Division of Licensing and Protection
HC 2 South, 280 State Drive
Waterbury VT 05671-2060
http://www.dail.vermont.gov
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

May 20, 2020

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

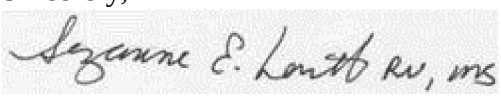
Dear Mr. Rank:

This letter is to follow up regarding the results of the Informal Dispute Review (IDR) conducted by this office on May 19, 2020. You requested an IDR following an Infection Control Survey conducted by staff of this office. An offsite survey was conducted on April 20, 2020, with an onsite conducted on April 23, 2020, that resulted in a determination of a deficiency at F880. Based on a review of the additional information provided, the deficiencies were removed.

Attached is a revised Form 2567.

If you disagree with the above IDR decision, you may pursue further review through the formal federal appeals process, by contacting the Centers for Medicare & Medicaid Services (CMS) Boston Regional Office. Please call if you need an address or phone number.

Sincerely,



Suzanne Leavitt, RN, MS
State Survey Agency Director
Assistant Director, Division of Licensing & Protection

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	475050	A. BUILDING _____ B. WING _____	04/23/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THOMPSON HOUSE NURSING HOME	**80 MAPLE STREET BRATTLEBORO, VT 05301**

(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 An unannounced onsite CMS Focused Infection Control survey was completed by the Division of Licensing and Protection on April 23, 2020, following an offsite review of information on April 20, 2020. The facility was found to be in substantial compliance with requirements around infection prevention and control."	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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.