



AGENCY OF HUMAN SERVICES
DEPARTMENT OF DISABILITIES, AGING AND INDEPENDENT LIVING
Division of Licensing and Protection
103 South Main Street, Ladd Hall
Waterbury VT 05671-2306
<http://www.dail.vermont.gov>
Voice/TTY (802) 241-2345
To Report Adult Abuse: (800) 564-1612
Fax (802) 241-2358

December 29, 2010

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 annual survey conducted on **December 1, 2010**. 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,

A handwritten signature in black ink that reads "Pamela M. Cota RN". The signature is written in a cursive style.

Pamela M. Cota, RN
Licensing Chief



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

PRINTED: 12/13/2010
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 12/01/2010
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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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F 000	INITIAL COMMENTS	F 000	F 159	12/20/10
F 159 SS=B	<p>483.10(c)(2)-(5) FACILITY MANAGEMENT OF PERSONAL FUNDS</p> <p>Upon written authorization of a resident, the facility must hold, safeguard, manage, and account for the personal funds of the resident deposited with the facility, as specified in paragraphs (c)(3)-(8) of this section.</p> <p>The facility must deposit any resident's personal funds in excess of \$50 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.)</p> <p>The facility must maintain a resident's personal funds that do not exceed \$50 in a non-interest bearing account, interest-bearing account, or petty cash fund.</p> <p>The facility must establish and maintain a system that assures a full and complete and separate accounting, according to generally accepted accounting principles, of each resident's personal funds entrusted to the facility on the resident's behalf.</p> <p>The system must preclude any commingling of resident funds with facility funds or with the funds of any person other than another resident.</p> <p>The individual financial record must be available through quarterly statements and on request to</p>	F 159	<p>\$100.00 petty cash will be maintained in the West Wing medication cart for use by residents for access to personal funds outside of Business Office hours.</p> <p><i>F159 POC Accepted 12/20/10 K. Campos RNL [Signature]</i></p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE Administrator	(X8) DATE 12/22/10
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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.

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F 159	Continued From page 1 the resident or his or her legal representative. The facility must notify each resident that receives Medicaid benefits when the amount in the resident's account reaches \$200 less than the SSI resource limit for one person, specified in section 1611(a)(3)(B) of the Act; and that, if the amount in the account, in addition to the value of the resident's other nonexempt resources, reaches the SSI resource limit for one person, the resident may lose eligibility for Medicaid or SSI. This REQUIREMENT is not met as evidenced by: Based on staff interviews, the facility failed to assure that resident's personal funds were available to them during non-business hours. Findings include: 1. During the Personal Funds review on 12/1/10, the business office staff confirmed that the resident's personal funds are available to them on Monday through Friday during normal business hours. There is no petty cash system or other system to allow access to their funds on weekends, evenings, or holidays when the business office staff are not there.	F 159			
F 279 SS=E	483.20(d), 483.20(k)(1) DEVELOP 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	F 279	F 279 Resident #2's care plan was updated to address weight loss. Resident #9's care plan was updated to address dental needs.	12/20/10 12/1/10	

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F 279	<p>Continued From page 2</p> <p>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 record review and staff interview(s) the facility failed to develop comprehensive care plans for 4 of 31 residents in the total sample. (Residents #2, 9, 21, 60) Findings include:</p> <p>1. Per record review conducted on 11/30/10, Resident #2 failed to have a comprehensive care plan developed for weight loss even though s/he had lost 16 pounds (lbs.), equal to 11.6% of his/her body weight, in the 6 months between the dates of May 13, 2010 and November 25, 2010. Per interview on 12/1/10 at 9:30 AM, the Registered Dietician (RD), and Director of Nursing Services (DNS) both stated they were aware that the resident was 'losing weight' and confirmed that no care plan had been developed for weight loss. The MDS (Minimum Data Set) Coordinator, who has the ultimate responsibility to ensure that all care plans are completed, confirmed that although s/he was aware that there had been a 16 lb. weight loss, no care plan had been developed. Refer also to F325.</p>	F 279	<p>Resident #60's comprehensive care plan was developed and in place.</p> <p>Resident #21's comprehensive care plan was developed and in place.</p> <p>All resident care plans were reviewed to ensure that all identified needs are addressed.</p> <p>Policies regarding care planning were reviewed and updated as necessary.</p> <p>DNS/SDC provided education to staff involved in care planning.</p> <p>DNS or designee will perform audits of 5 resident care plans per quarter to ensure that all identified needs are addressed</p> <p>Results will be reported at QA meetings. DNS to monitor for compliance.</p> <p><i>F279 POC Accepted 12/28/10 K. Campos RN / P. Metcalf RN</i></p>	<p>12/2/10</p> <p>12/1/10</p> <p>12/24/10</p> <p>12/22/10</p> <p>12/24/10</p> <p>Ongoing</p> <p>Ongoing</p>

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F 279	Continued From page 3 2. Per record review on 11/30/10, Resident #9's MDS Assessment and RAP summary dated 1/15/10 identified a need for dental care and was checked to proceed to care planning in this area. Per review of the Plan of Care, the only reference to dental needs was an entry regarding the need for antibiotics to be administered prior to any dental appointment, but no interventions to monitor for mouth pain or other dental problems. Per interview on 12/1/10 at 8:55 AM, the MDS coordinator confirmed that the care plan should have been developed to address the dental concerns of this resident, and it was an oversight to not include this in the care plan. 3. Per record review on 12/1/10 at 11:40 AM, there is no comprehensive care plan in place for Resident #60, who was admitted to the facility on 10/20/10. The DNS confirmed on 12/1/10 at 12:48 PM that there was no comprehensive care plan in place as required. 4. Per record review and staff interview on 12/01/10, there was no comprehensive care plan developed for Resident #21. The Resident was admitted on 10/6/10 and the admission MDS was completed on 10/20/10. In an interview at 8:40 AM on 12/1/10, the DNS confirmed that there was no Comprehensive Care Plan in place for this resident.	F 279			
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS	F 281	F 281 Resident #60's MD order to obtain weekly weights was included in care plan.	12/2/10	

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F 281	Continued From page 4 The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to meet professional standards of quality regarding implementing physician orders for 1 of 31 residents in the sample (Resident # 60). Findings include: Per record review on 12/1/10 at 1:29 PM, staff failed to follow a physician's order to weigh Resident #60. On 10/21/10, the physician ordered a supplemental milk shake twice a day due to low weight and compromised nutrition and ordered to weigh the Resident weekly. On 12/1/10 at 1:45 PM, the DNS confirmed that weights were not recorded for 3 weeks between 11/9/10 - 12/1/10 despite physician orders for weekly weights.	F 281	Direct care staff were educated regarding care plan update. All resident care plans were reviewed to ensure MD orders are included. Policies regarding care planning were reviewed and updated as necessary. DNS/SDC provided education to staff involved in care planning. DNS or designee will perform audits of 5 resident care plans per quarter to ensure that all identified needs are addressed. Results will be reported at QA meetings. DNS to monitor for compliance.	12/2/10 12/24/10 12/22/10 12/24/10 Ongoing Ongoing
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 observation, interview and record review, the facility failed to provide services in accordance with 1 of 31 residents' plan of care (Residents #42). Findings include:	F 282	<i>F281 POC Accepted 12/28/10 K Campos RN / Amata RN</i> F 282 Resident #42's care plan was reviewed and updated regarding supervision for meals. The seating plan for meals in the dining room was reviewed and updated.	12/9/10 12/9/10

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F 282	Continued From page 5 1. Per observation of the noon meal on 11/29/10 between 12:30 PM and 1:05 PM, Resident # 42, who has a diagnosis of dysphagia, was not eating under close supervision as indicated in the Resident's care plan. Resident #42 was sitting in the east side of the dining room and no staff were observed supervising his/her intake. Resident #42's care plan states that s/he requires supervision for meals, to supervise all oral intake, encourage to take small sips, keep chin tucked, small bites and to clear left side of mouth after each bite. Per record review on 12/1/10, on 10/14/10, the facility Speech Therapist recommended close supervision at meals. Per interview with the Therapy Program Director on 12/1/10 at 11:22 AM, s/he confirmed that close supervision means staff should be seated at the Resident's table. During a 10:45 AM interview, the DNS confirmed that the care plan could not be implemented with no staff in the dining room with the resident.	F 282	Direct care staff were educated regarding care plan intervention. All resident care plans were reviewed to ensure that all identified needs are addressed and implemented. Policies regarding care planning were reviewed and updated as necessary. DNS/SDC provided education to staff involved in care planning and implementation. DNS or designee will perform audits of 5 resident care plans per quarter to ensure that all identified needs are addressed and implemented.	12/9/10 12/24/10 12/22/10 12/24/10 Ongoing
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to monitor/supervise 1 resident in the total sample to prevent accidents. (Resident # 42) Findings Include:	F 323	Results will be reported at QA meetings. DNS to monitor for compliance. <i>F282 POC Accepted 12/28/10 K. Campos RN / JMCotURN</i> F 323 Resident #42's care plan was reviewed and updated regarding supervision for meals. The seating plan for meals in the dining room was reviewed and updated.	Ongoing 12/9/10 12/9/10

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F 323	Continued From page 6 Per observation of the lunch meal served on 11/29/10 at 12:30 PM Resident #42, who has a diet order for coarsely ground food because s/he is a potential choking risk, was eating a meal consisting of ground meat and whole pieces of vegetable (broccoli) while seated in an area of the dining room where staff were unable to observe/supervise the resident. At 12:45 PM, with no facility staff present, the resident began to cough and expelled a piece of whole broccoli. Per interview on 12/1/10 at 9:30 AM, this surveyor shared the observation with the RD (Registered Dietician) and the DNS. The RD confirmed that the resident had a diet order for 'course ground foods' and it was their expectation that all foods, including vegetables, be coarsely ground because the resident was a choking risk and that s/he required supervision while eating.	F 323	Direct care staff were educated regarding seating plan update. Policies regarding supervision and assistance at mealtimes were reviewed and updated as necessary. DNS/SDC provided education to staff regarding supervision and assistance at mealtimes. DNS or designee will perform audits of mealtimes 5 times per quarter to ensure that policies and procedures are implemented.	12/9/10 12/22/10 12/24/10 Ongoing
F 325 SS=D	483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview(s) the facility failed to monitor and put interventions in	F 325	Results will be reported at QA meetings. DNS to monitor for compliance. <i>F323 POC Accepted 12/28/10 K. Campos RN / [Signature]</i> F 325 Resident #2's care plan was updated to address weight loss. Resident #2's physician was notified of continued weight loss and weight loss was addressed by physician. Resident #2's responsible party was notified of weight loss.	Ongoing 12/20/10 12/2/10 12/5/10 12/22/10

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F 325	Continued From page 7 place to prevent significant weight loss for 2 of 31 residents in the total sample. (Residents #2, 21) Findings include: 1. Per record review on 12/1/10, Resident #2, with profound mental status changes, experienced a 16 pound (lb.) weight loss (11.6% of total body mass) between the dates of 5/13/10 and 11/25/10, a 6-month period. Per interview on 12/1/10 at 9:30 AM, the RD and DNS stated that the resident had been "losing weight" but they were not aware that s/he had lost 16 lbs since May 2010. The RD dietary notes between 4/5/10 and 7/5/10 (the last dietary note in the chart) state that the resident's "food intake varies r/t mental status", that s/he had "unstable food and drink intake" and that food intake "varies upon the residents mood." The RD confirmed that no new interventions were implemented (such as fortified foods or extra supplements) although the resident had been losing weight. In addition, the DNS confirmed that neither the family nor the physician had been notified and there was no care plan or strategies in place to prevent further weight loss. Refer also to F279. 2. Per record review on 12/01/10, Resident #21 experienced a 7.64% weight loss in the first month of residence in the facility. The DNS stated in an interview at 10:45 AM on 12/01/10 that s/he was aware of the weights but that s/he was doubtful of the accuracy of the admission weight. The admission weight was recorded as 144 pounds on 10/06/10 and subsequent weights on 10/21/10, 11/04/10, 11/11/10, and 11/17/10 were all between 132.9 pounds and 134 pounds. Despite this weight discrepancy, there was no notation in the Dietary notes or on the existing interim care plan regarding monitoring weights or	F 325	Dietary interventions were put into place for Resident #2 to for fortified foods and supplements. Direct care staff were educated regarding interventions. Resident #21's care plan was updated to address weight loss. Dietary interventions were put into place for Resident #21 to for supplements. Direct care staff were educated regarding interventions. All resident weights were reviewed for past 6 months to ensure appropriate interventions and notifications are in place. Policies regarding monitoring resident weight were reviewed and updated as necessary. DNS/SDC provided education to staff regarding policy update. DNS or designee will perform audits of 5 resident records per quarter to ensure that weight changes are addressed. Results will be reported at QA meetings. DNS to monitor for compliance. <i>F325 PDC Accepted 12/28/10 K Campos RN J McArthur</i>	12/20/10 12/20/10 12/1/10 12/6/10 12/6/10 12/22/10 12/22/10 12/24/10 Ongoing Ongoing

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F 325	Continued From page 8 interventions to maintain weight. This was confirmed with the Registered Dietitian, Director of Nurses and MDS Coordinator in an interview at 10:55 AM on 12/01/10.	F 325	F 431 The medication refrigerator was replaced, and attached to the support surface to prevent moving it.	11/30/10
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. 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. 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.	F 431	An alarm was placed on the medication refrigerator to alert staff to a temperature outside accepted range. All medication stock was audited to ensure none were outdated. Policy regarding monitoring refrigerator temperatures was reviewed and updated. Policy regarding medication storage was reviewed and updated. DNS/SDC provided education to staff regarding policy updates. Maintenance Director or designee will check temperature log and sign monthly to ensure continued compliance. DNS or designee will perform audits of medication storage areas 5 times per quarter to ensure that medications are not outdated. Results will be reported at QA meetings. DNS to monitor for compliance.	11/30/10 11/30/10 12/3/10 12/22/10 12/22/10 12/24/10 Ongoing Ongoing Ongoing

*F431 POC Accepted 12/28/10
K. Campos RN / Amoturn*

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F 431	Continued From page 9 This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to store all drugs and biologicals under proper temperature controls and ensure stored medications were not expired. Findings include: Per observation of the 1st floor medication refrigerator on 11/30/10 at 10:05 AM, there were 37 dates between 1/7/10 - 11/30/10 that temperatures exceeded the facility guidelines of 36 - 46 degrees Fahrenheit (F). The out of range temperatures ranged from 47 to 63 degrees F. This observation was confirmed by the Director of Nurses on 11/30/10 at 10:18 AM. Per observation of the second floor med room on 11/30/10 at 11:10 AM, there were two bottles of Geri-Kot, a laxative, that had an expiration date of 9/10. This was confirmed at the time of observation by the Unit Nurse.	F 431			