VERMONT

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

January 30, 2025

Ms. Tara Pratt, Administrator
Thompson House Nursing Home
80 Maple Street
Brattleboro, VT 05301

Dear Ms. Pratt:

Enclosed is a copy of your acceptable plans of correction for the recertification survey conducted on **January 8, 2025.** 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, BS
Assistant Division Director
State Survey Agency Director

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 ______	C 01/08/2025

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 The Division of Licensing and Protection conducted an emergency preparedness review during the annual recertification survey on 1/8/25. There were no regulatory deficiancies identified.	E 000		
F 000	INITIAL COMMENTS The Division of Licensing and Protection conducted an unannounced, onsite recertification survey, one FRI (Facility Reported Incident) investigation (ACTS #23248), and one complaint investigation (ACTS #22915) from 1/6/2025 through 1/8/2025 to determine compliance with 42 CFR Part 483 requirements for Long Term Care Facilities. The following deficiency was identified:	F 000		
F 689 SS=E	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure each resident remains as free of accident hazards as is possible regarding reviewing interventions for effectiveness and attempting new Care Plan interventions to prevent falls for residents identified as fall risks for 3 residents [Res. #29, #6 #7] of 18 sampled residents. Findings include:	F 689	See attached **Tag F 689 POC accepted on 1/30/25 by C. Howard/S. Stem**	

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

TITLE Administrator

(X6) DATE 1/27/25

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 689	Continued From page 1	F 689		

1.) Per record review, Res.#29 was admitted to the facility with diagnoses that include dementia with mood disturbance and generalized muscle weakness. The resident's Care Plan identified the resident as "at risk for falls and falls with injury related to deconditioning, gait/balance problems, vision/hearing problems and use of assistive devices (rolling walker), and muscle weakness". Res.#29's Care Plan also assessed the resident as having "impaired cognitive function related to dementia" and "has limited physical mobility related to weakness, deconditioning and natural aging."

Per review of Progress Notes for Res.#29 dated 12/15/24, the resident suffered an "unwitnessed fall. Patient reports putting [h/her] arm out" and has a "Laceration/skin tear of left forearm." Further review of Progress Notes for Res.#29 dated 11/17/24 reveal a staff member "saw this patient standing and going sideways. Writer runs to [h/her] side and catches [h/her] from hitting the floor."

Per review of the facility's 'Nursing Policy/Procedure: Fall Prevention' [revised 5/10/22]: "If falling recurs despite initial interventions, staff will implement additional or different interventions."

Review of Res.#29's Care Plan revealed no new interventions to prevent future falls after both the fall on 11/17/24 and the fall on 12/15/24 which resulted in a laceration on the resident's arm.

Further record review revealed on 1/2/25 "This patient was noted to be laying on the floor next to [h/her] bed on the window side. Patient noted to

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F 689	Continued From page 2	F 689		

have 2 skin tears: one on [h/her] forehead and one on the bridge of [h/her] nose."

An interview was conducted with the Director of Nursing [DON] on 1/8/25 at 9:30 AM. The DON confirmed the resident suffered a fall on 11/17/24 and no new interventions were added to prevent future falls. With no new interventions in place, The DON confirmed the resident fell again on 12/15/24, resulting in a laceration on the resident's arm. The DON confirmed again that after 12/15/24 no new interventions were added to prevent future falls, and the resident suffered another fall on 1/2/25 resulting in 2 skin tears: one on [h/her] forehead and one on the bridge of [h/her] nose.
2) Per record review, Resident # 6 was admitted to the facility with diagnoses that include dementia, anxiety, diabetes, and peripheral vascular disease (a progressive disorder of the blood vessels causing a decrease in healthy function; legs and feet are most often affected).

The resident's Care Plan identified the resident as "a high risk for falls related to gait balance problems, deconditioning, unaware of safety needs." Additionally, the Care Plan assessed Resident # 6 as having "impaired cognitive function related to dementia."

Per review of the progress note dated 8/8/24, Resident #6 suffered a witnessed fall where s/he reached for an item on the table and fell forward from the wheelchair, hitting his/her nose. A second note progress note entered on 8/8/24 indicates that Resident #6 was sent to the Emergency Department to evaluate a nosebleed that would not stop. The Emergency Department note revealed a broken finger on his/her left hand

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

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F 689	Continued From page 3 and a skin tear on his/her left wrist A review of a progress note on 12/31/24 indicates that Resident #6 had an unwitnessed fall, sliding down on his/her bed and landing on his/her knees on the floor A review of Resident #6's care plan revealed no new interventions to prevent future falls after either of the falls on 12/31/24 or 8/8/24 Per interview with the Director of Nursing (DON) on 1/8/2024 at approximately 10 30 AM, s/he confirmed that Resident #6 suffered a fall on 8/8/24 resulting in injuries, and no new interventions were added to prevent future falls The DON confirmed that the resident suffered a second fall on 12/31/24, and no new interventions were added to the care plan to prevent future falls 3) Per record review, Resident #7 who has diagnoses that include obstructive hydrocephalus (excessive fluid buildup in the brain) with significant muscle weakness and contractures, unspecified convulsions, and cerebral palsy (a group of disorders that affect movement , muscle tone, or posture) was found to be at a high risk for falls on 1/15/2016 per their care plan According to Resident #7's MDS (Minimum Data Set, a comprehensive assessment used as a care-planning tool) dated 5/1/24 Resident #7 is fully dependent on staff for all positioning and mobility and is unable to go from a lying to a sitting position without staff assistance According to nursing notes dated 4/8/24 "[Resident #7] was found on floor apparent fall was unwitnessed Patient head on floor and lower	F 689		

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F 689	Continued From page 4 body on bed. Patient was moaning." Per record review, there is no evidence of interventions or care plan updates to prevent future falls after the fall. On 11/5/24 Resident #7 fell out of the bed again. The following nursing note dated 11/5/24 states "This nurse entered the room and observed resident on the floor ..." There is no evidence of care plan updates or fall interventions to prevent future falls after the second fall on 11/5/24. Per interview with the Director of Nursing [DON] on 1/8/25 at 9:30 AM, the DON confirmed that care plan updates were not made after Resident #7's fall on 4/8/24 or 11/5/24 as they should have been per facility protocol.	F 689		

Plan of Correction:
Thompson House Nursing Home
80 Maple St, Brattleboro VT
Submitted By: Tara Pratt, Administrator

It is the policy of Thompson House to maintain compliance with F 689: Free of Accidents/ Hazards/ Supervision/ Devices. Residents who experience falls have the potential to be impacted by delayed care plan updates.

Corrective Action:
Immediate corrective action was taken to update care plans that were delayed. The Director of Nursing will oversee this process to ensure care plans are current and reflect the necessary interventions to prevent accidents.

Systematic Change:
Nursing staff involved with care plan updates have been re-educated on the importance of timely care plan updates, specifically focusing on accident and hazard prevention. This education will include the process for identifying and documenting necessary changes in care plans.

Measure of Success:
The Director of Nursing will conduct audits on the Risk Management System weekly for one month and monthly for two additional months to ensure timely updates. Audit results will be forwarded to the Quality Assurance and Process Improvement (QAPI) committee for review and recommendations.

Compliance date: 01/31/25