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

October 18, 2022

Ms. Judy Morton, Administrator
Thompson House Nursing Home
80 Maple Street
Brattleboro, VT 05301

Dear Ms. Morton:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on September 14, 2022. 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

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

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 ______	09/14/2022

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
E 000	Initial Comments A review of the facilitiy's Emergency Preparedness plan was conducted in conjunction with the annual recertification survey on September 12 through September 14, 2022. There were no regulatory deficiencies identified as a result of the review.	E 000		
F 000	INITIAL COMMENTS An unannounced onsite recertification survey and review of the staff Covid vaccincation requirment was conducted by the Division of Licensing and Protections September 12 through September 14, 2022. The following regulatory violations were identified:	F 000		
F 656 SS=E	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6).	F 656	It is the practice of this facility to develop and implement a person-centered comprehensive care plan for each resident that includes measurable objectives and time frames to meet resident medical, nursing, and psychosocial needs that are identified in the comprehensive assessment. Care plans are reviewed/initiated and updated by the IDT/Nurse Management team at the time of admission, quarterly, annually, and with change in condition. Resident's #44 and #46 no longer reside at the facility. Residents admitted have the potential to be affected by the alleged deficient practice.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Judith Minton	Administrator	10/17/22

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.

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F 656	Continued From page 1 (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to develop a comprehensive care plan to include measurable objectives and time frames for 3 residents in a sample size of 16 (# 18, 44 and 46). Findings include: 1. Review of medical record for resident # 44, reveals an admission to Thompson House Rehabilitation and Nursing on 06/22/22 due to a fall with a right femur fracture. S/he was discharged on 07/12/22 (21 days) to a Residential Care home. This resident has numerous diagnoses: (not all inclusive) Parkinson's Disease, Insomnia, Irritable Bowel Syndrome, Cataract, Repeated Falls, Anxiety Disorder, Major	F 656	A facility audit will be conducted by the DNS, Care Coordinator, and/or designee. This audit will include review of the resident care plans. This will ensure that needed and required care plans are in place. Care plans will be initiated if indicated, reviewed, and updated to reflect each resident's status. The Interdisciplinary Care Plan team and nursing staff in-service will be conducted on or before 10/12/22. This in-service will include review of the facility policy related to development and implementation of person-centered comprehensive care plans for each resident. Nursing staff will be re-educated on the process of reviewing, updating and following resident care plans as outlined in the comprehensive assessment. Ongoing compliance with this corrective action will be monitored through the QAPI Committee. The DNS/Designee will be responsible for completing the QAPI Audit Tool related to Care Plan Review weekly for 4 weeks and monthly for 3 months. The systemic changes for this alleged deficiency will be completed by 10/14/22.	

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F 656 Continued From page 2

Depressive Disorder, Abnormalities of Gait, Muscle Weakness, Cognitive Communication Deficit, Osteoporosis, Gastro-Esophageal Reflux Disease, and unspecified psychosis.

Present in the record was evidence of an initial comprehensive assessment (06/22/22) which contained general information about the resident. This document is titled Baseline Care Plan v1.0, however there is no comprehensive person-centered care plan developed and implemented within 7 days after completion of the comprehensive assessment. The Comprehensive Care Plan must contain problem areas, goals, in which address the resident's medical, physical, mental, and psychosocial needs and include interventions in which the Interdisciplinary Team reviews and updates quarterly and as needed for any changes. There is evidence of a "Care conference" conducted on 06/28/22.

The Director of Nursing (DON) and Care Coordinator confirms by interview (09/14/22 at 09:20AM) that a comprehensive care plan for resident #44 had not been completed.

2. Review of medical record for resident # 46, reveals an admission to Thompson House Rehabilitation and Nursing on 05/18/22 and was found deceased on 6/26/2022 (40 days). This resident had numerous diagnoses: (not all inclusive) Cerebral Infarction due to Thrombosis, Stenosis of Right Carotid Arteries, Cerebral Edema, Aftercare following Surgery on the Nervous System, Hypertension, Dysphagia, Major Depressive Disorder, Multinodular Goiter, Hemiplegia and Hemiparesis affecting Left Non-Dominant Side, and Gastroenteritis.

F 656

It is the practice of the facility to careplan antipsychotic medications management / monitoring.

Resident #18's careplan was reviewed and Psychotropic Medication careplan was completed on 9/21/22.
Residents prescribed psychotropic medication have the potential to be affected by the alleged deficient practice.
Facility audit of residents receiving psychotropic medication occurred on 10/5/22 and found to be in compliance with psychotropic careplan active.

The Interdisciplinary Care Plan team and nursing staff in- service will be conducted on or before 10/12/22. This in- service will include facility policy and procedure for initiating psychotropic careplan upon initiation of new psychotropic medication.

Ongoing compliance with this corrective action will be monitored through the QAPI Committee. The DNS/ Designee will be responsible for completing the QAPI Audit Tool related to psychotropic care planning weekly for 4 weeks and monthly for 3 months.

The systemic changes for this alleged deficiency will be completed by 10/14/22.

F656 POC accepted 10/18/22 AMC

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F 656	Continued From page 3	F 656		

F 656 Continued From page 3

Present in the record was evidence of an initial comprehensive assessment (05/18/22) which contained general information about the resident. This document is titled Baseline Care Plan v1.0, however there is no comprehensive person-centered care plan developed and implemented within 7 days after completion of the comprehensive assessment. The Comprehensive Care Plan must contain problem areas, goals, in which address the resident's medical, physical, mental, and psychosocial needs and include interventions in which the Interdisciplinary Team reviews and updates quarterly and as needed for any changes. There is evidence of a "Care conference" conducted on 05/26/22.

The Director of Nursing (DON) and Care Coordinator confirms by interview (09/14/22 at 09:20AM) that a comprehensive care plan for resident #46 had not been completed.

3. Per record review, resident #18 was admitted to the facility on 03/08/22 with diagnoses of Delusional disorder, Depression, Schizophrenia, Anxiety disorder and Parkinson's (not all inclusive).

The resident was prescribed Quetiapine (Seroquel) 25 milligrams (mg) twice daily and 75 mg at bedtime. S/he is also prescribed Fluoxetine 40 mg once daily for depression. Both drugs are considered Psychotropic medications. Psychotropic medications alter mood, perceptions, and behavior.

The Minimum Data Set (MDS) is a Federally mandated clinical assessment tool used for long term care residents. The admission MDS had an Assessment Reference Date (ARD) of 04/10/22, Psychotropic medication use was triggered to be care planned as the resident is receiving Seroquel and Fluoxetine.

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F 656	Continued From page 4 On record review it was discovered the resident did not have a comprehensive care plan for Psychotropic drug use. 09/14/22 09:30 AM The Director of Nursing (DON) and Care Coordinator confirms that there is not a care plan for Anti-psychotic medications in the resident's comprehensive care plan,	F 656		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced	F 657	It is the practice of the facility to create and review resident care plans in a timely manner, baseline careplan upon admission, comprehensive careplan within 7 days of admission, careplan updates quarterly, with changes in condition, resident preferences, or identified risks. Resident #22 careplan reviewed and careplan intervention for monitoring s/s of Ativan was discontinued on 9/21/22. Resident #22's careplan was also updated on 9/21/22 to indicate use of a divided plate and can feed herself. Puree meals are served on divided plates at Thompson House to prevent mixing of foods for taste quality. Resident #25's careplan was updated to indicate further fall interventions which had been initiated by the facility at the time of the falls of 8/18/22 and 9/12/22, but were not explicitly in the electronic health record careplan at the time of the survey.	

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F 657	Continued From page 5 by: Based on observation, record review, and interviews, it was determined that the facility failed to update 2 of 12 resident care plans in the survey sample. (Resident #22 and #25) 1. Record review revealed Resident #22's care plan listed a goal of "[proper name omitted]will be free from discomfort or adverse reactions related to anti-anxiety therapy through the review date." Interventions for this goal were as follows: "Educate [proper name omitted]/family/caregivers about risks, benefits and the side effects and/or toxic symptoms of Ativan." This goal was initiated on 08/20/2021 and was revised on 02/17/2022 with a target date of 09/18/2022. Review of the residents Medication Administration Record (MAR) revealed the resident did not have an order for Ativan. Review of all active and discontinued medications revealed an order for Ativan on 9/28/2021, this order was discontinued on 10/05/2021 and was not renewed. This order was discontinued 10/05/2021, prior to the care plan revision of this goal on 02/17/2022. Observation on 9/13/22 at approximately 12:45 PM in the main dining room on the first floor, revealed Resident #22 eating independently and she/he had a high edge/high lipped, divided plate with 3 sections for her/his meal. The resident had a goal listed on her/his care plan as follows: "[proper name omitted] will improve [pronoun omitted] current level of function in ADLs [Activities of Daily Living] and mobility through the review date" and an intervention specific to "EATING" that stated, "[proper name omitted] is dependent on one staff for all meals and drinks". This care plan was initiated on 12/14/2020, it was revised on 12/15/2020, and has a target date of	F 657	All residents have the potential to be affected by the alleged deficient practice. Facility-wide audit of care plans was conducted. Resident care plans were audited and found to be in compliance. The Interdisciplinary Care Plan team and nursing staff in- service will be conducted on or before 10/14/22. This in- service will include facility policy and procedure of timing and revision of resident careplans. Ongoing compliance with this corrective action will be monitored through the QAPI Committee. The DNS/ Designee will be responsible for completing the QAPI Audit Tool related to careplan timing and revision weekly for 4 weeks and monthly for 3 months. The systemic changes for this alleged deficiency will be completed by 10.14.22 F657 POC accepted 10/18/22 AMC	

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F 657	Continued From page 6 9/18/2022. There was no mention in this care plan regarding the residents use of specialty equipment for eating. Interview on 9/13/22 at approximately 2:45 PM with the Director of Nursing (DON), confirmed the above findings and stated the residents care plan should have been updated to reflect Resident #22's care needs accurately. 2. Per record review, resident #25 was admitted to the facility on 01/01/21 with diagnoses of parkinson's disease, unsteadiness on feet, muscle weakness, history of falling and diabetes (not all inclusive). On 09/13/22 1045 am during observation, it was noted the resident suffers from tremors that could increases his/her fall risk. An interview on 9/12/22 at 11:00 AM with the resident reveals s/he had a fall out of his/her bed because s/he was having tremors in his/her lower extremities that caused him/her to slip out of bed to the floor. Per record review it was noted that on 9/12/22 at 0203 AM this resident fell out of bed. It was also documented that the resident also had a fall on 08/18/22 at 14:56 PM from the wheelchair at the nurse's station. Review of the Resident's comprehensive care plan does not reflect any updates or interventions for the 2 falls. Interview on 09/13/22 at 12:38 PM with Director of Nursing confirms that the care plan was not updated after recent falls and that the Care Plan should have been reviewed and updated after falls.	F 657		