

AGENCY OF HUMAN SERVICES

DEPARTMENT OF DISABILITIES, AGING AND INDEPENDENT LIVING

Division of Licensing and Protection HC 2 South, 280 State Drive Waterbury, VT 05671-2060 <u>http://www.dail.vermont.gov</u> Survey and Certification Voice/TTY (802) 241-0480 Survey and Certification Fax (802) 241-0343 Survey and Certification Reporting Line: (888) 700-5330 To Report Adult Abuse: (800) 564-1612

February 12, 2020

Mr. Dane Rank, Administrator Thompson House Nursing Home 80 Maple Street Brattleboro, VT 05301

Dear Mr. Rank:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **January 14, 2020.** 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,

Jamila McotaRN

Pamela M. Cota, RN Licensing Chief

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dated 12/27/19, indicated that "assistive devices assigned to the resident were a walker and assisting devices assigned to the resident were a walker and						therapist for highest level of			
assigned to the resident were a walker and admission, quarterly, and upon						function will be completed up	on .	*	
							n		
						any change in condition.			
ORATORY DIRECTOR SOR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	OPATOD	TING TO TO TO TO TO TO TO		ATHER	1 6			(X6) DATE	

hy deficiency statement ending with an asterisk (') denotes a deficiency which the institution may be excused from correcting providing it is determined that her safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days lowing 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 is following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued ogram participation.

		AND HUMAN SERVICES & MEDICAID SERVICES			PRINTED: 01/29/2020 FORM APPROVED OMB NO. 0938-0391	
		(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	A CONTRACTOR CONTRACTOR	TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		475050	B. WING		C 01/14/2020	
	PROVIDER OR SUPPLIER	GHOME		STREET ADDRESS, CITY, STATE, ZIP COD 80 MAPLE STREET BRATTLEBORO, VT 05301		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE COMPLETION	
а 19 ^{– с} 10 – а	LNA, the resident w and only doing part femur on palpation' obtained an order f and knee. A Nurses stated "new order: leg". S/he was trans X-ray and returned fracture. S/he was	ge 1 s "Called into res bathroom by vas complaining of left leg pain ial weight bearing. Pain to left '. On 12/17/19 the nurse or a moble X-ray of left femur s Note dated 12/28/2019 11:44 tranfer to BMH for xray of left sported to the hospital for with the diagnosis of a left hip placed on pallitaive (comfort) the facility on 1/11/2020.	F 6	 89 All Staff inservice held to (of care plans, (2) reporting and (3) standards of care usage. Falls Report updated to in witness statement and rev charge nurse. All Falls Re be reviewed by DNS or de a period of 3 months to de accuracy of reporting and statements. 	changes, in gait belt clude a 01/14/20 view by ports will esignee for etermine	
	interview with the L ambulated Residen every day, but som a wheelchair becau The LNA also state a gait-belt, but s/he not used". Accordin ambulating the resi walker. While enter her/his balance and her/his left side. Th not used a gait-belt	pproximately 2:30 PM, during NA, s/he stated that staff t #1 "with a walker almost e days (Resident #1) required se s/he was too unsteady". d that s/he "usually would use has seen one both used and g to the LNA s/he was dent to her/his room with a ing the room the resident lost I fell to the left, landing on e LNA confirmed that s/he had and that the resident fell, wered to the floor as s/he had		Falls report presented qua QAPI meetings will include with proper use of the new and reporting or witness e Review and modification of process will be completed needed. F669 Pol accepted 2(12)20	e issues and / form, ongoing rrors. of form or as	
	the RN, s/he stated him/her that the res and was lowered to that the resident ha her/him however the her/him at the time a gait-belt is "used to going to the left or r	PM, during an interview with that the LNA had "told ident had become unsteady the floor". The RN confirmed d a gait-belt assigned to ere was no gait-belt on of the fall. The RN stated that to keep the resident from ight" and "a gait-belt can help e floor and prevent further				
ORM CMS-25	37(02-99) Previous Versions	Obsolete Event ID: 15F111		Facility ID: 475050	ontinuation sheet Page 2 of 3	

CENTER	RS FOR MEDICARE	AND HUMAN SERVICES					OMB	ORM APPROVE NO. 0938-039	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 475050				(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3	(X3) DATE SURVEY COMPLETED	
			B. W	B. WING				C 01/14/2020	
NAME OF F	PROVIDER OR SUPPLIER			STR	EET ADDRESS, CITY	STATE, ZIP CO	DE	0111412020	
THOMPS	ON HOUSE NURSIN	G HOME			MAPLE STREET ATTLEBORO, VT	05301			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)		ID REFIX TAG	(EACH CORRE CROSS-REFERE	PLAN OF CORF CTIVE ACTION S NCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETION E DATE	
F 689	Continued From pa	age 2	20 - 20	F 689					
	1/14/20 at 1:20 PM the resident fell rati floor. The DNS con to use a gait-belt w	he Director of Nursing on , s/he had not been aware her than being lowered to th firmed that staff are expect hen assisting a resident wh ce with transfers or	ie ed		• •				
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