <p>483.20, 483.20(b) COMPREHENSIVE ASSESSMENTS</p> <p>The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity.</p> <p>A facility must make a comprehensive assessment of a resident's needs, using the RAI specified by the State. The assessment must include at least the following:                      Identification and demographic information;                      Customary routine;                      Cognitive patterns;                      Communication;                      Vision;                      Mood and behavior patterns;                      Psychosocial well-being;                      Physical functioning and structural problems;                      Contenance;                      Disease diagnosis and health conditions;                      Dental and nutritional status;                      Skin conditions;                      Activity pursuit;                      Medications;                      Special treatments and procedures;                      Discharge potential;                      Documentation of summary information regarding the additional assessment performed through the resident assessment protocols; and                      Documentation of participation in assessment.</p>	F 272	<p>F 272</p> <p>A 3 day Bowel and Bladder assessment was initiated on 1/7/10 for resident #45 to establish pattern.</p> <p>Care plan was updated for resident #45. Direct care staff were educated regarding care plan update.</p> <p>A Bowel and Bladder assessment was completed on all residents, and will be completed on admission, quarterly and with any significant change, by DNS or designee.</p> <p>Policies regarding comprehensive assessments of residents were reviewed and updated as necessary.</p> <p>DNS/SDC will provide education to all staff regarding the resident assessment process.</p> <p>DNS or designee will perform random audits of 5 resident records per quarter to ensure comprehensive assessments are reviewed and updated as necessary</p> <p>Results will be reported at QA meetings. DNS to monitor for compliance.</p>	<p>2/2/10</p> <p>2/2/10</p> <p>2/4/10</p> <p>2/2/10</p> <p>2/4/10</p> <p>Ongoing</p> <p>Ongoing</p>

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE  
 Administrator 01/29/10

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 272

Continued From page 1

This REQUIREMENT is not met as evidenced by:  
Based on staff interview and record review, the facility failed to assure that 1 of 18 total residents in the phase 2 sample was reassessed after changes in physical functioning. (Resident #45) Findings include:

1. Per review of the admission assessment on 1/6/10, Resident #45 was continent of bowel upon admission to the facility. The record documents that the resident developed bowel incontinence, less than daily, within a month of admission to the facility. Per interview on the afternoon of 1/6/10, the DNS (Director of Nurses) confirmed that staff had not reassessed the resident to determine the possible causes of the bowel incontinence.

F 279  
SS=D

483.20(d), 483.20(k)(1) COMPREHENSIVE CARE PLANS

A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.

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.

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

F 272

*F272 POC accepted 2/3/10  
May Balto, RN*

F 279

Resident #3's care plan was updated to include the use of Seroquel for psychosis with agitated behaviors. 1/6/10

F 279

Resident #52's care plan was updated to include psychological concerns of depression and anxiety. 1/7/10

Resident #9's care plan was updated to address pain management concerns. 1/7/10

All resident care plans were reviewed to ensure that all identified needs are addressed. 2/2/10

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

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F 279	Continued From page 2 §483.10, including the right to refuse treatment under §483.10(b)(4).  This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility failed to develop a comprehensive care plan to address all of the resident's identified needs for 3 of 18 residents in the applicable sample. (Residents #3, 52 & 9) Findings include:  1. Per record review on 1/5/10, Resident #3 had no care plan to address the use of an antipsychotic medication (Seroquel) used daily to treat symptoms of psychosis with agitated behaviors, due to a psychotic condition. This omission was confirmed during interviews with the MDS nurse and the DNS on the morning of 1/6/10. 2. Per record review on 1/06/10, Resident # 52's care plan did not address the resident's needs regarding depression and anxiety. The resident was admitted during June, 2009. Up until December 2009 the resident had a PRN (as needed ) order for a benzodiazapine to be given for increased anxiety. The resident's family requested that the medication be given routinely in the evenings as the resident had a long history of obsessive- compulsive type behavior with increased anxiety, especially later in the day. In December 2009, the physician ordered Xanax 12.5 mg. to be given on a scheduled basis twice a day. There was no care plan to address the psychological concerns of depression and anxiety for this resident, including the use of psychoactive med use and counseling, as well as possible non-pharmacological interventions. Per interview on 1/07/10 at 10:00 AM, the charge nurse confirmed	F 279	<i>F279 POC accepted 2/3/10 Mig Balto, RN</i>		

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F 279	Continued From page 3 that the care plan was never developed to address the psychosocial needs of this resident related to the concerns of depression and anxiety.	F 279		
F 309 SS=D	<p><b>483.25 QUALITY OF CARE</b></p> <p>Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility failed to provide the necessary care to assure all residents maintained the highest practicable level of physical and mental well-being for 2 applicable residents in the sample. (Residents #45 &amp; 3) Findings include:</p> <p>1. Per record review and confirmed by nursing staff interview on 1/6/10, Resident #45, who developed bowel incontinence after admission to the facility, was not assessed for causative factors and was not provided with a plan of care</p>	F 309	<p>F 309</p> <p>A 3 day Bowel and Bladder assessment was initiated on 1/7/10 for resident #45 to establish pattern, and toileting schedule.</p> <p>Care plan was updated for resident #45. Direct care staff were educated regarding care plan update.</p> <p>Resident #3's pain and behaviors reviewed with MD. Order received for scheduled pain medication.</p> <p>A Bowel and Bladder assessment was completed on all residents, and care plans updated accordingly.</p> <p>A pain assessment was completed on each resident and interventions implemented or changed as necessary.</p>	<p>2/2/10</p> <p>2/2/10</p> <p>1/7/10</p> <p>2/2/10</p> <p>2/2/10</p>

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F 309	Continued From page 4 to direct staff and help maintain the highest level of bowel continence possible. Per interview with the Licensed Nursing Assistant (LNA) providing care on the morning of 1/6/10, she stated that the resident usually has a bowel movement after lunch and that the resident states they are not always aware of the urge to defecate. The LNA stated that 'if we catch.....then he/she will go on the toilet after lunch'. During interview with the DNS later the same day, she verified that the bowel incontinence was not assessed nor included on the care plan and that there was no bowel toileting plan for this resident. Refer also to F272  2. Per record reviews on 1/6/10, Resident #3, who was diagnosed with chronic pain, was administered lorazepam and tramadol concurrently for "?pain" on the evening of 1/3/10; there was no evidence of the use of any type of pain rating scale prior to administration of these medications. The nurse documented on the back of the MAR that she gave the medications for "? pain" and also documented on the front of the MAR that the resident had no pain for that shift. (Lorazepam PRN was ordered to treat the resident's anxiety.) The medical record detailed increased behaviors during the month of December, 2009 and the resident's psychotherapist documented in his consult note on 12/17/09 that the resident stated that he became angry (and agitated) because his body hurt. There was no evidence that nursing staff were aware of this consult based on documentation and interview 1/7/10 with the day shift nurse. She stated that she was not aware of the therapist's note with information on the resident's pain and behaviors. The resident had a physician order to assess pain every shift and per	F 309	Policies regarding comprehensive assessments of residents were reviewed and updated as necessary, to include a pain rating scale.  DNS/SDC will provide education to all staff regarding the resident assessment process  DNS or designee will audit 5 resident Records each quarter to ensure that all assessments are complete and timely.  Results will be reported at QA meetings. DNS to monitor for compliance.	2/2/10  2/4/10  Ongoing  Ongoing

*F 309 POC accepted 2/3/10  
Mey Balth, RN*

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F 309	Continued From page 5 the facility's policy on pain management, when behaviors such as agitation are present, nurses should consider possible pain as the reason for the agitation. Refer also to F329	F 309	F 329 Resident #3's pain and behaviors reviewed with MD. Order received for scheduled pain medication.	1/7/10
F 329 SS=D	483.25(l) UNNECESSARY DRUGS 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 staff interview and record review, 2 residents had physician orders for PRN medications with dosing ranges and no parameters for use and 1 applicable resident in the sample of 18 received a PRN psychotropic	F 329	Resident #9's medications were reviewed and clarified, to include route of administration, parameters for use, and indications for use.  Diagnosis list requested and received for Resident #24, to include indication for use of albuterol.  Prior lab results requested and received for Resident #24 to include electrolytes. A CMP (comprehensive metabolic panel) was ordered and completed.  MAR's (Medication Administration Records) were audited for all residents to ensure route of administration, parameters for use, indications for use, and appropriate lab orders are in place.  Admission Checklist was updated to ensure route of administration, parameters for use, indications for use, and appropriate lab orders are in place at the time of admission.	2/2/10  1/7/10  1/8/10  2/2/10  2/2/10

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F 329	<p>Continued From page 6 medication without indication for use. (Residents #3, 9 &amp; 24). Findings include:</p> <p>1. Per Medication Administration Record (MAR) review on 1/6/10, Resident #3 received a PRN dose of lorazepam 0.5 mg. for '? pain' on the evening of 1/3/10. The nurse documented on the back of the MAR that she had given tramadol (analgesic medication) and lorazepam (antianxiety medication) at the same time for "? pain". There was no evidence that the nurse conducted a pain assessment prior to administering the lorazepam and the nurse documented on the MAR in the box, 'pain assessment every shift' that the resident had no pain for the same shift (the MAR was documented "0" pain on 1/3/10 box). Refer also to F309</p> <p>Per record review of Resident #9, the current physician orders included the following medications that did not include either the route of administration, parameters for use, or indications for use. The orders for "Beneprotein one scoop 3x per day" and "Duoneb Q 6 hours" did not include a route of administration. The order for " Diphenhydramine 25 mg. one-two caps (25-50 mg.) PO Q 6 hours as needed" did not have an indication for use or parameters for the dose range, and " Morphine 15 mg. one - two tabs (15-30 mg.) PO every 4 hours for severe pain" had a range of dosage without parameters to determine which dose should be administered. Per interview on 1/06/10 at 2:40 PM, the charge nurse confirmed that the orders for these medications were incomplete as written.</p> <p>3. Per record review on 1/6/10, Resident #24 did</p>	F 329	<p>Policies regarding Physician Orders were reviewed and updated as necessary.</p> <p>DNS/SDC will provide education to all nursing staff regarding Physician Orders policy.</p> <p>DNS or designee will audit 5 resident records each quarter to ensure that Physician orders are complete and accurate.</p> <p>Results will be reported at QA meetings. DNS to monitor for compliance.</p>	<p>2/2/10</p> <p>2/4/10</p> <p>Ongoing</p> <p>Ongoing</p>

*F329 POC accepted 2/3/10  
Mey Boltz, RN*

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F 329	Continued From page 7 not have an indication for use of Albuterol Inhaler, two puffs inhaled every four hours as needed. Per interview on 1/6/10 at 2:45, the Charge nurse and Director of Nursing (DNS) confirmed there was no indication for use of the Albuterol Inhaler. In addition, per record review, Resident #24 did not have any lab results since admission on 11/12/09 for monitoring of the use of Lasix (a diuretic) 20mg PO daily and KDUR (potassium) 20 meq one PO twice daily. Per interview on 1/6/10 at 2:45 PM, the Charge Nurse and DNS confirmed there were no labs ordered to monitor the use of Lasix and KDUR.	F 329		
F 353 SS=F	<b>483.30(a) NURSING SERVICES - SUFFICIENT STAFF</b>  The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care.  The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans:  Except when waived under paragraph (c) of this section, licensed nurses and other nursing personnel.  Except when waived under paragraph (c) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty.	F 353	<b>F 353</b>  All staff were educated regarding staffing pattern for RCH and LTC Units.  An additional Personal Care attendant will be hired to provide care for the RCH unit on the 11-7 Shift.  The Personal Care Attendant for the 11-7 shift on the RCH Unit was educated to call for Emergency services assistance if necessary for RCH residents, to maintain Nursing coverage in the LTC Units. The Administrator, DNS or Designee will conduct daily visits to second floor at mealtimes to ensure compliance with staffing pattern.  The Administrator, DNS or Designee will conduct a weekly unannounced visit on all shifts to second floor to ensure compliance with staffing pattern.	2/4/10  2/5/10  2/4/10  Ongoing  Ongoing

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F 353

Continued From page 8  
This REQUIREMENT is not met as evidenced by:  
Based on observation, staff interview, and facility staffing report, the facility failed to consistently provide sufficient nursing staff for residents on the 2nd floor unit during 4 days of survey. (Residents #6, 16, 24, & 25) Findings include:

1. Based upon observations on 1/4/10 at 12:15, no staff were observed on the 2nd floor Long Term Care Unit. Per observation and interview on 1/4/10 at 12:52, an LNA confirmed that she was the only staff on the 2nd floor on 1/4/10 at 12:52 and she was assisting residents in the 2nd floor Residential Care Home (RCH) dining room. There were no staff on duty in the 2nd floor Long Term Care (LTC) Unit at that time. LTC Residents #6 and #24 were in their rooms and Resident #6 received a meal tray (Resident #24 refused a meal tray) and there were no LTC nursing staff available on the unit to supervise these residents.

2. Based upon observation on 1/6/10 at 12:17 three residents were in their rooms (second floor unit) waiting to be transported to the dining room by non licensed staff. (Residents #6, 16, & 25). No licensed staff were observed on the LTC 2nd floor unit from 12:17 PM to 12:29 PM. Per observation, the LPN returned to the unit at 12:29. Per interview on 1/6/10 at 12:17, the LNA confirmed the only staff member on the 2nd floor was the LNA assigned to the 2nd floor Residential Care Home dining room. Per interview on 1/6/10 at 12:29, the LPN confirmed that there were no nursing home staff on the 2nd floor LTC unit while the LPN was off the unit on the first floor unit.

3. Based upon review of Facility staffing report on

F 353

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

Ongoing

*F353 POA accepted 2/3/10  
Meg Balth, RN*

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**F 353** Continued From page 9  
1/7/10, staffing patterns for 1/4/10 to 1/6/10 revealed that one licensed staff was scheduled to work the night shift (11 PM to 7 AM) on the 2nd floor, which includes both the Long Term Care Unit and Residential Care Home. Per interview on 1/7/10 at 9:57, the DNS verified that one licensed staff worked the night shift (11 PM to 7 AM) on 1/4/10 to 1/6/10 on the 2nd floor (for both units), which left the LTC unit residents' unattended periodically when the licensed staff went to the RCH unit to provide care to the RCH residents.

**F 387 SS=D** 483.40(c)(1)-(2) FREQUENCY OF PHYSICIAN VISITS  
The resident must be seen by a physician at least once every 30 days for the first 90 days after admission, and at least once every 60 days thereafter.  
A physician visit is considered timely if it occurs not later than 10 days after the date the visit was required.  
This REQUIREMENT is not met, as evidenced by:  
Based upon staff interview and record review, the facility failed to ensure that 1 of 18 total residents in the phase two sample was seen by the physician at the required intervals after admission. (Resident #24). Findings include:  
1. Based upon record review on 1/7/10, there was no evidence that Resident #24's physician had visited the resident since admission on 11/12/09. Staff interview on 1/7/10 at 8:35 AM with the DNS confirmed that no physician visits were conducted for Resident #24 since

**F 353**

**F 387**  
Resident #24 was seen by the Physician for admission visit. 1/9/10  
Resident #9's physician was provided a copy of the requirement for frequency of Physician Visits. 2/2/10  
All resident records were reviewed to ensure timely Physician visits are completed. 2/2/10  
All physician's were notified by fax of the requirement for frequency of Physician Visits. 2/2/10  
DNS or designee will audit 5 resident records each quarter to ensure that Physician orders are complete and accurate. Ongoing  
Results will be reported at QA meetings. DNS to monitor for compliance. Ongoing

*F 387 POC accepted  
2/3/10  
Mary Boeth, MD*

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

PRINTED: 01/20/2010  
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  01/07/2010
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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
F 387	Continued From page 10 admission.	F 387	F 428	
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW  The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist.  The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon.  This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the attending physician and the DNS failed to act on a pharmacist's recommendation for 1 of 18 residents in the applicable sample. (Resident #3) Findings include:  Per record review on 1/6/10, Resident #3 had a pharmacy recommendation for the physician dated 11/23/09 to review the effectiveness of a dose change to an antidepressant medication (Remeron). The review stated that the dose had increased in May, 2009 from 15 mg. (milligrams) to 30 mg and there had been no documentation regarding the effectiveness of the dose change in the medical record as of 11/23/09. There was no documented response from the physician. The pharmacy review had a notation that the recommendation was faxed to the physician (during November, 2009); however, per interview with the DNS, there had been no response as of 10 AM on 1/7/10.	F 428	The pharmacist recommendation for Resident #3 was received from the Physician.  All resident records were reviewed To ensure that pharmacist recommendations have been addressed as appropriate.  DNS or designee will audit all Pharmacist recommendations monthly to ensure all have been addressed as appropriate.  Results will be reported at QA meetings. DNS to monitor for compliance.	1/7/10  2/2/10  Ongoing  Ongoing

*F 428 PC accepted 2/3/10  
Mey Walter RN*