

Division of Licensing and Protection
103 South Main Street, Ladd Hall
Waterbury, VT 05671-2306
<http://www.dail.vermont.gov>
Voice/TTY (802) 871-3317
To Report Adult Abuse: (800) 564-1612
Fax (802) 871-3318

June 4, 2014

Mr. Dane Rank, Administrator
Thompson Residential Home
80 Maple Street Po Box 1117
Brattleboro, VT 05302-1117

Dear Mr. Rank:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **April 30, 2014**. 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

Division of Licensing and Protection

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0156	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	MAY 30 14 Licensing and Protection	(X3) DATE SURVEY COMPLETED 04/30/2014
--	--	--	---------------------------------------	--

NAME OF PROVIDER OR SUPPLIER THOMPSON RESIDENTIAL HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 80 MAPLE STREET PO BOX 1117 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) COMPLETE DATE
R100	Initial Comments: An unannounced on-site survey investigation was completed by the Division of Licensing and Protection on 4/30/2014. There were regulatory findings with this investigation.	R100	R104 5.2.a The admission agreement for Resident #1 was located and placed in the record.	5/1/14
R104 SS=A	V. RESIDENT CARE AND HOME SERVICES 5.1 Admission 5.2.a Prior to or at the time of admission, each resident, and the resident's legal representative if any, shall be provided with a written admission agreement which describes the daily, weekly, or monthly rate to be charged, a description of the services that are covered in the rate, and all other applicable financial issues, including an explanation of the home's policy regarding discharge or transfer when a resident's financial status changes from privately paying to paying with SSI or ACCS benefits. This admission agreement shall specify at least how the following services will be provided, and what additional charges there will be, if any: all personal care services; nursing services; medication management; laundry; transportation; toiletries; and any additional services provided under ACCS or a Medicaid Waiver program. If applicable, the agreement must specify the amount and purpose of any deposit. This agreement must also specify the resident's transfer and discharge rights, including provisions for refunds, and must include a description of the home's personal needs allowance policy. (1) In addition to general resident agreement requirements, agreements for all ACCS participants shall include: the ACCS services, the specific room and board rate,	R104	All records were reviewed to ensure admission agreements are in the record. Audits will be done quarterly to ensure admission agreements are in record. Results will be reported at QA meetings.	5/28/14 Ongoing Ongoing

Division of Licensing and Protection LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE Administrator	(X6) DATE 5/28/14
---	------------------------	----------------------

R104, R228, R134, R135, R136, R141, R145, R170, R171, R173, R179, R185 + R186
 POC's accepted 6/4/14 BBortell RN/pmc

Division of Licensing and Protection

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0156	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 04/30/2014
--	--	--	--

NAME OF PROVIDER OR SUPPLIER THOMPSON RESIDENTIAL HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 80 MAPLE STREET PO BOX 1117 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) COMPLETE DATE
R104	Continued From page 1 the amount of personal needs allowance and the provider's agreement to accept room and board and Medicaid as sole payment. This REQUIREMENT is not met as evidenced by: Based on record review and staff the facility failed to insure that 1 of 5 residents reviewed, or their legal representative, was provided with a written admission agreement prior to or at the time of the admission to the Residential Care Home. The findings include: Review of 5 records presented that 1 of the 5, Resident #1, did not have an admission agreement in the medical record. Per interview with the Registered Nurse (RN) responsible for the oversight of the Residential Care Home (RCH) at 6:25PM, that there was no admission agreement in the record.	R104	R128 5.5.c MAR was reviewed and updated for Resident #1 to include B/P monitoring, and recording of BM. Policies regarding administration and documentation of medications and treatments were reviewed and updated as necessary. DNS or designee to provide education to staff responsible for administration of medications and treatments.	5/19/14 5/19/14 5/28/14 Ongoing
R128 SS=E	V. RESIDENT CARE AND HOME SERVICES 5.5 General Care 5.5.c Each resident's medication, treatment, and dietary services shall be consistent with the physician's orders. This REQUIREMENT is not met as evidenced by: Based on observation, review, and staff interview the facility failed to insure that 2 of 5 residents reviewed in the survey sample had medication services consistent with the physician's orders. Findings include:	R128	Resident MAR's and TAR's will be reviewed quarterly for compliance. Corrective action will be done as needed. Results will be reported a QA meetings.	Ongoing Ongoing

Division of Licensing and Protection

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0156	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 04/30/2014	
NAME OF PROVIDER OR SUPPLIER THOMPSON RESIDENTIAL HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 80 MAPLE STREET PO BOX 1117 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) COMPLETE DATE
R128	<p>Continued From page 2</p> <p>1.) Review of physician orders for Resident #1 presents that resident is to receive Norvasc 2.5mg po every 8 hours as needed (prn) for systolic blood pressure (B/P) over 180 or for diastolic B/P over 100. Per review of the medication administration record (MAR), there is no evidence that Resident #1 has B/P checked every 8 hours. Review of February, March and April 2014 MAR, it is listed to obtain a B/P and pulse weekly on Wednesday on the day shift. In April 2014, there was a B/P obtained on 4/26/14, and no other B/P checks were done. This was confirmed by the LPN at 5:30PM. It was also confirmed by the LPN at this time that there is no physician order to take the B/P only once a week on Wednesday, day shift.</p> <p>2.) During observation of medication pass for Resident #5 at 4:30PM, the LPN prepared Tums 500mg in a medication cup that was separate from the rest of his/her evening medications. Once in the room of Resident #5, the LPN put the medicine cup with the Tums on the night stand. After administration of medications and insulin, the LPN told the resident where the Tums were and left the room. At 5:20PM, after completion of medication observation, this surveyor returned to the room of Resident #5 and the medication cup with the Tums was still on the night stand and the resident was in the dining room finishing the evening meal. The LPN accompanied the surveyor to the room and confirmed that the Tums was still on the night stand and it had been left at the bedside. H/she further confirmed that the resident was in the dining room and was finishing his/her meal. Review of the physician orders with the LPN at 5:28PM, presented that the Tums were to be administered before meals.</p>	R128		

Division of Licensing and Protection

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0156	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/30/2014
--	---	---	---

NAME OF PROVIDER OR SUPPLIER THOMPSON RESIDENTIAL HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 80 MAPLE STREET PO BOX 1117 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) COMPLETE DATE
R128	Continued From page 3 3.) Review of MAR for Resident #1 presents to use Imodium A-D 2mg caplet po as needed for loose stool and maximum dose is 4 doses/day. There is also an entry that resident is not to use Imodium unless bowel movement (BM) loose, document observed stool. Resident #1 also has an order for Imodium 2mg every day at bedtime. Review of physician orders confirms the MAR entries. Per interview with PCA at 5:45PM, there is no recording of the resident's BM. Confirmation was made at 6:25PM by the Licensed Practical Nurse that there is no recording for BMs for the Residential Care Home residents and that the physician order indicates that documentation is to be done.	R128	R134 5.7.a Assessment completed for Resident # 2. All records reviewed to ensure assessments are completed. Audits will be completed quarterly to ensure that assessments are complete. Results will be reported at QA meetings.	5/5/14 5/28/14 Ongoing Ongoing
R134 SS=A	V. RESIDENT CARE AND HOME SERVICES 5.7 Assessment 5.7.a An assessment shall be completed for each resident within 14 days of admission, consistent with the physician's diagnosis and orders, using an assessment instrument provided by the licensing agency. The resident's abilities regarding medication management shall be assessed within 24 hours and nursing delegation implemented, if necessary. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility failed to to complete an assessment for 1 of 5 residents, within 14 days of admission, consistent with the physician's diagnosis and orders, using an assessment instrument provided by the licensing agency. The findings include:	R134		

Division of Licensing and Protection

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0156	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 04/30/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER THOMPSON RESIDENTIAL HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 80 MAPLE STREET PO BOX 1117 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) COMPLETE DATE
R134	Continued From page 4 Resident #2 was admitted to the Residential Care Home (RCH) on 10/23/13 and per review of the medical record, there was no admission assessment completed as of the date of this survey, 4/30/14. Per interview at with the Registered Nurse (RN) responsible for completion 6:55PM, h/she had not completed an admission assessment for Resident #2.	R134	R135 5.7.b Assessment completed for Resident # 2.	5/5/14
R135 SS=A	V. RESIDENT CARE AND HOME SERVICES 5.5 Assessment 5.7.b If a resident requires nursing overview or nursing care, the resident shall be assessed by a licensed nurse within fourteen days of admission to the home or the commencement of nursing services, using an assessment instrument provided by the licensing agency. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to insure that 1 of 5 residents reviewed, were assessed by a licensed nurse within fourteen days of admission to the home or the commencement of nursing services, using an assessment instrument provided by the licensing agency. Findings include: Resident #2 was admitted to the Residential Care Home (RCH) on 10/23/13 and per review of medical record, there was no admission assessment completed as of the date of this survey, 4/30/14. Per interview at with the Registered Nurse (RN) responsible for completion 6:55PM, h/she had not completed an	R135	All records reviewed to ensure assessments are completed. Audits will be completed quarterly to ensure that assessments are complete. Results will be reported at QA meetings.	5/28/14 Ongoing Ongoing

Division of Licensing and Protection

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0156	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 04/30/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER THOMPSON RESIDENTIAL HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 80 MAPLE STREET PO BOX 1117 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) COMPLETE DATE
R135	Continued From page 5 admission assessment for Resident #2.	R135	R104 5.2.a <i>Error fn</i>	
R136 SS=C	V. RESIDENT CARE AND HOME SERVICES 5.7. Assessment 5.7.c Each resident shall also be reassessed annually and at any point in which there is a change in the resident's physical or mental condition. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to insure that 4 of 5 residents reviewed were reassessed annually and at any point in which there is a change in the resident's physical or mental condition. Findings include: 1.) Resident #1 was admitted to the facility 9/11/07 and the last annual assessment was completed by the Registered Nurse(RN) responsible on 4/11/10, which was 4 years prior to this survey. At 6:25PM the RN confirmed that h/she had not completed the annual assessment on Resident #1 per regulation. 2.) Resident #3 was admitted to the facility 7/18/05 and the last annual assessment was completed by the Registered Nurse(RN) responsible on 9/3/10. At 6:25PM the RN confirmed that h/she had not completed the annual assessment on Resident #3 per regulation. 3.) Resident #4 was admitted to the facility	R136	The admission agreement for Resident #1 was located and placed in the record. All records were reviewed to ensure admission agreements are in the record. Audits will be done quarterly to ensure admission agreements are in record. Results will be reported at QA meetings.	5/1/14 5/28/14 Ongoing Ongoing

See next page fn

Division of Licensing and Protection

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0156	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/30/2014
--	--	---	--

NAME OF PROVIDER OR SUPPLIER THOMPSON RESIDENTIAL HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 80 MAPLE STREET PO BOX 1117 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) COMPLETE DATE
R136	Continued From page 6 5/14/08 and the last annual assessment was completed by the Registered Nurse(RN) responsible on 7/29/10. At 6:25PM the RN confirmed that h/she had not completed the annual assessment on Resident #4 per regulation. 4.) Resident #5 was admitted to the facility 5/16/08 and the last annual assessment was completed by the Registered Nurse(RN) responsible on 5/29/10. At 6:25PM the RN confirmed that h/she had not completed the annual assessment on Resident #5 per regulation.	R136	R136 5.7.c Assessments completed for Residents #1, #3, #4, #5. All records reviewed to ensure assessments are completed. Audits will be completed quarterly to ensure that assessments are complete. Results will be reported at QA meetings.	5/16/14 5/28/14 Ongoing Ongoing
R141 SS=E	V. RESIDENT CARE AND HOME SERVICES 5.9 Level of Care and Nursing Services 5.9.a Residents who require more than nursing overview or medication management shall not be retained in a residential care home unless the provisions of the following subsections (i)-(5) are all met: (1) The nursing services required are either: i. Provided fewer than three times per week; or ii. Provided for up to seven days a week for no more than 60 days and the resident's condition is improving during that time and the nursing service provided is limited in nature; or iii. Provided by a Medicare-certified Hospice program; and (2) The home has a registered nurse on staff, or a written agreement with a registered nurse or home health agency, to provide the necessary	R141	R141 5.9.a <i>Mark Malloy, RN, will be responsible for providing the necessary nursing services and delegating related appropriate nursing care to qualified staff.</i>	5/28/14

Division of Licensing and Protection

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0156	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/30/2014
--	--	---	--

NAME OF PROVIDER OR SUPPLIER THOMPSON RESIDENTIAL HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 80 MAPLE STREET PO BOX 1117 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) COMPLETE DATE
R141	<p>Continued From page 7</p> <p>nursing services and to delegate related appropriate nursing care to qualified staff; and</p> <p>(3) The home is able to meet the resident's needs without detracting from services to other residents; and</p> <p>(4) The home has a written policy, explained to prospective residents before or at the time of admission, which explains what nursing care the home provides or arranges for, how it is paid for and under what circumstances the resident will be required to move to another level of care; and</p> <p>(5) Residents receiving such care are fully informed of their options and agree to such care in the residential care home. This REQUIREMENT is not met as evidenced by: Based on staff interview and review the facility failed to insure that residents who require more than nursing overview or medication management shall not be retained in a residential care home unless the provisions of the following subsections (1)-(5) are all met: #3 The home is able to meet the resident's needs without detracting from services to other residents. Findings include:</p> <p>Per interview with the Administrator on 4/30/14 at 1:35PM, h/she stated that there is Registered Nurse (RN) coverage for the Residential Care Home (RCH) and the Director of Nursing (DNS) of the Long Term Care (LTC) facility in which the RCH is housed, stated that h/she is the RN coverage for the RCH. The DNS also stated in a later interview, that h/she is responsible for both the LTC and RCH portion of the facility. The DNS stated that she</p>	R141		

Division of Licensing and Protection

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0156	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/30/2014
--	---	---	---

NAME OF PROVIDER OR SUPPLIER THOMPSON RESIDENTIAL HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 80 MAPLE STREET PO BOX 1117 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) COMPLETE DATE
R141	Continued From page 8 provides 40 plus hours to the LTC as well as whatever is needed for the RCH during the week.	R141	R145 5.9.c (2) Care plans were completed for Residents #1, #2, #3, #4, #5.	5/16/14
R145 SS=C	V. RESIDENT CARE AND HOME SERVICES 5.9.c (2) Oversee development of a written plan of care for each resident that is based on abilities and needs as identified in the resident assessment. A plan of care must describe the care and services necessary to assist the resident to maintain independence and well-being; This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to develop a written plan of care for 5 of the 5 survey sample residents that is based on abilities and needs as identified in the resident assessment. A plan of care must describe the care and services necessary to assist the resident to maintain independence and well-being. Findings include: 1.) Record review of Resident #1, 2, 3, 4 and 5 did not provide evidence of a written care plan that met the most current needs of the resident. Resident #1 last dated care plan was 3/31/08; Resident #2 does not have a care plan and had been admitted to the facility 10/23/13. Resident #3 has a care plan last dated on 8/3/09; Resident #4 last dated care plan was 7/29/10 and Resident #5 was last done on 5/15/08. Per interview with the Registered Nurse at 6:55PM, h/she has not developed care plans nor updated the originals.	R145	All records reviewed to ensure care plans are completed. Audits will be completed quarterly to ensure that care plans are complete. Results will be reported at QA meetings.	5/28/14 Ongoing Ongoing

Division of Licensing and Protection

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0156	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 04/30/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER THOMPSON RESIDENTIAL HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 80 MAPLE STREET PO BOX 1117 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) COMPLETE DATE
R170 R170 SS=D	<p>Continued From page 9</p> <p>V. RESIDENT CARE AND HOME SERVICES</p> <p>5.10 Medication Management</p> <p>5.10.f Residents who are capable of self-administration have the right to purchase and self administer over-the-counter medications. However, the home must make every reasonable effort to be aware of such medications in order to monitor for and educate the residents about possible adverse reactions or interactions with other medications without violating the resident's rights to direct the resident's own care. If a resident's over-the-counter medications use poses a significant threat to the resident's health, staff must notify the physician</p> <p>This REQUIREMENT is not met as evidenced by: Per observation, resident and staff interview and record review, the facility failed to insure that 1 of 5 residents in the survey sample was monitored for self administrations of over-the-counter medications. However, the home must make every reasonable effort to be aware of such medications in order to monitor for and educate the residents about possible adverse reactions or interactions with other medications without violating the resident's rights to direct the resident's own care. If a resident's over-the-counter medications use poses a significant threat to the resident's health, staff must notify the physician. Findings include:</p> <p>On 4/30/14 at 3:30PM, during interview with Resident #3, h/she showed the surveyor medications that h/she keeps in the top drawer of the dresser. These medications included: Sennaside 25mg; Colace 100mg and ASA 81mg.</p>	R170 R170	<p>R170 5.10.f</p> <p>Physicians orders were clarified for Resident #3 medications kept at bedside. Medication Self Administration Assessment was completed.</p> <p>All records reviewed to ensure that orders and assessments are complete for residents who self administer medications.</p> <p>Audits will be completed quarterly to ensure that that orders and assessments are complete for residents who self administer medications.</p> <p>Results will be reported at QA meetings.</p>	5/20/14 5/28/14 Ongoing Ongoing

Division of Licensing and Protection

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0156	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 04/30/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER THOMPSON RESIDENTIAL HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 80 MAPLE STREET PO BOX 1117 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) COMPLETE DATE
R170	Continued From page 10 Resident #3 stated that h/she has a constipation problem and for years has used laxatives. When asked if the staff were aware, h/she stated that h/she will tell the nurse when h/she needs to take the Sennaside, but h/she rarely takes the other medications and h/she likes to have them on hand in case h/she needs them. H/she further stated that h/she takes the Sennaside 4-5 times a week. At 7:00PM per interview with Licensed Practical Nurse (LPN), h/she was not aware of medications in the resident's room. Review of medical record, physician orders, presents Sennaside 25mg 1-2 tabs po daily prn for constipation, may use own. There is no order that resident may keep medications at bedside. Review of documentation on the Medication Administration Record (MAR) does not indicate that the resident has taken the medication. There is no assessment completed for self administration. Per observation of the medication cart, there are no Sennaside 25mg tablets for the resident for the staff to administer. The Registered Nurse stated that a resident may self administer after an assessment is completed and h/she was unaware the resident was taking the medication. Confirmation was made but the LPN at this time, that there is no self administration order, nor is there medication on the cart for staff to provide.	R170		
R171 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.10 Medication Management 5.10.g Homes must establish procedures for documentation sufficient to indicate to the physician, registered nurse, certified manager or representatives of the licensing agency that the	R171		

Division of Licensing and Protection

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0156	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/30/2014
--	---	---	---

NAME OF PROVIDER OR SUPPLIER THOMPSON RESIDENTIAL HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 80 MAPLE STREET PO BOX 1117 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) COMPLETE DATE
R171	<p>Continued From page 11</p> <p>medication regimen as ordered is appropriate and effective. At a minimum, this shall include:</p> <p>(1) Documentation that medications were administered as ordered;</p> <p>(2) All instances of refusal of medications, including the reason why and the actions taken by the home;</p> <p>(3) All PRN medications administered, including the date, time, reason for giving the medication, and the effect;</p> <p>(4) A current list of who is administering medications to residents, including staff to whom a nurse has delegated administration; and</p> <p>(5) For residents receiving psychoactive medications, a record of monitoring for side effects.</p> <p>(6) All incidents of medication errors.</p> <p>This REQUIREMENT is not met as evidenced by: The facility failed to provide documentation for all prn medications that were administered, including the date, time, reason for giving the medication, and the effect for 1 of the 5 residents in the survey sample. Findings include:</p> <p>1.) Per review of the medication administration record (MAR) for Resident #1 h/she had received Tums 2 tabs a total of 4 times, on 4/7/14 (twice) and again on 4/9/14 (twice), with no documentation as to time or reason given. Resident #2 had also, per the MAR, been given Lorazepam 0.25mg po as needed (prn) on 4/26/14 with no documentation as to time or reason given. The nurse confirmed there was no documentation for the medications at 5:30PM on 4/30/14.</p>	R171	<p>R171 5.10.g</p> <p>PRN medication use and documentation reviewed for Resident #1, #2.</p> <p>Policies regarding administration and documentation of medications and treatments were reviewed and updated as necessary.</p> <p>DNS or designee to provide education to staff responsible for administration of medications and treatments.</p> <p>Resident MAR's and TAR's will be reviewed quarterly for compliance. Corrective action will be done as needed.</p> <p>Results will be reported a QA meetings.</p>	<p>5/19/14</p> <p>5/19/14</p> <p>5/28/14</p> <p>Ongoing</p> <p>Ongoing</p>

Division of Licensing and Protection

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0156	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/30/2014
--	--	---	--

NAME OF PROVIDER OR SUPPLIER THOMPSON RESIDENTIAL HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 80 MAPLE STREET PO BOX 1117 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) COMPLETE DATE
R173 R173 SS=D	<p>Continued From page 12</p> <p>V. RESIDENT CARE AND HOME SERVICES</p> <p>5.10 Medication Management</p> <p>5.10.h.</p> <p>(1) Resident medications that the home manages must be stored in locked compartments under proper temperature controls. Only authorized personnel shall have access to the keys</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to insure that resident medications that the home manages were stored in locked compartments under proper temperature controls. Findings include:</p> <p>1.) On 4/30/14 during medication observation, at 4:30PM, the Licensed Practical Nurse (LPN), removed a container, that housed bottles of insulin, from the medication cart. H/she prepared the insulin to be administered to Resident #5, gathered supplies and proceeded to the Resident # 5 room, leaving the container of insulins on top of the medication cart instead of placing the insulin in a locked compartment. The LPN confirmed, at 5:50PM, that h/she had left the container of insulin unsecured on top of the medication cart.</p> <p>2.) The LPN returned to the medication cart and prepared medications for Resident #6, which included insulin. After preparing all medications for Resident #6, h/she proceeded to the room of</p>	R173 R173	<p>R173 5.10.h</p> <p>Policies regarding medication storage were reviewed and updated as needed.</p> <p>DNS or designee to provide education to staff responsible for medication storage.</p> <p>Audits will be completed quarterly for compliance. Corrective action will be done as needed.</p> <p>Results will be reported a QA meetings.</p>	5/19/14 5/28/14 Ongoing Ongoing

Division of Licensing and Protection

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0156	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 04/30/2014
--	--	--	--

NAME OF PROVIDER OR SUPPLIER THOMPSON RESIDENTIAL HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 80 MAPLE STREET PO BOX 1117 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) COMPLETE DATE
R173	Continued From page 13 Resident #6 leaving the container of insulins on top of the medication cart instead of placing the insulin in a locked compartment. The LPN, at 5:50PM, confirmed that h/she had left the container of insulin unsecured on top of the medication and had not secured them in a locked compartment.	R173	R179 5.11.b All PCA staff received training regarding First Aid and Emergency Response. Staff Development policy was reviewed and updated.	5/28/14 5/19/14
R179 SS=C	V. RESIDENT CARE AND HOME SERVICES 5.11 Staff Services 5.11.b The home must ensure that staff demonstrate competency in the skills and techniques they are expected to perform before providing any direct care to residents. There shall be at least twelve (12) hours of training each year for each staff person providing direct care to residents. The training must include, but is not limited to, the following: (1) Resident rights; (2) Fire safety and emergency evacuation; (3) Resident emergency response procedures, such as the Heimlich maneuver, accidents, police or ambulance contact and first aid; (4) Policies and procedures regarding mandatory reports of abuse, neglect and exploitation; (5) Respectful and effective interaction with residents; (6) Infection control measures, including but not limited to, handwashing, handling of linens, maintaining clean environments, blood borne pathogens and universal precautions; and (7) General supervision and care of residents. This REQUIREMENT is not met as evidenced	R179	Audits of Continuing Education hours will be completed quarterly to ensure compliance. Results will be reported at QA meetings.	Ongoing Ongoing

Division of Licensing and Protection

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0156	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 04/30/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER THOMPSON RESIDENTIAL HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 80 MAPLE STREET PO BOX 1117 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) COMPLETE DATE
R179	Continued From page 14 by: Based on review and staff interview, the facility failed to insure that staff demonstrate competency in the skills and techniques they are expected to perform before providing any direct care to residents. Findings include: Review of 5 Personal Care Attendants (PCAs) that work solely for the Residential Care Home presents with no documented evidence that training had been provided in the area of First Aid and Emergency Response. Per interview with the Registered Nurse (RN) at 1:10PM, the staff is expected to call 9-1-1 for emergencies and there are nurses that work RCH and they have all received training as nurses. H/she confirmed that there has been no education provided for PCAs that are assigned to the RCH.	R179	R185 5.12.a The admission agreement for Resident #1 was located and placed in the record. All records were reviewed to ensure admission agreements are in the record. Audits will be done quarterly to ensure admission agreements are in record. Results will be reported at QA meetings.	5/1/14 5/28/14 Ongoing Ongoing
R185 SS=A	V. RESIDENT CARE AND HOME SERVICES 5.8 Records/Reports 5.12.a The licensee shall be responsible for maintaining, filing and submitting all records required by the licensing agency. Such records shall be kept current and available for review at any time by authorized representatives of the licensing agency. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to maintain all records required by the licensing agency. Such records shall be kept current and available for review at any time by authorized representatives of the licensing agency. Findings include:	R185		

Division of Licensing and Protection

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0156	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 04/30/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER THOMPSON RESIDENTIAL HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 80 MAPLE STREET PO BOX 1117 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) COMPLETE DATE
R185	Continued From page 15 Review of 5 records presented that 1 of the 5, Resident #1, did not have an admission agreement in the medical record. Per interview with the Registered Nurse (RN) responsible for the oversight of the Residential Care Home (RCH) at 6:25PM, that there was no admission agreement in the record.	R185	R186H 5.12.b The admission agreement for Resident #1 was located and placed in the record. All records were reviewed to ensure admission agreements are in the record.	5/1/14 5/28/14
R186H SS=A	V. RESIDENT CARE AND HOME SERVICES 5.12 Records/Reports 5.12.b. The following records shall be maintained and kept on file: Based on record review and staff interview, the facility failed to maintain records according to State Regulation. Findings include: Review of 5 records presented that 1 of the 5, Resident #1, did not have an admission agreement in the medical record. Per interview with the Registered Nurse (RN) responsible for the oversight of the Residential Care Home (RCH) at 6:25PM, that there was no admission agreement in the record.	R186H	Audits will be done quarterly to ensure admission agreements are in record. Results will be reported at QA meetings.	Ongoing Ongoing