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
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 31, 2023

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 recertification survey conducted on **September 20, 2023.** 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

Pamela M. Cota, RN
Licensing Chief

Enclosure

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 ______	09/20/2023

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

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E 000	Initial Comments The Division of Licensing and Protection conducted an unannounced on-site Emergency Preparedness review, in conjunction with the annual re-certification survey from 9/18/23 through 9/20/23 to determine compliance with 42 CFR Part 483 requirements for Long Term Care Facilities. There were no regulatory deficiencies identified.	E 000		
F 000	INITIAL COMMENTS The Division of Licensing and Protection conducted an unannounced, onsite recertification survey from 9/18/23 through 9/20/23 to determine compliance with 42 CFR Part 483 requirements for Long Term Care Facilities. Deficiencies were cited as a result of this survey.	F 000		
F 550 SS=E	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility	F 550	It is the practice of Thompson House to treat residents with dignity and respect. Resident #39, #5, and #28 still reside at the facility and the alleged deficiency was corrected immediately during the survey on 9/20/23. On 9/20/23, verbal education from Director of Nursing to pharmacy and nursing staff during the vaccine clinic that the post-it notes used to indicate the 15-minute monitoring period for signs or symptoms of reaction to vaccine were not to be placed on the residents themselves. This was corrected immediately, was not a regular practice for the facility, and procedure was clarified for future vaccine clinics. Residents participating in vaccine clinics have the potential to be affected by the alleged deficient practice. The DNS or designee will audit future vaccine clinics to ensure pharmacy providers and nursing staff are not placing post-it notes on	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *Judy Morton*
TITLE: *Administrator*
(X6) DATE: *10/25/2023*

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 550	Continued From page 1 must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observations and interviews the facility failed to treat 4 of 24 residents (Residents #39, 5, 28 & 14) with dignity and respect. Findings include: 1. On September 20, 2023, at approximately 10:30 AM the Surveyor walked through the dining/activities room observing a group activity involving several residents. Also in this room, 3 wheelchair-bound residents (Residents # 39, 5, and 28) were noted to each have a yellow 3"x3" post-it note adhered to the front of their clothing. Upon further inspection, each note had what appeared to be a time written (10:32, 10:25, 10:40) on it. The Director of Nursing was consulted at 10:31 AM and stated residents were	F 550	residents. Policy and Procedure has been updated to include instruction on logistics of the 15-minute monitoring during vaccine clinics. Resident #14 still resides at the facility and the proposed deficiency that resident received her meal 10 minutes after the other residents at the table was reviewed. On 9/19/2023, nurse management re-educated dietary and nursing departments on residents sitting at the same table to be served at the same time. Resident #5 still resides at the facility. Nursing and IDT staff, including the business office manager, were educated on the resident's care plan when the alleged deficiency of 9/20/23 was identified. All residents have the potential to be affected by F550. A facility audit will be conducted by the DNS, Administrator, and IDT team. This audit will include Quality of Life rounds to ensure dignified practices are enforced, including but not limited to personal appearance, dining experience, and dignified communication and intervention techniques. The Interdisciplinary team including Director of Nursing will provide Inservice to staff to review the regulations and facility policy related to F550 Resident Rights and Dignity, which will include the aforementioned as well as a focus on residents who are hearing or visually impaired and techniques for dignified communication.	

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F 550	Continued From page 2 being provided with vaccines and these post-it notes indicated when the post-vaccine monitoring could end. The Director of Nursing stated the notes should not be affixed to residents. 2. On September 18, 2023, during observation of lunch service in the dining room, Resident #14 was noted to be seated at a round table with 2 other residents. At 12:25 PM the two diners seated with Resident #14 were provided with meals which they began to eat. At 12:35 PM Resident #14 made eye contact with and motioned for the Surveyor to approach. The Surveyor spoke to Resident #14 who appeared to be non-verbal but tapped on the table where their plate should be. The Surveyor then asked the Registered Nurse where Resident # 14's lunch was, the nurse stated, "That's a good question" and questioned the kitchen staff who passed the lunch out. The kitchen staff informed the nurse the resident had been noted to require increased assistance therefore the resident's lunch had been held back until feeding assistance was available. On September 19, 2023, at 1 PM the Director of Nursing confirmed all residents seated together should be served at the same time. 3. Per observation on 9/20/2023 at 11:40 am, Resident #5 was seen being assisted off the elevator to the basement level of the facility by the Business Office Manager (BOM). The BOM turned the resident in the wheelchair and attempted to wheel her/him backwards off the elevator stating "[s/he] won't pick up [his/her] feet." As the wheelchair started to move, the resident grabbed the hand bar in the elevator. The resident's facial expression was distressed,	F 550	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 Dignity/Resident Rights for 4 weeks and monthly for 3 months and as needed on going. The systemic changes for this alleged deficiency will be completed by 11/1/2023 **Tag F 550 POC accepted on 10/31/23 by D. Hoffman/P. Cota**	

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F 550	Continued From page 3 and he/she was attempting to communicate by making distressed verbal sounds. The BOM stated to the resident "Come on dear let go" and removed the resident's hand from the handrail by pulling her/his fingers off the rail. The BOM then brought the resident out of the elevator backwards. The BOM then turned the resident in a forward-facing position to proceed down the hall. The resident grabbed the handrail in the hall continuing to have a distressed facial expression. Again, the BOM removed the residents' hand from the handrail, making the resident release his/her grasp, stating, "let go dear, we have to go." Per record review Resident #5 has diagnoses that include dementia, anxiety, and is deaf non-speaking. Review of Resident #5's care plan reveals that s/he has a communication problem related to deafness, non-speaking, impaired vision, and cognitive decline. Care plan interventions reveal that the resident can understand and communicate by lip reading, writing, communication board, gestures, sign language, and translator. Further interventions include face when speaking and make eye contact. At no time during the interaction between the BOM and Resident #5 was the BOM observed to be communicating with the resident by sign language, nor was s/he facing the resident when speaking to ensure that the Resident could read her/his lips. On 09/20/23 at 11:50 am the Director of Nurses (DON) and the facility Administrator, were informed of the interaction that was witnessed between the BOM and the resident. The DON revealed resident #5 is deaf and communicates only through sign language and lip reading. The	F 550		

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F 550	Continued From page 4 DON and Administrator both confirmed that the interaction between the BOM and Resident #5 should not have happened in this manner.	F 550		
F 585 SS=F	Grievances CFR(s): 483.10(j)(1)-(4) §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay. §483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph. §483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident. §483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include: (i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file	F 585	It is the practice of Thompson House to track and document conclusions to grievances, including steps taken to investigate, summary of findings, confirmation, and corrective action with dates that written decisions were issued. All residents have the potential to be affected by the alleged deficiency. On 9/20/2023 Grievance Form locations were audited by the administrator, and the sign which had fallen off one location was reaffixed. Administrator audited Grievance Log and obtained documented resolution which had been completed at the time of the grievance. On 9/26/2023 the Administrator provided education to the interdisciplinary team on the regulations and facility process and procedure for Grievances, including but not limited to ensuring completed grievance investigations are promptly given back to the administrator for tracking purposes. The Interdisciplinary team including Director of Nursing will provide Inservice to staff to review the regulations and facility policy related to F585 Grievances.	

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F 585	Continued From page 5 grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system; (ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations; (iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated; (iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law; (v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance,	F 585	Ongoing compliance with this corrective action will be monitored through the QAPI committee. Administrator will be responsible for completing the QAPI Audit Tool related to Grievances monthly for 3 months. Grievance Review is a topic discussed Quarterly in QAPI committee on going and will continue to be reviewed Quarterly after the aforementioned POC audit period. Staff are and will continue to be educated on Grievances upon hire, annually, and as needed to ensure ongoing compliance. The systemic changes for this alleged deficiency will be completed by 11/1/2023. **Tag F 585 POC accepted on 10/31/23 by D. Hoffman/P. Cota**	

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F 585	Continued From page 6	F 585		

the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued;
(vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and
(vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision.
This REQUIREMENT is not met as evidenced by:
Based on observation, interview, and record review the facility failed to ensure that all grievances were tracked through to their conclusion by failing to document all decisions including steps taken to investigate the grievance, a summary of the pertinent findings or conclusions, whether the grievance was confirmed or not confirmed, and any corrective action taken or to be taken, and the date the written decision was issued.

During observations on the second floor on 9/18/2023 at 1:00 PM there was a clear file holder containing a stack of papers that was affixed to the wall diagonally across the nurses station. Review of the papers in the holder revealed that they were Concern Forms that are intended to be used to file grievances. The provided contact

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F 585	Continued From page 7 information for the grievance officer included the name of the past Administrator, and there was no identifying information to indicate to residents and others that the Concern Forms were available in the holder. Per observation of the first floor on 9/20/2023 at 10:30 AM there was a file holder containing a manilla folder with papers in it affixed to the wall between the elevator and the Administrators office. Review of the papers revealed that they were Concern Forms. These forms did have the current Administrator's name and contact information however, there was no signage or writing on the folder to alert residents that there were Concern Forms available in the folder. Review of the Grievance Log and Grievances filed revealed that nine grievances filed since January of 2023 did not have documented action taken or the date they were resolved. During interview on 9/20/2023 at 1:16 PM with the administrator and director of nursing the administrator confirmed that the grievance forms did not have evidence that the grievances were acted on or the date they were resolved. At approximately 2:20 PM the DNS did provide email documentation of the actions taken however, this had not been tracked through the grievance process, and there was no documentation regarding written responses to these grievances.	F 585		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must -	F 812		

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F 812	Continued From page 8 §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observations the facility failed to store food in accordance with professional standards. Findings include: On September 20, 2023, at approximately 1PM during a tour of the dry food storage area with the Food Service Manager and Regional Food Service Director, the following observations were made: In the corners of shelves holding both bags and cans of food, there are accumulations of dried white, brown, and black debris, it is not possible to identify or rule out insect or rodent droppings in this debris. On another shelf there was a large bag (50 lbs.) of semolina that had the corner taped closed. Upon closer review it was noted the tape was not firmly adhered leaving the contents accessible.	F 812	It is the practice of Thompson House to store food in accordance with professional standards. On 9/20/23, the alleged deficiency was immediately corrected. Food storage surfaces and food items have the potential to be affected by the alleged deficiency. On 9/21/23, further auditing of facility food storage shelving ensued and no further accumulation of debris noted. The large 50 pound bag was corn meal. Dried food such as corn meal are stored in sealable bins. The Regional Dietary Manager and Maintenance director will educate contracted and facility staff on regulations, policy, and procedure of F812. Food storage area was relocated to the middle level adjacent to the kitchen. Excess equipment, emergency water supply and paper products will remain in the current storage location. Ongoing compliance with this corrective action will be monitored through the QAPI Committee. The Maintenance Director or designee will be responsible for completing the QAPI Audit Tool related to F812 for 4 weeks and monthly for 3 months and as needed on going to ensure compliance. The systemic changes for this alleged deficiency will be completed by 11/1/23. **Tag F 812 POC accepted on 10/31/23 by D. Hoffman/P. Cota**	

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F 812	Continued From page 9 The Kitchen Manager and Regional Director noted they did not know the composition of the debris, and acknowledged the semolina bag was not sealed.	F 812		