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

August 23, 2021

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 **July 21, 2021**. 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,

Jamela Mcota RN

Pamela M. Cota, RN Licensing Chief

	ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA ID PLAN OF CORRECTION IDENTIFICATION NUMBER;		A. BUILDING		(X3) DATE SURVEY COMPLETED
A75050 NAME OF PROVIDER OR SUPPLIER THOMPSON HOUSE NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 80 MAPLE STREET BRATTLEBORO, VT 05301	07/21/2021	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCE® TO THE APPROPR DEFICIENCY)	BE COMPLETIO
E 000	An unannounced of Preparedness review 7/20/2021, in conjur re-certification surve	n-site Emergency w was conducted on action with the annual ay by the Division of Licensing are were no regulatory	E 000		k
F 000	deficiencies identifie INITIAL COMMENT	ed.	F 000		
	was conducted by the Protection between	n-site re-certification survey ne Division of Licensing and 7/18/21 - 7/20/21. The team ng regulatory deficiencies.			
F 880 SS=F	Infection Prevention CFR(s): 483.80(a)(1 §483.80 Infection Co The facility must est infection prevention designed to provide comfortable environ	& Control)(2)(4)(e)(f) ablish and maintain an and control program a safe, sanitary and ment and to help prevent the ansmission of communicable	F 880	The facility did have a system to tra trend, and report to QA an infection prevention program at the time of t survey. However the personnel or was unable to access the records a time of the survey. Orientation of staff to the IPCP pro included identification of the location these records in order to demonstr compliance for state and federal ag	n duty at the gram on of ate
	program. The facility must est and control program a minimum, the follo §483.80(a)(1) A syst reporting, investigati and communicable d	prevention and control ablish an infection prevention (IPCP) that must include, at wing elements: em for preventing, identifying, ng, and controlling infections liseases for all residents, tors, and other individuals		Reviewed all IPCP documentation Staff educated to type and location umentation for IPCP program. Current QAPI for laundry had been on July 8th, 2021 and was in proce pertaining to change in staffing of t department and timing of drying we laundry. As a result of that QAPI, s were educated to IPCP regulations load left undone), and staggering s cover drying time for last load of the	of doc- ess he et staff s (no hifts to
	providing services un arrangement based	nder a contractual upon the facility assessment j to §483.70(e) and following		Quarterly reports to QA committee terly to monitor ongoing compliance	quar-

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.

		(X1) PROVIDER/SUPPLIER/CLIA				(X3) DATE SURVEY COMPLETED	
AND PLAN OF	CORRECTION		A. BUILDI	NG_		COMP	LETED
		475050	B. WING			07/21/2021	
NAME OF PROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE			
THOMPSO	N HOUSE NURSING HO	OME		80	MAPLE STREET		
				В	RATTLEBORO, VT 05301		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETIO DATE
F 880			F	880	TAG F 880 POC Accepted on 8/2 by J. Kendall/P. Cota	23/21	
	procedures for the pr	n standards, policies, and ogram, which must include,					
	but are not limited to: (i) A system of survei	illance designed to identify					
	possible communical	1					
	infections before they						
)	persons in the facility						
		m possible incidents of se or infections should be					
	reported;	se of meetions should be					
		nsmission-based precautions					
		vent spread of infections;					
		olation should be used for a					
	resident; including bu (A) The type and dura						
		infectious agent or organism					
	involved, and			1			
	(B) A requirement that	at the isolation should be the					
		ble for the resident under the	ł.				
	circumstances.	a under which the facility					
		s uneer which the facility ees with a communicable					
		kin lesions from direct					
	contact with residents	s or their food, if direct					
	contact will transmit t						
	(vi)The hand hygiene by staff involved in di	procedures to be followed rect resident contact.		1			
		em for recording incidents					
	identified under the fa corrective actions tak						
	§483.80(e) Linens.						
		lle, store, process, and s to prevent the spread of					
	and the second secon						

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CENTER	S FOR MEDICARE &	MEDICAID SERVICES				OMB N	NO. 0938-039
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
475050		B. WING	_	;	07/21/2021		
NAME OF P	ROVIDER OR SUPPLIER			1	STREET ADDRESS, CITY, STATE, ZIP CODE		4. (. 3 . (.)
THOMPSO	ON HOUSE NURSING HO	ME			80 MAPLE STREET BRATTLEBORO, VT 05301		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 880	 §483.80(f) Annual rev The facility will condu IPCP and update their This REQUIREMENT by: Based on observatio review, the facility fail prevention and control system for preventing investigating, and con- communicable disease linens so as to prevent Findings include: 1. Per review of all do the facility's infection program (IPCP), there in the IPCP document historical or ongoing reporting of all actual communicable disease meets the regulation. Per interview with the on 7/20/2021 at appro- confirmed that they con- historical or ongoing in disease surveillance in 12:23 pm, additional co- by the DON. They cor- provide evidence of a and disease data traci- additional documental sufficient to meet the results. 	 view. ct an annual review of its r program, as necessary. is not met as evidenced n, staff interview, and record ed to establish an infection of program that includes a , identifying, reporting, strolling infections and es, as well as process at the spread of infection. bournentation provided for prevention and control e was not sufficient evidence to provided that there is nonitoring, documenting, or infections and es within the facility that Director of Nursing (DON) primately 5:30 pm, they puid not provide evidence of infection and communicable in the IPCP. On 7/22/21 at locumentation was provided for infection ked by the facility. The ion provided was not regulation. 	F	880	0		
		y processing area was first 1 at 3:00 pm. Outside the					

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area, a sign on the locked door stated that the laundry department was open from 6am to 3pm.

Event ID: F76K11

Facility ID: 475050

If continuation sheet Page 3 of 10

		MENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA DEAN OF CORRECTION UMBER:		E CONSTRUCTION	(X3) DATE SURV COMPLETED	
Desite 211/2		475050	B. WING		07/21/2021	
	Rovider or Supplier On House Nursing H	OME		STREET ADDRESS, CITY, STATE, ZIP COD 80 MAPLE STREET BRATTLEBORO, VT 05301	E	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL ELSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETЮ DATE
F 880	staff present. There washing machine co towels, and other re- interface read that If There was also a sm running that contain various cleaning rag minutes left on the co Upon return to the la day at 3:30 pm, the were present, and th contained washed fa washing machine wi minute left in the cyc Upon return to the la day at 4:15 pm, both contained the items No staff were preser Per interview with th and laundry on 7/20, room hours are from is "sometimes" a lau Manager also confirm not daily, practice th member to leave for facility linens prior to sit overnight in the w in the dryer the next also start a load of th cleaning rags after th overnight to be place laundry staff membe Per interview with a 7/20/21 at 12:00 pm, regularly start a load	s were off and there were no was a large industrial ontaining facility stock sheets, usable linens. The machine's his was a completed cycle. haller washing machine ed mop covers and other s that had approximately 30 ycle. Aundry processing area that hights remained off, no staff he large washing machine still acility linens. The small th cleaning rags had one cle. aundry processing area that washing machines still from completed wash cycles, at and the lights were off. e Manager of housekeeping /21 at 11:00 am, the laundry 6am to 2pm daily, and there ndry aide at night. The med that it is a regular, but at the last laundry staff the day will start a load of leaving. Those linens then rashing machine to be placed morning. Housekeeping staff heir mop covers and/or heir shifts that then sit ed in the dryer when the next	F 884) ;lk;lk		

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER		IPLE CONSTRUCTION	(X3) DATE COMF	SURVEY
		475050	B. WING		07/	21/2021
NAME OF PROVIDER OR SUPPLIER THOMPSON HOUSE NURSING HOME			STREET ADDRESS, CITY, STATE 80 MAPLE STREET BRATTLEBORO, VT 05301			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIV CROSS-REFERENCE	AN OF CORRECTION E ACTION SHOULD BE D TO THE APPROPRIATE CIENCY)	(X5) COMPLETIC DATE
F 880	to leaving for the day they regularly come mornings to complet placement in the dry not to leave linen in laundry staff member difficult to process en towels, washcloths, without starting one they leave. Per review of the lau 7/20/21 at approximi- evidence of staff beil evening hours on ma- there were on averag- one scheduled after Leaving wet linens for	y. They also confirmed that in for their shift in the ted wash cycles awaiting ers. They stated that they are the dryers when there is no er working, and it would be nough facility linens (sheets, etc.) for the following day last load in the washer as undry staffing schedules on ately 7:00 pm, there was ng scheduled to work during any days of the week, but ge three days a week with no	F	380		
F 883 SS=D	ventilation creates th and other microorgan killed by the dryer cy linens are used for e facility, this practice l residents. Influenza and Pneum CFR(s); 483,80(d)(1) §483.80(d) Influenza immunizations §483.80(d)(1) Influenza immunizations §483.80(d)(1) Influenza immunizations for and procedu (i) Before offering the each resident or the receives education re	e risk for the growth of mold nisms which may not all be role. Since the reprocessed very resident throughout the has the potential to impact all nococccal Immunizations)(2) a and pneumococcal bza. The facility must develop rres to ensure that- e influenza immunization, resident's representative egarding the benefits and of the immunization;	F	tation. Compliance with educa	compliance with regula- fy other affected resi- n and documentation of viewed and signed by ndardized for immuni- All nurses were educat- r immunization documen-	08/27/21 and ongoing

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CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/02/2021 FORM APPROVED OMB NO: 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION					(X2) MULTIPLE CONSTRUCTION A. BUILDING			
		475050	B. WING			07	/21/2021	
	Novider or supplier	ME		80 MAPI	ADDRESS, CITY, STATE, ZIP CODE LE STREET LEBORO, VT 05301			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE	
	contraindicated or the immunized during this (iii) The resident or the has the opportunity to (iv)The resident's med documentation that in following: (A) That the resident of was provided education and potential side effec- immunization; and (B) That the resident of immunization or did n immunization or did n immunization due to r refusal. §483.80(d)(2) Pneum- must develop policies that- (i) Before offering the immunization, each re- representative receives benefits and potential immunization; (ii) Each resident is of immunization, unless medically contraindica already been immuniz (iii) The resident or the has the opportunity to (iv)The resident's medi- documentation that in- following: (A) That the resident of	 a through March 31 mmunization is medically resident has already been a time period; e resident's representative or resident's representative dicates, at a minimum, the for resident's representative for receive the influenza for receive the resident's es education regarding the side effects of the fered a pneumococcal the immunization is ated or the resident has ted; for resident's representative refuse immunization; and 	F		AG F 883 POC Accepted o J. Kendall/P. Cota	n 8/23/21		

PRINTED: 08/02/2021 FORM APPROVED

CENTERS	FOR MEDICARE &	MEDICAID SERVICES				DINIR NC	0. 0938-039
	DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 · ·		CONSTRUCTION	(X3) DATE COMF	SURVEY
	475050		B. WING	B. WING			21/2021
NAME OF PROVIDER OR SUPPLIER THOMPSON HOUSE NURSING HOME			80	TREET ADDRESS, CITY, STATE, ZIP CODE) MAPLE STREET RATTLEBORO, VT 05301			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
	the pneumococcal im contraindication or rei This REQUIREMENT by: Based on staff interv facility failed to ensum resident representativ regarding the benefits of the pneumococcal medical record includ indicates this education residents (Resident # 1. Per review of Resident for the pneumococcal by Resident #22 for b This is also reflected There was no docume #22's record that educ and potential side effec- immunization was pro- resident representativ Per interview with the 7/20/21 at approximal	either received the mization or did not receive munization due to medical fusal. T is not met as evidenced iew and record review, the e that each resident or ve receives education is and potential side effects immunization and that the es documentation that on was provided for one of 5 22). Findings include: dent #22's record, consent l immunization was refused oth the 1st and 2nd dose. in Resident #22's care plan. ented evidence in Resident cation regarding the benefits ects of the pneumococcal ovided to the resident or a	F	883			
F 887 (SS=D (#22's record regarding mmunization education or a resident represer COVID-19 Immunizat CFR(s): 483.80(d)(3)(g pneumococcal on provided to the Resident ntative. ion i)-(vii)	F		Audited all current resident charts for i munization records for compliance with tory guidelines to identify other affected dents.	regula-	08/27/21 and ongoing
t		0-19 immunizations. The alop and implement policies sure all the following:			Resident #22, education and documer COVID - 19 vaccine reviewed and sign resident.		

					OMB NO. 0938-039 (X3) DATE SURVEY	
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	10		(X3) DATE COMPI	
		475050	B. WING		07/2	21/2021
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS. CITY, STATE, ZIP CODE	And the second second		
THOMPS				80 MAPLE STREET		
THOMPS	ON HOUSE NURSING H			BRATTLEBORO, VT 05301		
(X4) ID PREFIX TAG	(EACH DEFICIENC	IATEMENT OF DEFICIENCIES OY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE
F 887	 (i) When COVID-19 facility, each resident is offered the COVID immunization is med resident or staff men immunized; (ii) Before offering Clamembers are provide regarding the benefit effects associated wit (iii) Before offering Clamembers are provide resident or the resider receives education for risks and potential si the COVID-19 vaccing (iv) In situations whe requires multiple dos resident representation provided with current additional doses. Inc benefits or risks and associated with the COVID-19 vaccine, a ditional doses; (v) The resident, resimember has the opp COVID-19 vaccine, a ditional doses; (v) The resident's me documentation that in the following; (A) That the resident was provided education covided education of the resident; or solve and potential covided and potential covided education of the resident; or the resident;	vaccine is available to the t and staff member I-19 vaccine unless the ically contraindicated or the aber has already been OVID-19 vaccine, all staff ed with education is and risks and potential side ith the vaccine; OVID-19 vaccine, each ent representative egarding the benefits and de effects associated with he; re COVID-19 vaccination les, the resident, ve, or staff member is information regarding those luding any changes in the potential side effects COVID-19 vaccine, before for administration of any dent representative, or staff ortunity to accept or refuse a and change their decision; edical record includes indicates, at a minimum, or resident representative ion regarding the I risks associated with and VID-19 vaccine administered	F 887	 Documentation was standardize ed to new procedure for immunitation. Review of education of residents reviewed quarterly and reported TAG F 887 POC Accepted of by J. Kendall/P. Cota 	s were educat- zation documen- s will be in QA meetings	

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Facility ID: 475050

CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/02/2021 FORM APPROVED OMB NO. 0938-0391

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		475050	B. WING		07/21/2021		
	Rovider or supplier	ME		STREET ADDRESS, CITY, STAT 80 MAPLE STREET BRATTLEBORO, VT 0530			
(X 4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID' PREFI) TAG	(EACH CORRECTI CROSS-REFERENCE	LAN OF CORRECTION VE ACTION SHOULD B ED TO THE APPROPRIA FICIENCY)		(X5) COMPLETION DATE
F 887	to staff COVID-19 vac includes at a minimum (A) That staff were pri- the benefits and poter associated with COVI (B) Staff were offered information on obtain (C) The COVID-19 va- related information as Disease Control and Healthcare Safety Ne This REQUIREMENT by: Based on staff intervi- facility failed to ensur- resident representative regarding the benefits of the COVID-19 vac- record includes docume education was provide (Resident #36). Findin 1. Per review of Resid consent for the COVID by Resident #36, Per Doctor)/NP (Nurse Pr Assistant) Admission state) that (they have) vaccine and does not was no documented of record that education potential side effects of was provided to the re- representative. Per interview with the 7/20/21 at approximate	efusal; and ains documentation related conation that n. the following: ovided education regarding ntial risks ID-19 vaccine; the COVID-19 vaccine or ing COVID-19 vaccine; and accine status of staff and a indicated by the Centers for Prevention's National twork (NHSN). is not met as evidenced iew and record review, the a that each resident or re receives education a and potential side effects bine and that the medical mentation that indicates this ed for one of 5 residents bigs include: dent #36's medical record, D-19 vaccine was refused Resident #36's MD (Medical actitioner)/PA (Physicians note from 7/1/2021, "[they not had a COVID-19 intend to have one." There evidence in Resident #36's regarding the benefits and of the COVID-19 vaccine esident or a resident	F 8				
J 0110-200	7(02-99) Previous Versions Obs	biete Event ID: F76K11		Facility ID: 475050	H COLIUA	Lanon Shee	t Page 9 of 10

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

PRINTED: 08/02/2021 FORM APPROVED OMB NO. 0938-0391

STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		3) DATE SURVEY COMPLETED
		475050	B. WING			07/21/2021
	Rovider or supplier	ME		STREET ADDRESS, CITY, STATE, ZIP 80 MAPLE STREET BRATTLEBORO, VT 05301	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC (DENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 887	#36's record regardin	e 9 In could be found in Resident g COVID-19 vaccination the Resident or a resident	F 84			
EORM CMS 255	7(02-99) Previous Versions Obse	oiete Event ID: F76K1	1	Facility ID:: 475050	If continuetio	on sheet Page 10 of 10