

Division of Licensing and Protection  
103 South Main Street, Ladd Hall  
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

December 16, 2013

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

Dear Mr. Rank:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **November 12, 2013**. 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

PC:jl

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

RECEIVED  
Division of  
Licensing and  
Protection  
PRINTED: 11/26/2013  
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 _____	DEC 11 13 Licensing and Protection	(X3) DATE SURVEY COMPLETED  <b>R 11/12/2013</b>
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 281 SS=D	<p>An unannounced on-site follow up survey was conducted by the Division of Licensing and Protection on 11/12/13. Regulatory findings include:</p> <p><b>483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS</b></p> <p>The services provided or arranged by the facility must meet professional standards of quality.</p> <p>This REQUIREMENT is not met as evidenced by: Based upon staff interview and record review, the facility failed to assure that the medical records of 4 of 10 residents [Residents #1, #2, #3, &amp; #4] of the sample group were maintained according to professional standards of quality as referenced by the American Journal of Nursing. Findings include: 1). Per record review Physician Orders for Resident #1 dated 10/25/13 read " ...medihoney [a wound treatment ointment] daily x 14 days " for an open area on the resident ' s coccyx and excoriated buttocks. After the 14 days, another order is written to " continue medihoney to buttocks x 7 days " . Per record review of Resident #1 ' s Medication Administration Record [MAR] and Treatment Record, the ointment is initialed as being given on the first day, 10/25/13. After that, there is no documentation that the treatment was administered for the next 9 days. The treatment is then initialed as done on 11/4 thru 11/8, completing the 14 days. When the order is written to continue the treatment for 7 more days, 7 days are counted out on the Treatment Record but there are no initials or</p>	F 281	<p>F 281</p> <p>All resident records were reviewed to ensure MD orders are accurate.</p> <p>Policies regarding order transcription and documentation were reviewed and updated as necessary.</p> <p>DNS/SDC provided education to staff involved in order transcription and documentation.</p> <p>DNS or designee will perform audits of all resident records, MAR's and TAR's weekly for 12 weeks and if substantial compliance is achieved, then 5 resident records per quarter, to ensure that orders are properly transcribed and documentation on MAR's and TAR's is accurate and complete.</p> <p>Results will be reported at QA meetings. DNS to monitor for compliance.</p> <p><i>F281 POC accepted 12/12/13 TDougherty/RN/PML</i></p>	11/30/13	11/30/13
				12/9/13	Ongoing
					Ongoing

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

TITLE

(X6) DATE



*Administrator*

*12/06/13*

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 281	<p>Continued From page 1</p> <p>documentation indicating that the treatment was given or continued.</p> <p>2). Per record review Physician Orders for Resident #1 dated 5/9/13 include " Foley catheter- flush with acetic acid 60 ml. [milliliters] daily. Per record review of Resident #1 's MAR and Treatment Record for October 2013 and November 2013, there are only 2 days [11/3 &amp; 11/5] out of 43 days [Oct. thru this investigation on 11/12/13] that are initialed as the treatment having been given. Per interview on 11/12/13 at 1:40 P.M. Nurse #1 stated that h/she had completed the Foley catheter flush ordered for Resident #1 on that day and previous days, but h/she did not document it on Resident #1 's MAR or Treatment Record and had not documented it anywhere on the resident 's medical record.</p> <p>3). Per record review Physician Orders for Resident #2 include ' gabapentin [an anti-convulsant] 100 mg by mouth every day at bedtime ', and ' levothyroxine [a thyroid drug] 25 mg 1 tab by mouth daily ' . Per review of Resident #2 's MAR for October 2013, there are no initials or documentation that the gabapentin was administered on 10/25, or the levothyroxine given on 10/28.</p> <p>4). Per record review Physician Orders for Resident #3 include ' metformin [a diabetes drug] 500 mg by mouth daily in A.M. ' , ' lisinopril [for blood pressure] 5 mg by mouth daily ' , ' fluoxetine [an anti-depressant] 20 mg capsule by mouth daily in A.M ' , and ' aspirin 81 mg. chew tab by mouth daily ' . Per review of Resident #3 's MAR for October 2013, there are no initials or documentation that the 4 medications were administered on 10/24/13.</p> <p>5). Per record review Physician Orders for Resident #4 include ' simvastatin [for cholesterol] 40mg tablet by mouth daily ' , miralax powder [a</p>	F 281		

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F 281	<p>Continued From page 2</p> <p>laxative] 17 grams by mouth in 240 ml. fluid daily , and ' abilify [an anti-psychotic] 2 mg by mouth daily ' . Per review of Resident #4 ' s MAR for October 2013, there are no initials or documentation that the 3 medications were administered on 10/17/13, nor the abilify initialed as given on 10/18 and 10/27.</p> <p>Per interview on 11/12/13, 3 Nurses on duty including Nurse #1 stated that they had recently received education and in-services that included order transcription and documentation.</p> <p>Per review of the American Journal of Nursing, July 2007 article " Documentation, Part 1: Principles for Self Protection- Preserving the Medical Record- ' Regardless of the practice setting, nurses must preserve the integrity of the medical record in the following ways;</p> <p>All documentation practices must be consistent ...Accurate and complete patient information must be entered on all paper and electronic documents [related to] ... completed treatments, procedures, and interventions, as well as those that have not been completed and the reason they were not completed. '</p> <p>(&lt;<a href="http://www.nursingcenter.com/lnc/journalarticle?Article_ID=727905">http://www.nursingcenter.com/lnc/journalarticle?Article_ID=727905</a>&gt;)</p> <p>Per interview with the DNS on 11/12/13 at 2:30 P.M. it is h/her expectation that medications and treatments given to residents would be initialed and documented as being done on the resident ' s Medication Administration Record and Treatment Record, or documented regarding why they were delayed, incomplete, or missed. The DNS confirmed that the licensed nursing staff had recently received education and in-services that included documentation policy and practices. The DNS confirmed the MARs and Treatment Records for Residents #1, #2, #3, &amp; #4 were not complete and/or accurate, and contained</p>	F 281		

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F 281  F 514 SS=D	<p>Continued From page 3</p> <p>absences of initials or documentation that treatment and medications were or were not given to the residents.</p> <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 upon staff interview and record review, the facility failed to maintain complete and accurate clinical records in accordance with accepted professional standards and practices on 4 of 10 residents [Residents #1, #2, #3, &amp; #4] of the sample group. Findings include:</p> <p>1). Per record review Physician Orders for Resident #1 dated 10/25/13 read " ...medihoney [a wound treatment ointment] daily x 14 days " for an open area on the resident 's coccyx and excoriated buttocks. After the 14 days, another order is written to " continue medihoney to buttocks x 7 days " . Per record review of</p>	F 281  F 514	<p>F 514</p> <p>All resident records were reviewed to ensure MD orders are accurate.</p> <p>Policies regarding order transcription and documentation were reviewed and updated as necessary.</p> <p>DNS/SDC provided education to staff involved in order transcription and documentation.</p> <p>DNS or designee will perform audits of all resident records, MAR's and TAR's weekly for 12 weeks and if substantial compliance is achieved, then 5 resident records per quarter, to ensure that orders are properly transcribed and documentation on MAR's and TAR's is accurate and complete.</p> <p>Results will be reported at QA meetings. DNS to monitor for compliance.</p> <p><i>F514 POC accepted 12/12/13 TDougherty RN/PhA</i></p>	11/30/13  11/30/13  12/9/13  Ongoing  Ongoing

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F 514	<p>Continued From page 4</p> <p>Resident #1 ' s Medication Administration Record [MAR] and Treatment Record, the ointment is initialed as being given on the first day, 10/25/13. After that, there is no documentation that the treatment was administered for the next 9 days. The treatment is then initialed as done on 11/4 thru 11/8, completing the 14 days. When the order is written to continue the treatment for 7 more days, 7 days are counted out on the Treatment Record but there are no initials or documentation indicating that the treatment was given or continued.</p> <p>2). Per record review Physician Orders for Resident #1 dated 5/9/13 include " Foley catheter- flush with acetic acid 60 ml. [milliliters] daily. Per record review of Resident #1 ' s MAR and Treatment Record for October 2013 and November 2013, there are only 2 days [11/3 &amp; 11/5] out of 43 days [Oct. thru this investigation on 11/12/13] that are initialed as the treatment having been given. Per interview on 11/12/13 at 1:40 P.M. Nurse #1 stated that h/she had completed the Foley catheter flush ordered for Resident #1 on that day and previous days, but h/she did not document it on Resident #1 ' s MAR or Treatment Record and had not documented it anywhere on the resident ' s medical record.</p> <p>3). Per record review Physician Orders for Resident #2 include ' gabapentin [an anti-convulsant] 100 mg by mouth every day at bedtime ' , and ' levothyroxine [a thyroid drug] 25 mg 1 tab by mouth daily ' . Per review of Resident #2 ' s MAR for October 2013, there are no initials or documentation that the gabapentin was administered on 10/25, or the levothyroxine given on 10/28.</p> <p>4). Per record review Physician Orders for Resident #3 include ' metformin [a diabetes drug] 500 mg by mouth daily in A.M. ' , ' lisinopril [for</p>	F 514		

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F 514	<p>Continued From page 5</p> <p>blood pressure] 5 mg by mouth daily', fluoxetine [an anti-depressant] 20 mg capsule by mouth daily in A.M., and aspirin 81 mg. chew tab by mouth daily'. Per review of Resident #3's MAR for October 2013, there are no initials or documentation that the 4 medications were administered on 10/24/13.</p> <p>5). Per record review Physician Orders for Resident #4 include simvastatin [for cholesterol] 40mg tablet by mouth daily', miralax powder [a laxative] 17 grams by mouth in 240 ml. fluid daily', and abilify [an anti-psychotic] 2 mg by mouth daily'. Per review of Resident #4's MAR for October 2013, there are no initials or documentation that the 3 medications were administered on 10/17/13, nor the abilify initiated as given on 10/18 and 10/27.</p> <p>Per interview on 11/12/13, 3 Nurses on duty including Nurse #1 stated that they had recently received education and in-services that included order transcription and documentation.</p> <p>Per review of the American Journal of Nursing, July 2007 article "Documentation, Part 1: Principles for Self Protection- Preserving the Medical Record- Regardless of the practice setting, nurses must preserve the integrity of the medical record in the following ways;</p> <p>All documentation practices must be consistent ...Accurate and complete patient information must be entered on all paper and electronic documents [related to] ... completed treatments, procedures, and interventions, as well as those that have not been completed and the reason they were not completed.'</p> <p>(&lt;<a href="http://www.nursingcenter.com/Inc/journalarticle?Article_ID=727905">http://www.nursingcenter.com/Inc/journalarticle?Article_ID=727905</a>&gt;)</p> <p>Per interview with the DNS on 11/12/13 at 2:30 P.M. it is h/her expectation that medications and treatments given to residents would be initiated</p>	F 514		

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F 514	Continued From page 6 and documented as being done on the resident 's Medication Administration Record and Treatment Record, or documented regarding why they were delayed, incomplete, or missed. The DNS confirmed that the licensed nursing staff had recently received education and in-services that included documentation policy and practices. The DNS confirmed the MARs and Treatment Records for Residents #1, #2, #3, & #4 were not complete and/or accurate, and contained absences of initials or documentation that treatment and medications were or were not given to the residents.	F 514		