

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

November 15, 2018

Mr. Dane Rank, Manager Thompson Residential 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 **October 16, 2018.** 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

PamlaM Cota RN

Disability and Aging Services Licensing and Protection

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED C 10/15/2018	
NAME OF P	ROVIDER OR SUPPLIER	and the state of t	DDREŚS, CITY,	B. WING		
THOMPS	ON RESIDENTIAL H	ORAC	E STREET BORO, VT	05301		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	SHOULD BE COMPLETE	
R100 Initial Comments:		R100				
and different management of the second managem	conducted by the D Protection on 10/10 complaint investigate regarding the comp	in-site re-licensure survey was Division of Licensing and 6/18 in conjunction with a ation. There were no findings plaint and the following s a result of the survey.	*			
R:104 SS=C		REAND HOME SERVICES	R104	All Resident admission agr were reviewed to identify o affected residents.		
	5.1 Admission 5.2.a Prior to or at the time of admission, each resident, and the resident's legal representative if any, shall be provided with a written admission agreement which describes the daily, weekly, or monthly rate to be charged, a description of the services that are covered in the rate, and all other		and the state of t	Residents identified during view were given a copy of admission agreement, which includes resident rights during transfer or discharge, and to sign for receipt.	the ch ring	
	explanation of the discharge or trans status changes fro with SSI or ACCS	Il issues, including an home's policy regarding fer when a resident's financial om privately paying to paying benefits. This admission		Social Services, or designer review the resident charts to insure inclusion of evide receipt of admission agree	quarterly and ence of ongoing	
	services will be pro charges there will services; nursing s management, laur	pecify at least how the following ovided, and what additional be, if any: all personal care services; medication dry; transportation; toiletries; services provided under ACCS		Any omissions will be repo the Manager quarterly for t	follow-up. and ongoing	
	or a Medicaid Wai agreement must s of any deposit. The the resident's tran- including provision	ver program. If applicable, the pecify the amount and purpose his agreement must also specifiser and discharge rights, as for refunds, and must include home's personal needs	y y	R104 POCALLER 11/4/18 B, Bort	eller/s.leng	
	(1) In addition to grequirements, agn	general resident agreement eements for all ACCS				

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(XO) DATE

If continuation sheet 1 of 2

STATE FORM

6809

6ZN011

PRINTED: 10/23/2018 FORM APPROVED

Division	of Licensing and Pro	tection		W 2		
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION .	(X3) DATE COMP	SURVEY LETED
		0156	B. WING		10/1	6/2018
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
THOMPS	SON RESIDENTIAL H	OME 80 MAPLE	2347 247 17			x ii
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC (DENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	ED 8E	(X5) COMPLETE DATE
R104	Continued From pa	ge 1	R104			
	the amount of pers	shall include: the specific room and board rate, onal needs allowance and the nt to accept room and board le payment.		,		,
	by: Based on staff inter facility failed to incli discharge rights in	NT is not met as evidenced view and record review, the ude the resident's transfer and the admission agreement for 3 e sample, Resident #1, 2 and c.				
	there was no evide agreement includes transfer and discha made by the house on 10/16/18 at 2:40 transfer and discha and if the need aris	w for Residents #1, 2 and 3, nee that the admission information regarding rge rights. Confirmation was manager during an interview PM, s/he stated that the rge rights are given separately es and further stated that it is mission agreement.				
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