

(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 226	Continued From page 1 that the employee, now terminated, had worked as an LNA performing direct care to residents for 1 week.	F 226	DNS or designee will perform random audits of 5 staff members per quarter to ensure knowledge of policy is current.	Ongoing
	3. Per record review on 12/2/08, there was evidence of criminal convictions in 4 of the 11 personnel records of staff employed by the facility. Per interview on 12/3/08 at 10:30 AM, the Administrator confirmed that staff were employed by the facility in violation of a Department of Disability, Aging and Independent Living policy that prohibits the employment of individuals, who provide direct care, who have a history of criminal convictions.		Results will be reported at QA meetings. DNS to monitor for compliance.	Ongoing
F 278 SS=B	483.20(g) - (j) RESIDENT ASSESSMENT	F 278	F 278	
	The assessment must accurately reflect the resident's status.		MDS coding requirements have been reviewed with all staff members responsible for coding the MDS.	12/05/08
	A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.		An audit of all resident MDS, RAPs and Care plans was performed to ensure that required records are complete, current and available.	12/05/08
	A registered nurse must sign and certify that the assessment is completed.		DNS or designee will perform audits of 5 resident records per quarter to ensure records are complete, current and available.	Ongoing
	Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.		Results will be reported at QA meetings. DNS to monitor for compliance.	Ongoing
	Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$5,000 for each		DOC accepted 12/26/08 C. Kales R SR	

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

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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 12/03/2008
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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 278	<p>Continued From page 2 assessment.</p> <p>Clinical disagreement does not constitute a material and false statement.</p> <p>This REQUIREMENT is not met as evidenced by: Per observation, interview and review of records, the MDS (Minimum Data Set) did not accurately reflect the resident's status or was incomplete for 8 of 11 residents. (Residents #1, #2, #3, #4, #5, #6 #11, #12) Findings include:</p> <p>1. Per review of records on the three days of survey, Resident #1, #2, #3, #4, #5 and #12 were coded as having side rails used for resident restraint. The Residents were observed during the three days of survey as having 1/2 side rails in use as positioning aids. During an interview with the MDS coordinator on 12/3/08 at 9:30 AM he/she confirmed that the side-rails were not used as a restraint and did not impede the movement of the above residents.</p> <p>2. Per review of the 11/25/08 MDS for Resident #11 on 12/2/08, bathing was coded as having not occurred in the 7 day look-back period. During an interview with the MDS coordinator at 3:30 PM on 12/2/08, the coding was confirmed to be inaccurate as bathing had taken place but had not been captured by the facility's care tracking software used to gather data for the MDS assessment.</p> <p>3. Per records review for Resident #6 on 12/2/08, the Resident Assessment Protocol (RAP) was not available on the unit. At 9:15 AM on 12/2/08, the MDS coordinator generated an unsigned RAP</p>	F 278		
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F 278	Continued From page 3 from the facility's computer. During an interview with the DNS at this time, he/she confirmed that the RAP had never been completed per her own audit of the Resident's record at the departure of the previous MDS coordinator.	F 278	F 282	12/04/08
F 282 SS=D	483.20(k)(3)(ii) COMPREHENSIVE CARE PLANS 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, staff interview and record review, the facility failed to ensure that care was provided in accordance with the comprehensive care plan for 1 of 10 residents in the sample (Resident #5). Findings include: 1. Per observation of the noon meal on 12/1/08 and the morning meal on 12/2/08, Resident #5 did not receive Resource (a nutritional supplement) as indicated on the Resident's care plan. Per record review, on 11/8/08, the Facility Dietician recommended 6 ounces of Resource twice a day with the morning and noon meals. Per review of the Resident's meal "card" with the Food Services Director on 12/2/08, there was no indication that the Resident was to receive Resource. During a 2:00 PM interview on 12/2/08, the Unit Charge Nurse confirmed that the Resident should be getting the Resource as indicated on the care plan.	F 282	Resident # 5 was receiving Resource BID with her medications, as indicated on her MAR. A physician's order was obtained to reflect this and the care plan was updated. DNS or designee will review all resident care plans to ensure that services identified in the residents plan of care are being provided accordingly. DNS or designee will audit 5 resident care plans each quarter to ensure that services identified in the plan of care are being provided accordingly. Results will be reported at QA meetings. DNS to monitor for compliance.	12/29/08 Ongoing Ongoing
F 371	483.35(i) SANITARY CONDITIONS	F 371		

*POC accepted 12/26/08 C. Koes AM
SG*

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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 371 SS=F	<p>Continued From page 4</p> <p>The facility must -</p> <p>(1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and</p> <p>(2) Store, prepare, distribute and serve food under sanitary conditions</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to store perishable food under sanitary conditions. Findings include:</p> <p>1. During a kitchen tour at 11:25 AM on 12/1/08 with the Food Service Director, the following was observed: In the walk-in refrigerator:</p> <p>A plastic bag containing cooked beef was not labeled or dated. 2 plastic containers of cooked pot roast were not labeled or dated. A large piece of pot roast was on a sheet pan without covering, labeling or dating. The sheet pan was had congealed fat and meat juices over the entire surface. A 2 inch hotel pan with cooked stuffing with no label or date</p> <p>In the walk-in freezer</p> <p>5 coffee cups containing ice cream were uncovered with no label or date Cooked roast pork dated 7/3 with torn</p>	F 371	<p>F 371</p> <p>All food items that were not covered, dated or properly stored were discarded.</p> <p>All food service staff have been educated regarding proper dating, labeling and storage of food.</p> <p>AM/PM Cook's checklist updated to include ensuring all food products are properly dated and labeled.</p> <p>Food Service Director will perform 5 audits per quarter to ensure proper dating, labeling and storage of food.</p> <p>Results will be reported at QA meetings. Food Service Director to monitor for compliance.</p> <p><i>PAC accepted 12/26/08 CKao AW</i></p>	<p>12/01/08</p> <p>12/05/08</p> <p>12/24/08</p> <p>Ongoing</p> <p>Ongoing</p>

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F 371	Continued From page 5 plastic wrap, exposing the meat to air and evidence of freezer burn.	F 371		
F 431 SS=E	483.60(b), (d), (e) PHARMACY SERVICES	F 431	F 431	
	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.		All dated medications were checked and discarded if out of date.	12/05/08
	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.		All Hospice medications no longer in use were destroyed and accounted for by 2 RN's.	12/03/08
	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.		Policies for storage of medications , receipt and accounting for Hospice medications and destruction of controlled substances were reviewed and updated as necessary.	12/05/08
	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.		DNS/SDC will provide education to nursing staff regarding storage of medications , receipt and accounting for Hospice medications and destruction of controlled substances.	12/30/08
	This REQUIREMENT is not met as evidenced		DNS or designee will perform audits of medication storage and Hospice medications monthly to ensure proper labeling and destruction.	Ongoing
			Results will be reported at QA meetings. DNS to monitor for compliance.	Ongoing

POC accepted 12/15/08 C. Koepp
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F 431	<p>Continued From page 6</p> <p>by: Based on observation, interview and records review, the facility failed to store medications, including controlled medications, in accordance with accepted professional principles. Findings include:</p> <ol style="list-style-type: none"> 1. Per observation on 12/1/08 at 12:00 PM, the medication refrigerator on the 1st floor of the facility contained 1 vial of tuberculin PPD testing solution labeled " opened 9/18/08 " and " discard within 30 days of opening ". It also contained a vial of Novolin N insulin labeled as opened on 9/11/08 and in current use. Per interview at the time of this observation, the DNS confirmed that both vials were labeled as above and should have been discarded 30 days after opening. 2. During this same observation, 2 single-resident-use medication packs from Hospice containing medications to treat pain and anxiety, including narcotics and other medications with a potential for misuse, were found to be in the possession of the facility 3 and 17 days after the deaths of the respective residents. At this time, the DNS confirmed that the medications could not be returned or used by another resident and should have been destroyed by 2 licensed nurse witnesses after the deaths of the intended recipients. The DNS was unable to identify a timeframe in which this should take place and stated that the facility had no written policy for disposing of Hospice medications. At 10:20 AM on 12/3/08, the two Hospice medications packs noted on the first day of survey were observed intact in the medication refrigerator. This was confirmed by the DNS at the time of this observation and the medications were destroyed and accounted for by two licensed nurses prior to 	F 431		
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F 431	Continued From page 7 exit at the request of this surveyor.	F 431	
F 444 SS=D	483.65(b)(3) PREVENTING SPREAD OF INFECTION	F 444	F 444
	<p>The facility must require staff to wash their hands after each direct resident contact for which handwashing is indicated by accepted professional practice.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility staff failed to use appropriate hand washing techniques to prevent cross-contamination when performing cares during 2 of 2 observations. (Residents #2 and #8) Findings include:</p> <p>1. Per observation at 11:20 AM on 12/2/08, during a dressing change for Resident #2, the facility LPN removed the soiled dressing, performed wound care and redressed the wound without washing or sanitizing his/her hands during 3 glove changes as he/she transitioned between soiled and clean portions of the procedure. This was confirmed in interview with the LPN immediately following the observation.</p> <p>2. Per observation of incontinence care for Resident # 8 at 10:45 AM on 12/2/08, a Licensed Nursing Assistant (LNA) touched a bottle of peri-wash with soiled gloves after cleansing the Resident's perineal area. The LNA then changed gloves without sanitizing his/her hands and proceeded to cleanse the Residents buttocks. Immediately after the observation, the LNA confirmed that he/she touched the peri-wash with soiled gloves and did not sanitize between glove changes.</p>		<p>DNS/SDC will provide staff education regarding appropriate handwashing and glove changing procedures.</p> <p>DNS or designee will conduct 5 random staff audits quarterly to ensure appropriate handwashing and glove changing is occurring. Results will be reported at QA meetings.</p> <p>12/30/08</p> <p>Ongoing</p> <p><i>POC accepted 12/30/08 c/Kals RN/Su</i></p>

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F 514 SS=B	<p>483.75(l)(1) CLINICAL RECORDS</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 review of Resident records on the three days of survey, the facility failed to maintain complete and/or readily accessible records for 3 of 10 Residents. (Residents #4, #5 and #6) Findings include:</p> <p>1. Per records-review for Resident #6 on 12/2/08, the Resident Assessment Protocol (RAP) was not available on the unit. At 9:15 AM on 12/2/08, the MDS coordinator generated an unsigned RAP from the facility's computer. During an interview with the DNS at this time, he/she confirmed that the RAP had never been completed per her own audit of the Resident's record at the departure of the previous MDS coordinator.</p> <p>2. Per record review on 12/1/08, the RAPs from the Minimum Data Set (MDS) dated 11/13/08 and 6/12/08 for Residents # 4 & 5 respectively were not readily available on the unit. The MDS nurse confirmed that they were not on the unit during a</p>	F 514	<p>F 514</p> <p>An audit of all resident MDS, RAPs and Care plans was performed to ensure that all required records are complete, current and available.</p> <p>DNS or designee will perform audits of 5 resident records per quarter to ensure records are complete, current and available.</p> <p>Results will be reported at QA meetings. DNS to monitor for compliance.</p> <p><i>POC accepted 12/26/08 S. Howard J. P. Koehn</i></p>	<p>12/05/08</p> <p>Ongoing</p> <p>Ongoing</p>
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F 514	Continued From page 9 1:00 PM interview.	F 514		