

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

June 4, 2015

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 **May 13, 2015**. 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: 05/20/2015
FORM APPROVED
OMB NO. 0938-0391

JUN 04 2015

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 C 05/13/2015
NAME OF PROVIDER OR SUPPLIER THOMPSON HOUSE NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 80 MAPLE STREET BRATTLEBORO, VT 05302		
(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	F 000	F 156	5/14/15	
F 156 SS=C	<p>An unannounced on-site recertification survey and complaint investigation was conducted by the Division of Licensing and Protection from 5/11/15 through 5/13/15. The findings include the following:</p> <p>483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES</p> <p>The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing.</p> <p>The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5) (i)(A) and (B) of this section.</p> <p>The facility must inform each resident before, or at the time of admission, and periodically during</p>	F 156	<p>The correct telephone number for the office of Licensing and Protection was updated on the posters.</p> <p>ADM or designee will perform audits of postings throughout the facility each quarter to ensure that phone numbers are correct.</p> <p>Results will be reported quarterly at QA meetings. ADM to monitor for compliance.</p> <p><i>F156 POC accepted 6/4/15 mbertrand RN /mc</i></p>	Ongoing	Ongoing

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

TITLE

Administrative

(X6) DATE

6/2/15

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 156	<p>Continued From page 1</p> <p>the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate.</p> <p>The facility must furnish a written description of legal rights which includes: A description of the manner of protecting personal funds, under paragraph (c) of this section;</p> <p>A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels.</p> <p>A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements.</p> <p>The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care.</p>	F 156			

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F 156	<p>Continued From page 2</p> <p>The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and confirmed by administrative staff, the facility failed to post the correct telephone number for the State Licensure Office, the office whereby a resident may file a complaint concerning abuse, neglect and misappropriation of resident property. The findings include the following:</p> <p>Per facility tour on 5/12/15 at approximately 3 PM, posters prominently displayed on both nursing home units, evidenced the incorrect telephone number of the office of Licensing and Protection.</p> <p>Confirmation was made by both the Social Service Designee on 5/13/15 at 2:45 PM and the Licensed Nursing Home Administrator at approximately 3:30 PM that the number was in fact incorrect.</p>	F 156		
F 225 SS=D	<p>483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS</p> <p>The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have</p>	F 225		

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F 225	<p>Continued From page 3</p> <p>had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.</p> <p>The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.</p> <p>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p> <p>This REQUIREMENT is not met as evidenced by: Based on medical record review and confirmed by staff interview the facility failed to immediately investigate and report an allegation of a verbal abuse for 1 of 14 applicable residents in the</p>	F 225	<p>F 225</p> <p>Resident #2's allegation of verbal abuse was investigated and reported.</p> <p>Policies regarding Abuse Reporting were reviewed and updated as necessary.</p> <p>Clinical Coordinator provided education to all staff regarding Abuse Reporting.</p> <p>DNS or designee will review Abuse Reporting with 5 staff members per quarter to ensure understanding of policy.</p> <p>Results will be reported at QA meetings. DNS to monitor for compliance.</p> <p><i>F225 POC accepted 6/4/15 MBertrand/RN/PMC</i></p>	<p>5/11/15</p> <p>5/26/15</p> <p>5/27/15</p> <p>Ongoing</p> <p>Ongoing</p>

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F 225	<p>Continued From page 4</p> <p>Stage 2 sample, (Resident #2). The findings include the following:</p> <p>Per interview on 5/11/15 at 4:17 PM during Stage 1 interview with Resident #2, s/he was asked if staff or anyone else has ever verbally, physically or sexually abused you here at the facility? Resident responded "Yes, verbally". Resident #2 continued to describe a situation that occurred. S/he could not recall the exact date, but did remember it was during the evening shift. The situation was described by the resident as taking place during a conversation with a Licensed Nurses Aide (LNA) in Resident #2's bedroom. The LNA used profanity and addressed the resident in a disparaging/belittling/derogatory manner during the conversation. Resident #2 is able to voice that s/he was very upset stated to the surveyor "I lost my cork" and in an attempt to move my lamp, it broke. Resident #2 is able to state that s/he has not seen the LNA since the incident. When asked if s/he reported the situation s/he stated "Yes to Social Services, s/he works down stairs".</p> <p>Per interview on 5/12/15 confirmation is made with the Social Service Designee (SS) that s/he was made aware of the broken lamp on 3/31/15 during a discussion at morning meeting. All department heads and administrative staff on duty, are present at the meeting.</p> <p>Per progress note dated 3/31/15, SS interviewed Resident #2, at which time s/he was informed of the profane/derogatory/belittling conversation that took place between the LNA and Resident #2. SS progress notes detail the conversation. Per progress note dated 4/2/15, SS followed up with Resident #2 and documents, that Resident #2</p>	F 225		

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F 225	Continued From page 5 was asked how the last several days have been going in-light of our conversation dated 3/31/15. Resident responded "things have been going well - no problem". Per facility policy titled Abuse Prevention - 1 b. defines "Verbal Abuse" as any use of oral, written or gestured language that includes disparaging or derogatory terms to residents or their families, or within their hearing distance, to describe residents, regardless of their age or ability to comprehend or disability. Per facility policy titled Abuse Reporting - Identifies all staff members as Mandated Reporters. #1-6 identifies the steps that must take place when an allegation of abuse is suspected. #4 of the Reporting Policy identifies that the Administrator or the Nurse on Call will make an initial report to Adult Protective Services and an internal investigation will be conducted immediately. Per interview with the Licensed Nursing Home Administrator (LNHA) and SS on 5/11/15 at approximately 4:30 PM and on 5/12/15 at approximately 10 AM, confirmation is made that an internal investigation and a report to the licensing agencies did not occur as per policy and/or per regulation. Per interview on 5/12/15 at 3 PM, with the Registered Nurse Clinical Care Coordinator (RN) in the presence of the LNHA, confirmation was made that a report was not made, therefor the internal investigation was not initiated/conducted and that the RN felt that the SS Designee was managing the incident. See also F226.	F 225			
F 226 SS=E	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES	F 226			

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F 226	Continued From page 6 The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on review of the facility's Abuse Prevention Policy, observation of postings in the facility and staff interviews, the facility failed to ensure that 3 of 3 licensed nursing staff (Nurse #1; Nurse #2; Nurse #3) and 1 of 2 Licensed Nurse Aides (LNA) (LNA #2) were knowledgeable of all aspects of the facility's abuse reporting policy including nursing staff's obligation, as mandated reporters, to ensure all allegations of abuse, neglect and/or misappropriation of resident property are reported to the appropriate State Agencies as required. In addition, the facility failed to implement the abuse policy in regards to an allegation of verbal abuse made by Resident #2. Findings include: During the Abuse Prohibition Review 5 direct-care staff and 3 front-line supervisors were interviewed to determine if staff were adequately trained and knowledgeable regarding their role as mandated reporters should their reporting of allegations not be investigated as required. Four of the five members of the nursing staff interviewed were unable to clearly articulate what their obligation is as a mandated reporter and their role in insuring that reported allegations were reported to the appropriate State Agency (SA).	F 226	F226 Resident #2's allegation of verbal abuse was investigated and reported. Policies regarding Abuse Reporting were reviewed and updated as necessary. Clinical Coordinator provided education to all staff regarding Abuse Reporting. DNS or designee will review Abuse Reporting with 5 staff members per quarter to ensure understanding of policy. Resident's Rights and Abuse Prevention and Reporting education will be provided on hire and at least annually. Results will be reported quarterly at QA meetings. DNS to monitor for compliance. <i>F226 POC accepted 6/4/15 mBertrand RN/PMC</i>	5/11/15 5/26/15 5/27/15 Ongoing Ongoing Ongoing	

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F 226	<p>Continued From page 7</p> <ol style="list-style-type: none"> Interview on 5/12/15 at 4:20 PM, Nurse #2 explained the facility's processes for reporting resident abuse allegations. When asked what he/she would do if there was no follow-up investigation of a reported allegation, the nurse stated that: I won't report it to the State Agency. I know some do, but doesn't have time for these calls. During interview on 5/12/15 at 3:15 P.M., Nurse #1 was asked the same question about what he/she would do if there was no facility response to a reported allegation of resident abuse. The nurse indicated that he/she would report the incident to someone else in the facility. When asked if there was still no response, would the nurse report the allegation directly to the SA, the nurse stated: No. Would never do that - call the State. Licensed Nurse Aid (LNA) #2 was interviewed 5/12/15 at 3:30 PM; Nurse #3 was interviewed on 5/13/15 at 8 AM. Both reported that if there was no follow-up to a reported allegation of resident abuse, they would report the allegation to the ombudsman. The facility's Abuse Reporting policy states that all allegations of resident mistreatment, neglect, abuse and misappropriation are immediately reported to the facility and the licensing agency and Adult Protective Services. <p>The procedure clearly states that all staff members of nursing community are mandated reporters. #9 further states: In all instances, and in addition to the above listed steps, any employee has the option of reporting directly to</p>	F 226		

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F 226	<p>Continued From page 8 DAIL.</p> <p>A posting was observed on each unit reminding staff that they are mandated reporters and includes the phone number of the State Agency for reporting any allegations.</p> <p>On 5/13/15 at approximately 10 AM, the Registered Nurse Clinical Care Coordinator was informed that 2 of the 5 nursing staff interviewed did not understand their obligation as mandated reporters; the three nursing staff members who did understand their mandated reporter role, did not know the appropriate State Agency for reporting these allegations and instead would report allegations to the State Ombudsman.</p> <p>5. Per interview on 5/11/15 at 4:17 PM during Stage 1 interview with Resident #2, s/he was asked if staff or anyone else has ever verbally, physically or sexually abused you here at the facility? Resident responded "Yes, verbally". Resident #2 continued to describe a situation that occurred. S/he could not recall the exact date, but did remember it was during the evening shift. The situation was described by the resident as taking place during a conversation with a Licensed Nurses Aide (LNA) in Resident #2's bedroom. The LNA used profanity and addressed the resident in a disparaging/belittling/derogatory manner during the conversation. Resident #2 is able to voice that s/he was very upset stated to the surveyor "I lost my cork" and in an attempt to move my lamp, it broke. Resident #2 is able to state that s/he has not seen the LNA since the incident. When asked if s/he reported the situation s/he stated "Yes to Social Services, s/he works down stairs".</p>	F 226		

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F 226	<p>Continued From page 9</p> <p>Per interview on 5/12/15 confirmation is made with the Social Service Designee (SS) that s/he was made aware of the broken lamp on 3/31/15 during a discussion at morning meeting. All department heads and administrative staff on duty, are present at the meeting.</p> <p>Per progress note dated 3/31/15, SS interviewed Resident #2, at which time s/he was informed of the profane/derogatory/belittling conversation that took place between the LNA and Resident #2. SS progress notes detail the conversation. Per progress note dated 4/2/15, SS followed up with Resident #2 and documents, that Resident #2 was asked how the last several days have been going in-light of our conversation dated 3/31/15. Resident responded "things have been going well - no problem".</p> <p>Per facility policy titled Abuse Prevention - I b. defines "Verbal Abuse" as any use of oral, written or gestured language that includes disparaging or derogatory terms to residents or their families, or within their hearing distance, to describe residents, regardless of their age or ability to comprehend or disability. Per facility policy titled Abuse Reporting - Identifies all staff members as Mandated Reporters. #1-6 identifies the steps that must take place when an allegation of abuse is suspected. #4 of the Reporting Policy identifies that the Administrator or the Nurse on Call will make an initial report to Adult Protective Services and an internal investigation will be conducted immediately.</p> <p>Per interview with the Licensed Nursing Home Administrator (LNHA) and SS on 5/11/15 at approximately 4:30 PM and on 5/12/15 at approximately 10 AM, confirmation is made that</p>	F 226		

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F 226	Continued From page 10 an internal investigation and a report to the licensing agencies did not occur as per policy and/or per regulation. Per interview on 5/12/15 at 3 PM, with the Registered Nurse Clinical Care Coordinator (RN) in the presence of the LNHA, confirmation was made that a report was not made, therefore the internal investigation was not initiated/conducted and that the RN felt that the SS Designee was managing the incident.	F 226	F 281 Resident #48 Medication omission was reviewed with the nurse responsible.	4/25/15	
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility failed to provide services that meet professional standards of quality regarding following physician orders for 1 of 14 residents, Resident #48. Findings include: During record review on 5/12/15 at 8:25 AM, the Medication Administration Record (MAR) showed evidence that Resident #48 on 4/23/15, had not received the application of a physician ordered Exelon 9.5mg/24 hour topical patch that is to applied daily. The dosage was initialed and circled and on the back of the MAR was the explanation that the dose was missed. Per interview with the nurse responsible, on 5/12/15 at 8:25 AM, s/he stated that s/he "just forgot to put it on that day". Reference: Lippincott Manual of Nursing Practice (9th ed.) Wolters Kluwer Health/Lippincott	F 281	Policies regarding medication administration were reviewed and updated. DNS/SDC provided education to all staff involved in medication administration. DNS or designee will audit 5 staff members during medication administration quarterly to ensure competence. Results will be reported quarterly at QA meetings. DNS to monitor for compliance.	6/12/15 6/19/15 Ongoing Ongoing	
			<i>F281 POC accepted 6/4/15 M.Bertrand RN/pmc</i>		

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F 281 F 309 SS=D	<p>Continued From page 11 Williams & Wilkins</p> <p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING</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 observation, interview, and record review the facility failed to provide the necessary care and services to attain and maintain the highest practicable physical, mental, psychosocial well-being for 1 of 14 sampled residents (Resident # 13). Findings include:</p> <p>Per record review, the facility failed to complete Neuro Vital Signs (NVS) following an unwitnessed fall for resident #13. Per nursing note on 5/2/15 the resident was found on the floor by a recliner in his/her room. Per the facility policy/procedure for any fall, accident, or injury to a resident, staff member, or visitor: If a resident struck head, check neuro signs every hour for four hours, then every shift for four shifts. If it is indicated that he/she did not strike head, check for obvious neuro changes such as slurred speech, decreased strength in extremities, or change in mental status. If there is uncertainty as to whether or not resident struck head, assume he/she did.</p>	F 281 F 309	<p>F 309</p> <p>Resident #13 Assessed and remains in usual cognitive state.</p> <p>Policies regarding Assessment following a Fall were reviewed and updated as necessary.</p> <p>DNS/SDC will provide education to all nursing staff regarding Assessment following a fall.</p> <p>DNS or designee will audit 5 resident records each quarter to ensure that assessments are complete.</p> <p>Results will be reported quarterly at QA meetings. DNS to monitor for compliance.</p> <p><i>F309 POC accepted 6/11/15 mbertrand RA/pmc</i></p>	<p>5/12/15</p> <p>6/12/15</p> <p>6/19/15</p> <p>Ongoing</p> <p>Ongoing</p>

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F 309	Continued From page 12 There is no evidence in the clinical record that the NVS were done. Per interview with the Director of Nurses (DNS) on 5/12/15 at 3:59 PM, the DNS stated that the resident's fall on 5/2/15 was unwitnessed. The DNS stated that all unwitnessed falls required that neuro vital signs (NVS) were to be done. The DNS confirmed that there is no evidence in the clinical record that NVS were done as per facility protocol.	F 309	F 315 Resident #2 Bowel and Bladder assessment completed. Bowel and Bladder assessment will be reviewed for all residents to determine candidacy for retraining.	6/12/15 6/12/15
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to ensure that a resident who is incontinent of bladder receives the appropriate treatment to restore as much normal bladder function as possible for 1 of 2 applicable residents in the Stage 2 sample for Resident #2. The findings include the following. Per medical record review, Resident #2 was admitted on 12/16/14, with diagnoses that include Alzheimer's Disease. Physician orders identified an indwelling catheter on admission. 2/11/15	F 315	Policies regarding Bowel and Bladder Assessment and retraining were reviewed and updated as necessary. DNS/SDC will provide education to all nursing staff regarding Bowel and Bladder retraining. DNS or designee will audit 5 resident records each quarter to ensure that assessments are complete. Results will be reported quarterly at QA meetings. DNS to monitor for compliance. <i>F315 POC accepted 6/4/15 MBatrand RN/PMC</i>	6/12/15 6/19/15 Ongoing Ongoing

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F 315	<p>Continued From page 13</p> <p>Physician orders direct staff to discontinue Foley Catheter.</p> <p>Per medical record review for Resident #2, evidences the Minimum Data Set (MDS), which is a comprehensive resident assessment tool, identifies on 1/15/15 Resident #2 has Foley in place. The assessment dated 3/13/15 identifies that there is no longer a Foley in place, there is no toileting program in place and Resident #2 is occasionally incontinent (less then 7 days a week). A 3/26/15 Bowel and Bladder Training assessment identifies a score of 05+ identifying Resident #2 is a good candidate for individual training.</p> <p>Resident Care Plan, updated on 3/24/15 identifies a problem for Urinary Incontinence with a goal of no incontinent episodes for 90 days. Approaches listed are to assist as needed to transfer to commode/toilet/bedpan, transfer stand pivot and assist of one, remind to toilet on rising, before and after meals and before bed assist as needed, provide prompt hygiene in the event of incontinence and to use protective undergarments.</p> <p>Per interview with the MDS Coordinator and the Director of Nurses (DNS) on 5/13/15 at approximately 4:20 PM confirmation is made that there is no definitive bladder training program developed for Resident #2. DNS also confirms that the facility does not have a Policy or Procedure to assist resident in restoring as much normal bladder function as possible.</p>	F 315		
F 325 SS=D	483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE	F 325		

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F 325	<p>Continued From page 14</p> <p>Based on a resident's comprehensive assessment, the facility must ensure that a resident -</p> <p>(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</p> <p>(2) Receives a therapeutic diet when there is a nutritional problem.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review and staff interview, the facility failed to ensure that nutritional status regarding a significant weight loss was identified in a timely manner for 1 of 14 residents sampled (Resident #49). Findings include:</p> <p>Per record review, Resident #49 was admitted on 11/14/14, with a height of 67 inches and weight of 131.2 pounds (lbs.) The Registered Dietician (R.D.) completed an initial assessment of this resident upon admission. Resident #49 experienced a 5.2 lb. weight loss in the first five weeks after admission, the R.D. alerted the physician, and added two types of supplements to the resident's diet. The resident's weight stabilized for a couple of months at around 127 lbs., until there was a documented weight loss of 8 lbs. between 3/6/15 and the following week on 3/13/15, when the weight was 119 lbs. Per further review of the record, there was no evidence that this was noticed by the Licensed Nurses Aide (LNA) who recorded the weight, the R.D., or any of the nursing staff.</p>	F 325	<p>F 325</p> <p>Resident #49 Reviewed by Dietician. 5/18/15 Reviewed by Physician. 5/21/15</p> <p>Weights will be reviewed for all residents to determine any change. 6/12/15</p> <p>Policies regarding Weight Change were reviewed and updated as necessary. 6/12/15</p> <p>DNS/SDC will provide education to all nursing staff regarding Weight Change. 6/19/15</p> <p>DNS or designee will audit 5 resident records each quarter to ensure that changes are reported. Ongoing</p> <p>Results will be reported quarterly at QA meetings. DNS to monitor for compliance. Ongoing</p> <p><i>F325 POC accepted 6/4/15 mBottrand/RN/PM</i></p>	

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F 325	<p>Continued From page 15</p> <p>Per review of the quarterly Minimum Data Set (MDS) and the Dietary Assessments completed at the end of February, the resident at that time was stabilized with the addition of nutritional supplements, and the intervention was recognized as being effective. Both of these quarterly assessments were due to be completed in late May again, when the R.D. would be doing the next review of the resident's weight pattern. Per interview on 5/12/15 at 3:30 PM, the Director of Nursing (DNS) confirmed that the 8 lb. weight loss was documented between 3/6/15 and 3/13/15, and that there was no evidence that nursing was aware of the weight loss. The DNS also confirmed that the LNA staff have been writing the weights directly in the weight record, and so they were responsible for noting weight changes and alerting the nurse.</p> <p>Per the facility policy "Nursing Policy/Procedure-Monitoring Resident Weight", any weight difference of greater than 3 lbs, whether a loss or gain, indicates that the resident will be weighed daily for three days, and the charge nurse and MDS Coordinator will be notified of the weight change. Policy also states that prompt notification to the Medical Doctor (MD) and dietician is the responsibility of nursing staff. Per the DNS, there was no process in place to ensure that the nurses were reviewing the weights recorded by the LNAs, and this weight change was not noticed by the staff.</p>	F 325		
F 329 SS=D	<p>483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS</p> <p>Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including</p>	F 329		

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F 329	<p>Continued From page 16</p> <p>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.</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility failed to insure that 1 of 14 residents, Resident #48, was without unnecessary medications. Findings include:</p> <p>Per review of medical record, Resident #48 had a scopolamine patch applied on 3/10/15 on the day shift and it was removed after the spouse had notified the nursing staff that there was an "odd patch" on him/her. Review of the physician orders presents that the resident does not have an order for scopolamine and per interview with the Director of Nurses (DON), the patch was for another resident and it was incorrectly applied.</p>	F 329	<p>F 329</p> <p>Resident #48 Medication error was reviewed with the nurse responsible.</p> <p>Policies regarding medication administration were reviewed and updated.</p> <p>DNS/SDC provided education to staff involved in medication administration.</p> <p>DNS or designee will audit 5 staff members during medication administration quarterly to ensure competence.</p> <p>Results will be reported quarterly at QA meetings. DNS to monitor for compliance.</p> <p><i>F329 POC accepted 6/4/15 M.Bertrand RN/PMC</i></p>	<p>3/12/15</p> <p>6/12/15</p> <p>6/19/15</p> <p>Ongoing</p> <p>Ongoing</p>

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F 441 SS=E	<p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS</p> <p>The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p>	F 441	<p>F 441</p> <p>Policies regarding infection control and handwashing were reviewed and updated as necessary.</p> <p>DNS/SDC will provide education to staff regarding infection control and handwashing on hire and at least annually.</p> <p>DNS or designee will perform audits of 5 staff members per quarter to ensure that infection control is maintained.</p> <p>Results will be reported quarterly at QA meetings. DNS to monitor for compliance.</p> <p><i>F441 POC accepted 6/4/15 mBertrand RN/PMC</i></p>	<p>6/12/15</p> <p>6/19/15</p> <p>Ongoing</p> <p>Ongoing</p>	

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F 441	<p>Continued From page 18</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, record review and staff interview, the facility failed to follow proper infection control practices to prevent the spread of infection during the medication pass observation of one of three nurses (Nurse #1) observed administering medications.</p> <p>Findings include:</p> <p>During the observation of the medication pass conducted on 5/12/15 at 8 A.M., Nurse #1 failed to follow proper hand hygiene practices when preparing and administering medications to three residents (Resident #12; Resident #20 and Resident #45.)</p> <p>1. After documenting in a resident's medical record, Nurse #1 indicated that he/she was about to start the medication pass. The nurse closed the Medical Record that he/she was documenting in and preceded to unlock the medication cart, opened the Medication Administration (MAR) book and began to pour medication for Resident #45 without washing or using sanitizing hand gel to clean his/her hands. After pouring the medications, the nurse locked the medication cart, and without doing any hand hygiene, proceeded to Resident #45's room and administered the medications. The nurse then proceeded to the Resident's bathroom and washed his/her hands.</p> <p>2. On return to the medication cart, Nurse #1 unlocked the medication cart and proceeded to pour medications for Resident #20. The Resident was to receive 5 oral medications and Cosopt eye drops, one drop (ggt) in each eye. After pouring</p>	F 441		

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F 441	<p>Continued From page 19</p> <p>the medications, the nurse wiped his/her forehead of sweat with the back of a hand, and without any hand hygiene, took the vial of eye medication and the plastic med cup containing the oral medications to the resident's room. The nurse donned one glove and preceded to administer 1 drop of medication in each eye. No tissue was provided to the resident to wipe the excess medication that dripped onto his/her face. The nurse removed the glove, did no hand hygiene and preceded to administer the resident's oral medication. After administering the medications, the nurse went to the bathroom to wash his/her hands.</p> <p>3. On return to the cart, Nurse #1 unlocked the medication cart and preceded to prepare the medications for Resident #12. After pouring two oral medications, Nurse #1 looked at the MAR and was unable to locate the stock medication prescribed for the resident in the medication cart. The nurse indicated to the surveyor that he/she needed to get a bottle of Tylenol from the medication storage room. Nurse #1 then put the plastic cup with the medication in the top drawer of the medication cart and locked the cart. The Nurse then went to the medication storage room on another floor and obtained a bottle of stock Tylenol and returned to the medication cart. Nurse #1 never used hand gel or washed her hands when returning to the medication cart. Nurse #1 then unlocked the cart, removed the med cup containing the Resident's oral medications and proceeded to pour the resident's Tylenol. The nurse next prepared the resident's Spiriva inhaler by removing the resident's inhaler from the medication cart, placed the capsule of medication for the inhaler onto her ungloved hand, and put the capsule into the inhaler. After</p>	F 441		

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F 441	Continued From page 20 wiping his/her forehead of sweat with the back of the hand, the nurse locked the cart, picked up the med cup and inhaler and preceded to the resident's room. The nurse again wiped sweat from his/her forehead after taking the resident's pulse. The nurse did not sanitize or wash the hands until all medications had been administered. During discussion on 5/14/15 at 8:45 AM, Nurse #1 stated he/she realized he/she needed to be more careful with hand hygiene. Interview with the RN Nurse Coordinator on 5/13/15 at approximately 8:45 AM indicated that the nurse had told him about the failure to sanitize and wash his/her hands and inserviced Nurse #1. The facility's Handwashing/Hygiene Policy/Procedure states that among the indications for hand hygiene includes: Before having direct contact with residents; after contact with medical equipment or inanimate objects and after removing gloves.	F 441		
F 465 SS=C	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation and staff confirmation the facility failed to ensure that the facility was	F 465	F 465 Exhaust vents in each resident room cleaned. Vents will be inspected quarterly by the Maintenance Director of his designee, and cleaned as necessary. A record of inspections shall be maintained in the Maintenance Service Log and reported to the Administrator or Director of Nursing in QA meetings quarterly. The plastic cover for the light was repaired on 5/25/15. All other resident night lights were inspected and found to be intact. Inspection of night light covers will be added to the monthly Maintenance rounds checklist and reported in QA meetings quarterly <i>F465 POC accepted 6/4/15 mBertrand PW/pmc</i>	5/15/15 Ongoing Ongoing 5/25/15 5/25/15 Ongoing

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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 C 05/13/2015
NAME OF PROVIDER OR SUPPLIER THOMPSON HOUSE NURSING HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 80 MAPLE STREET BRATTLEBORO, VT 05302		
(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 CORRECTIDN (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 465	<p>Continued From page 21</p> <p>maintained to provide a safe, functional and sanitary environment for staff and the public. The finding include the following:</p> <ol style="list-style-type: none"> 1. Per nursing home tour of both the main floor and upper level on 5/12/15 at approximately 2 PM, in the presence of the Maintenance Director, all resident bathroom intake vents were found to be heavily caked with dust and debris. At the completion of the tour the Maintenance Director confirmed that the vents were heavily caked with dust and debris and have not been cleaned/vacuumed for some time. 2. Per nursing home tour on 5/12/15 at approximately 2 PM, in the presence of the Maintenance Director, Room #112 was found to have a night light (located behind the bedroom door), with a glass face plate cracked and a corner piece of the glass was missing leaving sharp edges exposed. The Maintenance Director confirmed that the glass plate was broken and needed to be replaced. 	F 465		