

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

August 5, 2011

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 **July 6, 2011**. 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
AUG 04 11

PRINTED: 07/22/2011
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 _____	Licensing and Protection (X3) DATE SURVEY COMPLETED C 07/06/2011
--	---	--	---

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 282 SS=D	<p>The Division of Licensing and Protection conducted an unannounced on-site investigation for two complaints on 07/06/11. The following are regulatory findings.</p> <p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</p> <p>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>This REQUIREMENT is not met as evidenced by: Based on staff interview and medical record review, the facility failed to implement the care plan for 1 applicable resident in the sample (Resident #1). The findings include:</p> <p>1. Based on record review and confirmed through interview, Resident #1 did not receive treatment and services according to the written plan of care. Per record review on 07/06/11 at 10:15 AM, the care plan for lack of mobility and pain medication direct staff to follow the bowel protocol. Per the facility's policy:</p> <p>a) If a resident did not have a bowel movement after 6 shifts (3 days) the 3-11 shift nurse would administer Milk of Magnesia (M.O.M). b) If adequate results are not obtained by the following morning, a rectal suppository is to be administered by the 11-7 nurse. c) If adequate results are not obtained a fleets enema will be administered by the 7-3 nurse, with in the first 4 hours of the shift. d) Should adequate results not be obtained after</p>	F 282	<p>All (42) resident care plans were reviewed by DNS to ensure that identified needs are addressed and implemented.</p> <p>Policies regarding care planning were reviewed by DNS and updated as necessary.</p> <p>DNS/SDC provided education to Nursing staff and MDS Coordinator involved in care planning and implementation.</p> <p>DNS or designee will perform audits of 5 resident care plans per quarter to ensure that all identified needs are addressed and implemented.</p> <p>Results will be reported at QA meetings, and the Administrator upon completion. DNS to monitor for compliance.</p> <p><i>F282 POC Accepted 8/14/11 S. Emmons RN / AMcotarn</i></p>	<p>8/3/11</p> <p>8/3/11</p> <p>8/3/11</p> <p>Ongoing</p> <p>Ongoing</p>

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE Administrator	(X6) DATE 8/2/11
---	-------------------------------	----------------------------

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.

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

PRINTED: 07/22/2011
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 07/06/2011
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 282	Continued From page 1 this protocol, assess bowels sounds and notify the physician. Per review of the Medication and Treatment records, the resident did not have a bowel movement from March 31 - April 4 (4 days) before staff disinterred M.O.M. A suppository was administered on 4/5/11 at 10:35 AM, more than three and half hours late. The fleets enema was not administered by the 7-3 nurse but by the evening nurse. The Director of Nursing (DNS) at 3:15 PM confirmed that staff did not implement the care plan for Resident #1.	F 282		
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure that 1 applicable resident with a pressure sore received the necessary treatment and services to prevent pressure sores from developing and to identify pressure sores at an early stage. (Resident #1) Findings include: 1. Per record review on 07/06/11, Resident #1 is at risk for developing pressure sores as per the	F 314	F 314 LNA policy changed by DNS. LNA documentation implemented for daily skin checks and notifications. DNS to review weekly for continued compliance. Skin assessment completed on all Residents by DNS and MDS Coordinator. Policies for skin care updated by DNS. DNS/SDC provided education to staff involved in skin care and documentation regarding policy change and documentation. DNS or designee will perform audits of 5 resident records per quarter to ensure that skin assessments are completed. Results will be reported to Administrator upon completion and Ongoing at QA meetings. DNS to monitor for compliance. <i>F314 PDC Accepted 8/4/11 S. Emmons RN / J. McCormick RN</i>	7/15/11 8/3/11 8/3/11 8/3/11 Ongoing

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

PRINTED: 07/22/2011
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 07/06/2011
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 314	Continued From page 2 care plan dated 1/21/11 for skin- "monitor daily, report changes to nursing immediately, assist with mobility, remind to change position frequently". Resident #1 was sent to the Emergency Room (ER) on 03/31/11 due to a fall and sent back to the facility that same evening. The Emergency Physician Record dated 03/31/11 identified "left hip injury as well as an injury to the back", with the diagram indicating the L-S (lumbar-sacral) spine area. Per record review, there was no skin assessment prior to or after the resident returned from the hospital to address the back wound. Per a nursing note and diagram dated 04/05/11 (6 days later), they noted an open "large area 3.5 cm [centimeters] by 6.5 cm of red area with a 1.5 cm x 3.5 cm of black area in the center". During an interview on 07/06/11 at 11:15 AM, the Unit Manager stated that although the daily skin assessment was signed off as being completed, acknowledged that there was no documentation noting what type of injury to the spine, nor being notified of a pressure ulcer until 04/05/11. The DNS (Director of Nursing Services) confirmed at 3:15 PM that no skin assessment was done after the resident returned from hospital on the March 31, 2011 and stated "after any fall, we should be checking for bruising and that was not documented." The DNS also confirmed that for the skin to have a blackened area would indicate that "the pressure sore was several days old".	F 314			
F 319 SS=D	483.25(f)(1) TX/SVC FOR MENTAL/PSYCHOSOCIAL DIFFICULTIES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who displays mental or psychosocial adjustment	F 319			

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

PRINTED: 07/22/2011
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 07/06/2011
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 319	Continued From page 3 difficulty receives appropriate treatment and services to correct the assessed problem. This REQUIREMENT is not met as evidenced by: Per interview and record review, the facility failed to ensure 1 applicable resident who displays mental or psychosocial adjustment difficulty received appropriate treatment. (Resident #2) Findings include: 1. Per record review, Resident #2's Care Plan included a care area of "difficult interactions with others" and stated that the resident was involved in a resident to resident altercation on April 3, 2011. Per a meeting on 04/05/11, the resident, social service (SS), a family member and the Administrator agreed that a referral to Otter Creek Health Services would be made and the recommendation from the Psychiatrist/Psychologist would be followed. Per review of Resident#2's chart on 07/07/11 there was no documentation that there was a follow up with social service or contacting Otter Creek for a psychiatric appointment. There was no order for a psychiatric consultation, or psychiatric consultation progress notes regarding the incident. In addition, on 07/06/11 at 3:20 PM, the Administrator reported that he spoke with the Psychologist on 07/06/11 earlier in the day and s/he stated that s/he did not have a note on Resident #2 and if the resident was seen, they would have a record of it. On 07/06/11 at 3:20 PM the Administrator confirmed the resident did not receive treatment or services as indicated.	F 319	F 319 Resident #2 referral made to Psych Services. Residents reviewed by DNS And Social Services Director for need for Psych Services referral, implement as necessary. Policy for psych services referrals Reviewed by Administrator And DNS and updated. DNS/SDC provided education to staff involved in referrals, Reviewed weekly by DNS at "Resident at Risk" meeting. DNS or designee will perform audits of 5 resident records per quarter to ensure that identified psych services needs are addressed and implemented. Results will be reported to Administrator At QA meetings. DNS to monitor for compliance.	8/2/11 8/3/11 8/3/11 8/3/11 Ongoing Ongoing

*F319 PDC Accepted 8/4/11
S. Emmons RN / Director*

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER # 475050	MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	DATE SURVEY COMPLETE: 7/6/2011
NAME OF PROVIDER OR SUPPLIER THOMPSON HOUSE NURSING HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 80 MAPLE STREET BRATTLEBORO, VT	
ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES		
F 514	<p>483.75(I)(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: Per interview and record review, the facility failed to maintain complete clinical records for 1 of the applicable residents. (Resident #2) Findings include:</p> <p>1. Per record review on 07/06/11 12:08 P.M., Resident #2's chart did not have Social Service (SS) notes documenting SS meetings/Care Planning (CP) with the resident's family, follow up & post-incident meetings with same, or contacting Otter Creek for a psychiatric appointment, following an incident that occurred in April 2011. There was no order for a psychiatric consultation, or any psychiatric consultation progress notes regarding an incident in resident's chart. In addition, on 07/06/11 at 3:49 P.M. per interview the Director of Nursing Services (DNS) confirmed "the care plan approaches were not dated and and it was not possible to determine if or when any revisions to the Care Plan were made" and that the clinical record was not accurate and complete.</p>		

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

The above isolated deficiencies pose no actual harm to the residents