VERMONT

Department of Disabilities, Aging and Independent Living
Division of Licensing and Protection
280 State Drive/HC 2 South
Waterbury, VT 05671-2060
www.dlp.vermont.gov

[phone] 802-241-0344
[fax] 802-241-0343

AGENCY OF HUMAN SERVICES

February 17, 2026

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

Provider ID #: 475050

Dear Ms. Pratt:

Enclosed is a copy of your acceptable revised plans of correction post IDR for the complaint investigation conducted on **December 9, 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 CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	475050	A. BUILDING B. WING	**12/09/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Thompson House Nursing Home	**80 Maple Street , Brattleboro, Vermont, 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
F0000	INITIAL COMMENTS An unannounced onsite investigation of complaint #2669621 was completed by the Division of Licensing and Protection on 11/24/25, 12/1/25, 12/8/25, and 12/9/25 to determine compliance with 42 CFR Part 483 requirements for Long Term Care Facilities. Offsite record review was completed from 11/24/25 through 12/9/25. On 12/3/25, the survey team identified and notified the facility of deficiencies at the Immediate Jeopardy (IJ) level for F656, F689, and F919, related to violations around call light effectively working, accidents and hazards, resident supervision, and care plan interventions, which resulted in Resident #1's death. The facility had a census of 41 at the time of the survey. This IJ determination also resulted in substandard quality of care. An unannounced onsite assessment of IJ removal and extended survey was conducted on 12/8/25 and 12/9/25. The facility had completed sufficient corrective actions to remove the Immediate Jeopardy for F656, F689, and F919 but the non-compliance with requirements at F656, F689, and F919 remains. The facility removed the immediate jeopardy of F656 and F689 by reviewing all residents who were on hourly checks, updated their interventions, provided education to nursing leadership on care plan interventions, providing education to nursing staff on how to access resident care plans, implementing a policy on supervision, added a process to document on motion sensors and ensure they are functioning appropriately, and call bell audits of all rooms were completed and motion sensors, which was completed on 12/9/25. For F919, they removed the immediacy by providing maintenance to the call light system and providing education to nursing staff which was completed on 12/3/25.	F0000		
F0656 SS = J	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §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	F0656	This Plan of Correction is submitted in order to comply with federal and state requirements and to demonstrate the Facility's ongoing commitment to quality improvement. The Facility's completion of this Plan of Correction does not constitute an admission of the facts or findings alleged in the Statement of Deficiencies, nor an admission that the cited findings meet the elements of noncompliance under applicable regulations.	01/07/2026

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 reverse for further 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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Tara Wright	Administrator	02/17/26

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 475050	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 12/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Thompson House Nursing Home	**80 Maple Street , Brattleboro, Vermont, 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
F0656 SS = J	Continued from page 1 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). (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. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is NOT MET as evidenced by: Based on interview and record review, the facility failed to implement a comprehensive care plan to ensure the safety and well-being of 3 of 4 residents (Residents #1, #2, and #3). For Resident #1, the facility failed to provide required hourly safety	F0656	Any corrective actions described are undertaken to promote resident safety and regulatory compliance prospectively and are not to be construed as agreement with the characterization, scope, or severity of the survey findings. *While the Facility does not agree with all aspects of the survey findings for this tag, the Facility has implemented the following actions to ensure continued compliance with §483.21.* *The Facility conducted a focused review of fall-prevention interventions, including room motion sensors and Q1 hour checks, and determined these were not effective in preventing falls and would no longer be used as routine, standalone fall prevention interventions.* **Residents Affected and Identification of Others / Systemic Review** *For residents with motion sensors in place at the time of the review, the Facility reassessed fall risk, prior fall history, transfer status, and current functional abilities, and updated each care plan to reflect individualized, evidence-based fall prevention interventions instead of default use of sensors.* • *Residents #1 and #2 were no longer residing in the Facility due to death; their records were closed and thus were not candidates for care plan revision.* • *Resident #3's motion sensor was discontinued at his/her request after review of his/her lack of falls since 10/31/25 and his/her report that frequent sensor activations were disruptive; the medical record reflects his/her preference, the education provided on risks/benefits, and alternative interventions to monitor safety.* • *Resident #4's motion sensor was continued ("grandfathered") at the family's request to assist with staff awareness when s/he is awake or attempting to get up; the Facility educated the family that the device is primarily a movement notification tool and not a proven fall prevention intervention, and this discussion and the resident/family preference are documented in the medical record.* • *For three additional residents with sensors in place, the team reviewed fall history, current transfer practices, and resident/family preferences; sensors were removed when residents no longer attempted unsafe self-transfers and had no recent falls, with consent and education documented in their medical records*	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 475050	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 12/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Thompson House Nursing Home	**80 Maple Street , Brattleboro, Vermont, 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
F0656 SS = J	Continued from page 2 rounds. The facility failed to ensure a functioning motion sensor was used as planned for a resident at high risk of falls. Specifically, Resident #1—who had received laxatives, was non-ambulatory, and required maximal assistance for toileting—was found deceased on the floor with a detached call light and feces present, after nursing staff failed to monitor the resident according to the established fall-prevention interventions. These failures resulted in an Immediate Jeopardy due to the outcome of death for Resident #1. Findings include: 1. There was no evidence documented in the medical record that Resident #1 was receiving hourly rounding consistently, every hour, or had toileting hygiene completed since 11/7/25 at 14:59 PM. Resident #1 had been given scheduled Senna Docusate Sodium Oral tablet 8.6-50 MG “Give 2 tablet by mouth every morning and at bedtime for bowel management” with a start date of 10/09/25 (a medication used to help alleviate constipation) on 11/7/25 at 9:00 AM and again at 9:00 PM. Additionally, Resident #1 was given a PRN Senna Tablet 8.6 MG with a start date of 12/13/24.“Give 2 tablet by mouth as needed for constipation give 2 tablets = total dose of 17.2 mg for constipation. Bowel Protocol step 1, PRN for no BM in 72 hours.” The PRN was given on 11/7/25 at 9:31 AM. Per the documented survey report for the month of 11/25, Resident #1 had not had a bowel movement for approximately 72 hours with the last bowel movement dated 11/4/25 at 10:57 PM. Per record review, Resident #1 had end stage heart failure, chronic kidney disease, hypertension, and was placed on hospice care on 12/13/24. Resident #1 required substantial to maximum assistance for his/her toileting and hygiene needs per his/her Minimum Data Set (a tool used to identify resident abilities) dated 9/16/25. Resident #1 was at a high risk for falls, with his/her most recent fall assessment dated 9/13/25 with a score of 13. The Fall Risk Evaluation form states that a “Score 10 or higher indicated the resident is at high risk of fall.” Per Resident #1’s care plan reviewed on 9/18/25, they were care planned on 4/17/25 for “Q1hr checks in [on] resident while in bed to ensure all needs are met” as a fall intervention due to Resident #1’s risk for falls due to “impaired mobility and incontinence.” Additionally, Resident #1 was care planned for “Toilet use: The resident requires substantial/maximal assistance” dated 12/15/24 stating “The resident has an ADL self-care performance deficit r/t [due to] terminal prognosis, impaired mobility, pain and incontinence.” Resident #1 also had a motion sensor as a fall intervention on 10/31/25. Resident #1 had a history of five falls identified in their care	F0656	○ The first had been placed at request of his/her family; Since s/he has not fallen since July 2025, both family and the resident felt it appropriate to remove the sensor noting that his/her previous falls were relating to attempts to self-transfer which s/he no longer does ○ The second had the sensor added following a fall in May, but was removed with consent from family after reviewing that most recent fall was 08/28/25. ○ The third had been placed related to resident falling during attempts to self-transfer. Since resident no longer makes attempts to self-transfer and last fall was 11/1/25, family agreed with removal, feeling the sensor was not supportive in fall prevention. **Systemic Changes** • Following the equipment review, all residents still residing in the Facility had their comprehensive care plans reviewed and revised as needed to include measurable goals, timeframes, and individualized, non-sensor based fall prevention interventions (for example, toileting schedules, appropriate footwear, environmental modifications, assistive devices, and supervision), consistent with F656 requirements. • The Facility implemented a new process for Q1 hour checks that requires: (1) clear criteria for when hourly safety rounding is clinically indicated; (2) documentation of rounding in the medical record; (3) periodic evaluation of effectiveness and resident response; and (4) manager oversight to ensure the intervention remains appropriate, is communicated to staff, and is revised if ineffective, in alignment with person-centered, evidence-based fall prevention practices. **Monitoring/QAPI:** During quarterly QAPI meetings in 2026, the facility will review the 4 residents with the highest number of falls for that quarter and conduct an additional review of their care plan with a focus on appropriate fall interventions; The Care Coordination Nurse will be responsible for this project **Date of Completion:** 01/07/26 **Title of the staff person responsible for implementing and monitoring:** Administrator implemented initial process for systemic changes and provided education to appropriate team members; Director of Nursing responsible for process management and monitoring post-implementation.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 475050	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 12/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Thompson House Nursing Home	**80 Maple Street , Brattleboro, Vermont, 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
F0656 SS = J	Continued from page 3 plan since 3/10/25 with their sixth fall occurring on 11/8/25. Per interview with RN #1 on 11/24/25 at 4:00 PM, she reported that Resident #1 had not been acting like themselves during their shift. She reported she was visually checking in on all the residents and found Resident #1 on the ground deceased. When asked if any nursing staff was sleeping on the job, the RN #1 stated that she didn't witness anyone sleeping, but that the Licensed Nursing Assistant assigned to Resident #1 had taken a break that was "longer than I think was reasonable" and that he was gone "way longer than he should have been". She stated that it is fine if the LNA's want to clump their breaks together but that should be communicated to the nurse and she indicated that it wasn't communicated to her. Per interview with RN #1 on 12/2/25 at 12:38 PM, she stated that she had found Resident #1 deceased on the ground, the basin was on his/her bed with feces in it, the call light was detached from the wall on the ground by Resident #1's feet at the head of the bed, and that Resident #1 was lying on his/her right lateral side and there was feces on the floor. She confirmed that she told the DON all of this on 11/10/25. RN #1 confirmed that she was not aware that Resident #1 was on hourly checks and that it should have been added to the clipboard, care plan, computer, Medication Administration Record, or the Treatment Administration Record. When RN #1 was asked if she thought this accident with Resident #1 could have been prevented, she stated that Resident #1 was more agitated that night. RN #1 additionally stated that she couldn't leave the floor to find the LNA that was taking a long break because she would have left the floor unattended. When asked about the lack of documentation in Resident #1's medical record, she reported that this accident was traumatizing to her and that she contacted management to get instruction on what to do and that she confirmed that she didn't document the fall in the medical record or the circumstances surrounding Resident #1's death. Per interview with the ADON on 11/26/25 at 8:34 AM, she reported that RN #1 had found Resident #1 deceased on the floor and that she instructed them to move Resident #1 from the floor to the bed. When asked if she had heard anything about LNA's taking longer breaks than usual, she reported she heard from nursing staff on 11/9/25 that an LNA had left the floor and that LNA's were gone for a "long period of time for that break." The ADON then stated that they have had some LNA"s sleeping in their car and taking a nap, but that it is	F0656	**Care plan and Kardex access** **Systemic Changes** • Nursing staff were reeducated on how and where to access the comprehensive care plan and Kardex within the electronic medical record, to ensure that bedside care reflects the current, person-centered plan of care. • Copies of the Kardex will be printed and maintained in a binder at each nurses' station, so direct care staff have ready access to key resident care information. **Monitoring/QAPI:** During quarterly QAPI meetings in 2026, the facility will review the 4 residents with the highest number of falls for that quarter and conduct a review of their Kardex for appropriateness; The Care Coordination Nurse will be responsible for this project. **Date of Completion:** 01/07/2026 **Title of the staff person responsible for implementing and monitoring:** Staff education completed by staff educator with oversight of DON; Kardex process created by Administrator and process maintained by Unit Clerk with oversight of Administrator **LNA documentation and audits** • Licensed nursing assistant staff received education on the importance of accurate daily charting to support continuity of care, demonstrate implementation of care plan interventions, and meet regulatory documentation expectations. **Monitoring/QAPI:** • Charting completion percentages will be monitored through audits conducted weekly for one month, then monthly for two additional months, with results and any needed corrective actions reported to the QAPI committee for oversight and follow-up. • Audits will identify and address patterns through education or corrective action as needed, and QAPI committee will determine whether monitoring continues beyond the initial period. • The Staff development Coordinator will be responsible for oversight of this QAPI project **Date of Completion:** 01/07/26 **Title of the staff person responsible for implementing and monitoring:** Staff education provided by Administrator and Director of Nursing; Staff Development Coordinator and Administrator responsible for ongoing monitoring and as needed action to staff	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 475050	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 12/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Thompson House Nursing Home	**80 Maple Street , Brattleboro, Vermont, 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
F0656 SS = J	Continued from page 4 the expectation they are on the premises and let someone know where they are going in case of an emergency. The ADON confirmed that she was not aware that the call light was detached from the wall or that Resident #1 had defecated in a large basin prior to his/her death. The ADON stated that Resident #1 would self-transfer to the commode, that s/he wasn't care planned to self transfer, that Resident #1 was substantial to maximal assistance for transfers and didn't ambulate while they were there as they were bedbound by choice. Per interview with a Licensed Nursing Assistant #1 (LNA) on 11/24/25 at 4:22 PM, he confirmed that he was assigned to Resident #1's care at the time of their death. The LNA stated that the last time he visualized Resident #1 s/he was sleeping and then the LNA said that it was "kind of creepy" that Resident #1 could have passed and that he "could have checked on [Resident #1] and missed that". When asked if Resident #1 required any additional supervision, he reported that he didn't think they had any special rounding instructions that were any different from the other residents. When the LNA was asked about their documentation from their shift 11pm-7am (11/7/25-11/8/25) he reported that he wasn't sure what documentation he did but confirmed that any care given should be charted in the patient record. When asked about how long of a break the LNA #1 took that night, he said that he "took a long one that night" saying that some of the overnight crew sometimes take it all at once during the shift usually between 2-4 AM when there isn't a lot going on. Per record review, there is no evidence that LNA #1 provided care to Resident #1 for LNA #1's shift. The last documented toileting care for Resident #1 was on 11/7/25 at 14:59PM. Per interview with LNA #3 on 12/1/25 at 3:29 PM, she confirmed that she was unable to finishing documenting on Resident #1's care the evening shift on 11/7/25, prior to Resident #1's death. She reported that she was only able to document Resident #1's nutrition at 22:39 PM on 11/7/25. LNA #3 reported that shift was a busy shift so she couldn't finish her documentation. She confirmed that they are supposed to complete their charting by the end of the shift, and that she should be documenting toilet care at least once a shift and she didn't. She also confirmed that she was not aware that Resident #1 required additional supervision or hourly checks. Per interview with RN #2 on 12/1/25 at 12:30 PM, she	F0656	**Supervision and untimely death policies** **Systemic Changes** • A new policy addressing resident supervision was developed to clarify expectations for monitoring, response, and reporting when adverse events occur, consistent with QAPI requirements to track and analyze adverse resident events and implement preventive actions. • The Facility's Resident Death Policy was revised to enhance procedures related to resident death that may be untimely, requiring Facility investigation or additional reporting • The Facility's breaktime policy was revised to expressly prohibit combining breaks in a manner that would leave units inadequately supervised, and staff were educated that breaks must be taken as scheduled to ensure adequate resident supervision at all times. **Monitoring / QAPI:** Compliance with the supervision and breaktime policies will be monitored through random observations and review of incident reports monthly for three months, with findings reported to QAPI. QAPI committee will determine whether monitoring continues beyond the initial period; The Assistant Director of Nursing will be responsible for this project **Date of Completion:** 01/07/26 **Title of the staff person responsible for implementing and monitoring:** Policy updates implemented and presented by Administrator and Director of Nursing **Tag F 656 POC accepted on 2/17/26 by S. Stem**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 475050	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 12/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Thompson House Nursing Home	**80 Maple Street , Brattleboro, Vermont, 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
F0656 SS = J	Continued from page 5 confirmed that she was caring for Resident #1 on the evening shift 11/7/25 prior to Resident #1's death. She reported that there were a couple times during that shift that Resident #1 was trying to sit on the edge of the bed and trying to use the bathroom and that s/he appeared very stable at that time. RN #2 stated that Resident #1 was hallucinating and that s/he had been having hallucinations over the past month, but that they had been increasing. When asked how they keep track of who is completing the hourly checks, she reported that they have a document they use that gets split up between LNA's and nurses, and that once completed it gets scanned into the patient's chart. She stated that she was not aware that Resident #1 was on additional supervision checks. RN #2 reported that Resident #1 was eating, drinking, and taking medications like s/he usually did. Per record review of Resident #1's progress notes on 11/8/25 at 2:30 AM, Resident #1 was found unresponsive and without a pulse. The record does not reveal the circumstances surrounding Resident #1's death. Per interview with the Director of Nursing (DON) and Administrator on 11/24/25 at 5:35 PM, when asked what happened to Resident #1 they stated that they came in the following Monday morning after Resident #1's death (11/10/25) and interviewed RN #1 and LNA #2. They stated the nursing staff informed them that when RN #1 found Resident #1 deceased on the floor with a large amount of bowel movement. When asked why the fall was not in Resident #1's medical record, they reported that the RN #1 did not document it. The facility was unable to provide evidence from the medical record that Resident #1 consistently received hourly rounding per Resident #1's care plan intervention. 2. Per record review of Resident #2's medical record, Resident #2 has a medical diagnosis of Dementia, Muscle Weakness, Major Depressive Disorder, Peripheral vascular disease, Chronic Pain, Benign Prostatic Hyperplasia with Lower Urinary Tract Symptoms, Shortness of Breath, and Other Abnormalities of Gait and Mobility. Per review of their Fall Risk Assessment dated 11/7/25, it indicates a score of 12 and of Resident #2 being at a high risk of falls. Per Resident #2's care plan, they had a fall intervention of ensuring Resident #2's needs are met every hour when in common areas to reduce the risk of impulsiveness and falls dated 10/11/25 that were discontinued on 11/25/25 to frequently. Additional care plan interventions are to utilize wheelchair following during evening	F0656		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 475050	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 12/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Thompson House Nursing Home	**80 Maple Street , Brattleboro, Vermont, 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
F0656 SS = J	Continued from page 6 ambulation and extended distances due to increased fatigue and decreased stability dated 10/23/25, offering toileting after resident finishes each meal dated 11/21/25, and checking and changing Resident #2 every two hours at minimum during the night to ensures that the resident is comfortable and has a dry brief and to offer toileting opportunities when rounding to prevent incontinence and provide supervision when walking to the bathroom at night dated 2/10/25. Additionally, Resident #2 is care planned for a motion sensor in his/her room to help reduce the risk of falls dated 12/2/25. Per record review of a progress note, Resident #2 had a fall on 12/1/25 at 3:46 AM where the Resident was found sitting on the floor “sideways” on the right side of their bed with their pants pulled part way down and his/her “brief was wet.” This note mentions that the “alarm bell did not sound at nurse station. This nurse was able to determine the reason the alarm did not go off was because when resident gets up from left side of bed alarm sound. When resident gets up from the right side of the bed the censor is too far away to pick up the movement.” Per review of Resident #2’s toileting hygiene in the Kardex, there was no toileting hygiene documented for the overnight shift from the hours of 11pm to 7am on 12/1/25 including for any refusals. Per interview with the Administrator on 12/8/25 at 12:29 PM, she confirmed that Resident #2 did not have any documentation for his/her toileting and hygiene care for the hours of 11pm to 7am on 12/1/25 and that staff should have documented that. Per record review of a progress note dated 12/1/25 at 6:23 AM, it indicates that Resident #2 refused incontinence care at 2300 and 0100 and then fell out of bed at 3:20 AM and that hygiene care was then provided and Resident #2 was compliant with care given at 6:00 AM. A progress note dated 12/1/25 at 9:36 AM states that staff were reeducated on the care plan intervention placed on 2/10/25 and that Resident #2 is incontinent at night and should be checked and changed Q2 (every two hours) hours at minimum to ensure Resident #2 is comfortable and dry. It also states to offer toileting opportunities when rounding to prevent incontinence and provide supervision when walking to the bathroom at night. A progress note dated 12/1/25 at 2:33 PM states that Resident #2 denies pain but has a bruise noted on skin check from the fall. The note does not state where this	F0656		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 475050	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 12/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Thompson House Nursing Home	**80 Maple Street , Brattleboro, Vermont, 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
F0656 SS = J	Continued from page 7 bruise is. Per interview with LNA #5 on 12/1/25 at 5:31 PM, she initially stated she had assignment list #1, but confirmed she was actually assigned to assignment list #3 after being informed that a different staff member stated they had list #1. When asking about how to tell if residents are on fall precautions or have fall interventions, she reported the way to tell if a resident is on fall precautions and has fall interventions is if they have a mat on the floor, a motion sensor, or if they have wedges used to secure them in bed. When asked about how she knows if other residents require additional supervision, she stated that it would be communicated to her via other LNA's and nursing staff at the beginning of the shift. She reported not being aware of any residents recently on hourly checks in the past week or any who were actively on them. When asked how often she views the care plan, she stated that she views it as she deems it necessary, and that she reviews them monthly. When asked if she knew about any specific interventions for Resident #2, she was only able to mention that s/he had a motion sensor in their room. LNA #5 was not able to identify nonvisual resident specific interventions. She was not able to identify that Resident #2 was care planned for utilizing "wheelchair follow during evening ambulation and extended distances due to increased fatigue and decreased gait stability" (Fall intervention 10/23/25) or Fall intervention 11/20/25 "Offer toileting after resident finishes each meal", or Fall intervention 2/10/25 "Resident is incontinent at night and should be checked and changed Q2 hours at minimum to ensure [s/he] is comfortable and brief is dry. Offer toileting opportunities when rounding to prevent incontinence and provide supervision when walking to the bathroom at night". Additionally, she was not able to identify the Fall intervention dated 3/11/25 that states, utilize wheelchair for transfers when [Resident #2] is experiencing episodes of weakness." Per interview with the Charge Nurse who is an RN on 12/1/25 at 3:18 PM, she reported she had south and east end of the hall. She stated that she wasn't aware of anyone on hourly checks or who required additional supervision currently or over the past couple of weeks. The Charge Nurse had Resident's #2, Resident #3, and Resident #4 in her assignment, all were residents who had required additional supervision and had been on the hourly checks on 11/24/25. Resident #4 was still on Q1 hourly checks when in common areas as of 12/9/25. Per interview with LNA #4 on 12/1/25 at 5:08 PM, she reported that she is assigned to List #1 and that	F0656		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 475050	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 12/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Thompson House Nursing Home	**80 Maple Street , Brattleboro, Vermont, 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
F0656 SS = J	Continued from page 8 almost her whole list of residents were Hoyer transfers (a device used to assist with moving residents who need substantial assistance) and because of that, she didn't have anyone on fall precautions. She reported the way she knows if someone is on fall precautions is because it's on the clipboard and that you are supposed to check it every day. She stated that Residents who are Hoyer transfers aren't typically on fall precautions unless they roll a lot. When asked if she uses the care plan she admitted to not really using them and that she should probably look at it more. Per interview with LNA #5 on 12/1/25 at 2:59 PM, when asked if any residents were on additional checks or required additional supervision, she stated that she was not sure how to access the care plan and that the nurse tells her if a resident is on additional checks. She could not indicate if residents were on additional checks. This LNA had Resident #4 who was still actively on hourly checks in common areas as a fall intervention dated 4/11/25, and Resident #3 who had recently been changed from hourly checks to ensuring Resident #3's needs are met regularly when in unsupervised areas revised on 11/25/25. Per interview with a Licensed Practical Nurse (LPN) on 12/1/25 at 3:02 PM, she stated that she was not aware of anyone who required additional supervision or scheduled checks and that they have a paper for 15 minute neuro checks after a fall, or 15 minute checks for residents with suicidal ideation. 3. Per record review, Resident #3 has medical diagnosis of Parkinson's disease, tremor, Traumatic Fracture, Generalized Anxiety Disorder, Chronic Pain Syndrome, Muscle Weakness, Presence of Right Artificial Hip Joint, Overactive Bladder, and Bladder Neck Obstruction. Per Resident #3's Fall Assessment dated 9/7/25, they have a fall risk score of 11 indicating that they are at a high risk of falls. Per Resident #3's care plan, they have fall interventions of using a motion censor dated 5/28/25, when resident is showing signs of being uncomfortable and restless in bed, staff to provide 30 minute checks dated 6/20/25, offering the resident toileting assistance as frequently as they will tolerate dated 7/9/25, and they had been care planned for ensuring needs are met every hour when in unsupervised areas dated 5/21/25, which was changed on 11/25/25 to ensuring that Resident #3 needs are met regularly when in unsupervised areas. Per record review of facility incident reports provided via email communication on 12/3/25 at 10:01 AM , Resident #3 had 11 unwitnessed falls on 5/21/25,	F0656		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 475050	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 12/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Thompson House Nursing Home	**80 Maple Street , Brattleboro, Vermont, 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
F0656 SS = J	Continued from page 9 5/25/25, 5/28/25, 6/3/25, 6/4/25, 6/6/25, 6/19/25, 6/23/25, 7/14/25, 7/22/25, and 9/26/25. The Administrator confirmed that Resident #3 had these falls and that the Resident had hip surgery. Per record review of progress notes dated 5/21/25, Resident #3 had a fall around 12:20 AM and then was later sent out at 13:56 via emergency services to the hospital for evaluation of their right groin pain and low blood pressure. A progress note later that day at 16:35 states that Resident #3 had fracture their hip and would be admitted to the hospital. Per interview with the Administrator on 12/8/25 at approximately 5 pm, she confirmed that Resident #3 had a fall between 5/15/25 and 5/16/25 and that the care plan was not updated after this fall and that the facility did not complete an incident report for this fall. Per interview with the administrator on 12/12/25 at 4:59PM, she confirmed that they do not document the hourly checks for any residents that are on them. Per record review of the Q1 Hourly check list provided by the facility on 12/1/25, Resident #4 is not on this list as of 12/9/25. Per review of the documents provided by the facility of care plan updates and reviews for all residents who were on the hourly checks, Resident #4 is not identified as a resident in these documents. Per review of the Immediate Jeopardy removal education on “Q2h Checks Standard” it states “At this time, no residents require checks more frequently than Q2H [every two hours]”, dated 12/1/25. Additionally, the education to nursing leadership titled “Education:Q1 hour checks, 12/1/25” states, “The facility may add Q1 hour checks to a resident care plan if it is determined that all other interventions have already been used and the IDT [Interdisciplinary Team] agrees the more frequent checks may increase safety for the resident… If a Q1 hour check is added to the resident care plan, it MUST: Be added to the Kardex with included in the positions… Be educated to the direct care staff (LPN, LNA, RN, leadership team).” Per interview on 12/9/25 at 11:21 AM, the Administrator and Executive Director confirmed that no Residents were currently on Q1 (hourly) checks and that per their Immediate Jeopardy removal plan, all residents who were on Q1 hour checks would have care plans updated as of 12/2/25 and that the Interdisciplinary Team would have reviewed all residents with Q1 hour checks in their care plan. They then confirmed that Resident #4 was on Q1 hourly checks with the date of 4/11/25, and were	F0656		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 475050	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 12/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Thompson House Nursing Home	**80 Maple Street , Brattleboro, Vermont, 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
F0656 SS = J	Continued from page 10 unable to provide evidence that the care plan had been updated. When asked how they determined who was on Q1 Hourly checks they reported that they had nursing leadership go through the residents' charts. Per interview on 12/9/25 at 11:40 AM, the Administrator and ADON stated they intentionally left Resident #3 on hourly checks when in common areas. They confirmed they were not documenting or monitoring the effectiveness of the hourly checks. The Administrator and ADON also stated that a different Resident had been placed on the Q1 H (hourly) Check list that the facility created on 12/1/25 accidentally, and that this Resident was never on Q1 hourly checks. Per interview on 12/8/25 at 12:29 PM, the Administrator confirmed that they that don't have a policy for untimely death, for what to do when a resident is found on the floor deceased, and that they don't have a supervision policy, or a call light policy. Per review of the facilities "Bowel Protocol" policy, no date, it does not identify a timeframe to monitor the resident after being given bowel meds.	F0656		
F0689 SS = SQC-J	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 an environment free from accident hazards and failed to provide adequate supervision to prevent avoidable accidents for 3 of 3 residents (Residents #1, #2, and #3). Specifically, for Resident #1—who was at high risk for falls and required maximal assistance—staff failed to implement care-planned hourly safety rounds and failed to ensure functioning motion sensors and a working call light system were in place. On 11/8/25, Resident #1 experienced an unwitnessed fall and was found deceased on the floor	F0689	*While the Facility does not agree with all aspects of the survey findings for this tag, the Facility has implemented the following actions to ensure continued compliance with §483.21.* *The Facility conducted a focused review of fall-prevention interventions, including room motion sensors and Q1 hour checks, and determined these were not effective in preventing falls and would no longer be used as routine, standalone fall prevention interventions.* **Residents Affected and Identification of Others / Systemic Review** *For residents with motion sensors in place at the time of the review, the Facility reassessed fall risk, prior fall history, transfer status, and current functional abilities, and updated each care plan to reflect individualized, evidence-based fall prevention interventions instead of default use of sensors.* • Residents #1 and #2 were no longer residing in the Facility due to death; their records were closed and thus were not candidates for care plan revision. • Resident #3's motion sensor was discontinued at his/her request after review of his/her lack of falls since 10/31/25 and his/her report that frequent sensor activations were disruptive; the medical record reflects his/her preference, the education provided on risks/benefits, and alternative interventions to monitor safety.	01/07/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 475050	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 12/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Thompson House Nursing Home	**80 Maple Street , Brattleboro, Vermont, 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
F0689 SS = SQC-J	Continued from page 11 with the call light detached. These systemic failures in supervision and equipment maintenance constituted an Immediate Jeopardy due to the outcome of death for Resident #1. This is a repeat deficiency for this facility, with violations cited during the previous recertification survey dated 1/8/25. Findings Include: Per observation on 12/1/25 the facility call light system was not working effectively, see F919 for more information. Per interviews conducted on 11/24/25, 12/1/25, 12/2/25, 12/8/25, and 12/9/25 with LNAs, an LPN, and RN's, they were not aware that any Residents required additional supervision checks, see F656 for more information. Per interviews and record review, Resident #1 was found deceased on the floor on 11/8/25 at 2:30 AM, had defecated in a basin, the call light was detached from the wall, the resident had bowel movement on the bed, in the basin, and on the floor. The facility was unable to provide evidence that Resident #1 received hourly rounding as the facility does not document hourly rounding for residents who are care planned for hourly rounding. There is no evidence that Resident #1 was receiving hourly rounding consistently, every hour, in the medical record, or had toileting hygiene completed since 11/7/25 at 14:59 PM. Resident #1 had been given scheduled Senna Docusate Sodium Oral tablet 8.6-50 MG "Give 2 tablet by mouth every morning and at bedtime for bowel management" with a start date of 10/09/25 (a medication used to help alleviate constipation) on 11/7/25 at 9:00 AM and again at 9:00 PM. Additionally, Resident #1 was given a PRN Senna Tablet 8.6 MG with a start date of 12/13/24."Give 2 tablet by mouth as needed for constipation give 2 tablets = total dose of 17.2 mg for constipation. Bowel Protocol step 1, PRN for no BM in 72 hours." The PRN Senna was given on 11/7/25 at 9:31 AM. Per the documented survey report for the month of 11/25, Resident #1 had not had a bowel movement for approximately 72 hours with the last bowel movement dated 11/4/25 at 10:57 PM. 1. Per record review, Resident #1 had end stage heart failure, chronic kidney disease, hypertension, and was placed on hospice care on 12/13/24. Resident #1 required substantial to maximum assistance for his/her toileting and hygiene needs per his/her Minimum Data Set (a tool used to identify resident abilities) dated 9/16/25. Resident #1 was at a high risk for falls, with his/her most recent fall assessment dated 9/13/25 with a score of 13. The Fall Risk Evaluation form states	F0689	• Resident #4's motion sensor was continued ("grandfathered") at the family's request to assist with staff awareness when s/he is awake or attempting to get up; the Facility educated the family that the device is primarily a movement notification tool and not a proven fall prevention intervention, and this discussion and the resident/ family preference are documented in the medical record. • For three additional residents with sensors in place, the team reviewed fall history, current transfer practices, and resident/family preferences; sensors were removed when residents no longer attempted unsafe self-transfers and had no recent falls, with consent and education documented in their medical records. o The first had been placed at request of his/ her family; Since s/he has not fallen since July 2025, both family and the resident felt it appropriate to remove the sensor noting that his/her previous falls were relating to attempts to self-transfer which s/he no longer does o The second had the sensor added following a fall in May, but was removed with consent from family after reviewing that most recent fall was 08/28/25. o The third had been placed related to resident falling during attempts to self-transfer. Since resident no longer makes attempts to self-transfer and last fall was 11/1/25, family agreed with removal, feeling the sensor was not supportive in fall prevention. **Systemic Changes** • Following the equipment review, all residents still residing in the Facility had their comprehensive care plans reviewed and revised as needed to include measurable goals, timeframes, and individualized, non-sensor based fall prevention interventions (for example, toileting schedules, appropriate footwear, environmental modifications, assistive devices, and supervision), consistent with F656 requirements. • The Facility implemented a new process for Q1 hour checks that requires: (1) clear criteria for when hourly safety rounding is clinically indicated; (2) documentation of rounding in the medical record; (3) periodic evaluation of effectiveness and resident response; and (4) manager oversight to ensure the intervention remains appropriate, is communicated to staff, and is revised if ineffective, in alignment with person-centered, evidence-based fall prevention practices.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 475050	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 12/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Thompson House Nursing Home	**80 Maple Street , Brattleboro, Vermont, 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
F0689 SS = SQC-J	Continued from page 12 that a “Score 10 or higher indicated the resident is at high risk of fall.” Per Resident #1’s care plan reviewed 9/18/25, they were care planned on 4/17/25 for “Q1hr checks in [on] resident while in bed to ensure all needs are met” as a fall intervention due to Resident #1’s risk for falls due to “impaired mobility and incontinence”. Additionally, Resident #1 was care planned for “Toilet use: The resident requires substantial/maximal assistance” dated 12/15/24 stating “The resident has an ADL self-care performance deficit r/t [due to] terminal prognosis, impaired mobility, pain and incontinence”. Resident #1 also had a motion sensor as a fall intervention on 10/31/25. Resident #1 had a history of five falls identified in their care plan since 3/10/25 with their sixth fall occurring on 11/8/25. Per interview with Registered Nurse (RN) #1 on 11/24/25 at 4:00 PM, she reported that Resident #1 had not been acting like themselves during their shift. She reported she was visually checking in on all the resident and found Resident #1 on the ground deceased. When asked if any nursing staff was sleeping on the job, the RN #1 stated that she didn’t witness anyone sleeping, but that the Licensed Nursing Assistant (LNA) assigned to Resident #1 had taken a break that was “longer than I think was reasonable” and that he was gone “way longer than he should have been.” She stated that it is fine if the LNA’s want to clump their breaks together but that should be communicated to the nurse and she indicated that it wasn’t communicated to her. Per interview with RN #1 on 12/2/25 at 12:38 PM, she stated that she had found Resident #1 deceased on the ground, the basin was on his/her bed with feces in it, the call light was detached from the wall on the ground by Resident #1’s feet at the head of the bed, and that Resident #1 was lying on his/her right lateral side and there was feces on the floor. She confirmed that she told the DON all of this on 11/10/25. RN #1 confirmed that she was not aware that Resident #1 was on hourly checks and that it should have been added to the clipboard, care plan, computer, Medication Administration Record, or the Treatment Administration Record. When RN #1 was asked if she thought this accident with Resident #1 could have been prevented, Resident #1 was more agitated that night. RN #1 additionally stated that she couldn’t leave the floor to find LNA #1 that was taking a long break because she would have left the floor unattended. When asked about the lack of documentation in Resident #1’s medical record, she reported that this accident was traumatizing to her and that she contacted management to get instruction on what to do. RN #1 confirmed that	F0689	**Monitoring/QAPI:** During quarterly QAPI meetings in 2026, the facility will review the 4 residents with the highest number of falls for that quarter and conduct an additional review of their care plan with a focus on appropriate fall interventions; The Care Coordination Nurse will be responsible for this project **Date of Completion:** 01/07/26 **Title of the staff person responsible for implementing and monitoring:** Administrator implemented initial process for systemic changes and provided education to appropriate team members; Director of Nursing responsible for process management and monitoring post-implementation **Care plan and Kardex access** **Systemic Changes** • Nursing staff were reeducated on how and where to access the comprehensive care plan and Kardex within the electronic medical record, to ensure that bedside care reflects the current, person-centered plan of care. • Copies of the Kardex will be printed and maintained in a binder at each nurses’ station, so direct care staff have ready access to key resident care information. **Monitoring/QAPI:** During quarterly QAPI meetings in 2026, the facility will review the 4 residents with the highest number of falls for that quarter and conduct a review of their Kardex for appropriateness; The Care Coordination Nurse will be responsible for this project **Date of Completion:** 01/07/2026 **Title of the staff person responsible for implementing and monitoring:** The Care Coordination Nurse will be responsible for this Quality Project with oversight from the DON **LNA documentation and audits** • Licensed nursing assistant staff received education on the importance of accurate daily charting to support continuity of care, demonstrate implementation of care plan interventions, and meet regulatory documentation expectations. **Monitoring/QAPI:** • Charting completion percentages will be monitored through audits conducted weekly for one month, then monthly for two additional months, with results and any needed corrective actions reported to the QAPI committee for oversight and follow-up. • Audits will identify and address patterns through education or corrective action as needed, and QAPI committee will determine whether monitoring continues beyond the initial period. • The Staff development Coordinator with oversight of the Administrator will be responsible for oversight of this QAPI project	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 475050	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 12/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Thompson House Nursing Home	**80 Maple Street , Brattleboro, Vermont, 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
F0689 SS = SQC-J	Continued from page 13 she didn't document the fall in the medical record or the circumstances surrounding Resident #1's death. Per interview with the Assistant Director of Nursing (ADON) on 11/26/25 at 8:34 AM, she reported that RN #1 had found Resident #1 deceased on the floor and that she instructed them to move Resident #1 from the floor to the bed. When asked if she had heard anything about LNAs taking longer breaks than usual, she reported she heard from nursing staff on 11/9/25 that an LNA had left the floor and that LNAs were gone for a "long period of time for that break." The ADON then stated that they have had some LNAs sleeping in their car and taking a nap, but that it is the expectation they are on the premises and let someone know where they are going in case of an emergency. The ADON confirmed that she was not aware that the call light was detached from the wall or that Resident #1 had defecated in a large basin prior to his/her death. The ADON stated that Resident #1 would self-transfer to the commode, that s/he wasn't care planned to self transfer, that Resident #1 was substantial to maximal assistance for transfers and didn't ambulate while they were there as they were bedbound by choice. Per interview with a Licensed Nursing Assistant #1 (LNA) on 11/24/25 at 4:22 PM, he confirmed that he was assigned to Resident #1's care at the time of their death. The LNA stated that the last time he visualized Resident #1 s/he was sleeping and then the LNA said that it was "kind of creepy" that Resident #1 could have passed and that he "could have checked on [Resident #1] and missed that". When asked if Resident #1 required any additional supervision, he reported that he didn't think they had any special rounding instructions that were any different from the other residents. When the LNA was asked about their documentation from their shift 11pm-7am (11/7/25-11/8/25) he reported that he wasn't sure what documentation he did but confirmed that any care given should be charted in the patient record. When asked about how long of a break the LNA #1 took that night, he said that he "took a long one that night" saying that some of the overnight crew sometimes take it all at once during the shift usually between 2-4 AM when there isn't a lot going on. Per record review, there is no evidence that LNA #1 provided care to Resident #1 for LNA #1's shift. The last documented toileting care for Resident #1 was on 11/7/25 at 2:59 PM. Per interview with LNA #3 on 12/1/25 at 3:29 PM, she confirmed that she was unable to finishing documenting	F0689	**Date of Completion:** 01/07/26 **Title of the staff person responsible for implementing and monitoring:** Staff education provided by Administrator and Director of Nursing; Staff Development Coordinator responsible for ongoing monitoring and as needed action **<u>Supervision and untimely death policies</u>** **Systemic Changes** • A new policy addressing resident supervision was developed to clarify expectations for monitoring, response, and reporting when adverse events occur, consistent with QAPI requirements to track and analyze adverse resident events and implement preventive actions. • The Facility's Resident Death Policy was revised to enhance procedures related to resident death that may be untimely, requiring Facility investigation or additional reporting • The Facility's breaktime policy was revised to expressly prohibit combining breaks in a manner that would leave units inadequately supervised, and staff were educated that breaks must be taken as scheduled to ensure adequate resident supervision at all times. **Monitoring / QAPI:** Compliance with the supervision and breaktime policies will be monitored through random observations and review of incident reports monthly for three months, with findings reported to QAPI. QAPI committee will determine whether monitoring continues beyond the initial period; The Assistant Director of Nursing will be responsible for this project **Date of Completion:** 01/07/26 **Title of the staff person responsible for implementing and monitoring:** Policy updates implemented and presented by Administrator and Director of Nursing **Tag F 689 POC accepted on 2/17/26 by S. Stem**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 475050	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 12/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Thompson House Nursing Home	**80 Maple Street , Brattleboro, Vermont, 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
F0689 SS = SQC-J	Continued from page 14 on Resident #1's care the evening shift on 11/7/25, prior to Resident #1's death. She reported that she was only able to document Resident #1's nutrition at 10:39 PM on 11/7/25. LNA #3 reported that shift was a busy shift so she couldn't finish her documentation. She confirmed that they are supposed to complete their charting by the end of the shift, and that she should be documenting toilet care at least once a shift and she didn't. She also confirmed that she was not aware that Resident #1 required additional supervision or hourly checks. Per interview with RN #2 on 12/1/25 at 12:30 PM, she confirmed that she was caring for Resident #1 on the evening shift 11/7/25 prior to Resident #1's death. She reported that there were a couple times during that shift that Resident #1 was trying to sit on the edge of the bed and trying to use the bathroom and that s/he appeared very stable at that time. RN #2 stated that Resident #1 was hallucinating and that s/he had been having hallucinations over the past month, but that they had been increasing. When asked how they keep track of who is completing the hourly checks, she reported that they have a document they use that gets split up between LNA's and nurses, and that once completed it gets scanned into the patient's chart. She stated that she was not aware that Resident #1 was on additional supervision checks. RN #2 reported that Resident #1 was eating, drinking, and taking medications like s/he usual did. Per record review of Resident #1's progress notes on 11/8/25 at 2:30 AM, Resident #1 was found unresponsive and without a pulse. The record does not reveal the circumstances surrounding Resident #1's death. Per interview with the Director of Nursing (DON) and Administrator on 11/24/25 at 5:35 PM, when asked what happened to Resident #1 they stated that they came in the following Monday morning after Resident #1's death (11/10/25) and interviewed RN #1 and LNA #2. They stated the nursing staff informed them that when RN #1 found Resident #1 deceased on the floor with a large amount of bowel movement. They confirmed that Resident #1 had received bowel meds. When asked why the fall was not in Resident #1's medical record, they reported that the RN #1 did not document it. Per interview with the DON, Administrator and Executive Director on 12/1/25 at 1:41 PM, they reported not being given all the information about Resident #1 having defecated in a basin and the call light being disconnected from the wall and that if they had been given that information, they would have likely	F0689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 475050	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 12/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Thompson House Nursing Home	**80 Maple Street , Brattleboro, Vermont, 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
F0689 SS = SQC-J	Continued from page 15 completed a different investigation. The facility was unable to provide evidence from the medical record that Resident #1 consistently received hourly rounding per Resident #1's care plan intervention. 2. Per record review of Resident #2's medical record, Resident #2 has a medical diagnosis of Dementia, Muscle Weakness, Major Depressive Disorder, Peripheral vascular disease, Chronic Pain, Benign Prostatic Hyperplasia with Lower Urinary Tract Symptoms, Shortness of Breath, and Other Abnormalities of Gait and Mobility. Per review of their Fall Risk Assessment dated 11/7/25, it indicates a score of 12 and of Resident #2 being at a high risk of falls. Per Resident #2's care plan, they had a fall intervention of ensuring Resident #2's needs are met every hour when in common areas to reduce the risk of impulsiveness and falls dated 10/11/25 that were discontinued on 11/25/25 to frequently. Additional care plan interventions are to utilize wheelchair following during evening ambulation and extended distances due to increased fatigue and decreased stability dated 10/23/25, offering toileting after resident finishes each meal dated 11/21/25, and checking and changing Resident #2 every two hours at minimum during the night to ensures that the resident is comfortable and has a dry brief and to offer toileting opportunities when rounding to prevent incontinence and provide supervision when walking to the bathroom at night dated 2/10/25. Additionally, Resident #2 is care planned for a motion sensor in his/her room to help reduce the risk of falls dated 12/2/25. Per record review of a progress note, Resident #2 had a fall on 12/1/25 at 3:46 AM where the Resident was found sitting on the floor "sideways" on the right side of their bed with their pants pulled part way down and his/her "brief was wet." This note mentions that the "alarm bell did not sound at nurse station. This nurse was able to determine the reason the alarm did not go off was because when resident gets up from left side of bed alarm sound. When resident gets up from the right side of the bed the censor is too far away to pick up the movement." Per review of Resident #2's toileting hygiene in the Kardex, there was no toileting hygiene documented for the overnight shift from the hours of 11pm to 7am on 12/1/25 including for any refusals. Per interview with the Administrator on 12/8/25 at 12:29 PM, she confirmed that Resident #2 did not have any documentation on the Kardex for his/her toileting and hygiene care for the hours of 11pm to 7am on	F0689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 475050	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 12/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Thompson House Nursing Home	**80 Maple Street , Brattleboro, Vermont, 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
F0689 SS = SQC-J	Continued from page 16 12/1/25 and that staff should have documented that. Per record review of a progress note dated 12/1/25 at 6:23 AM, it indicates that Resident #2 refused incontinence care at 2300 and 0100 and then fell out of bed at 3:20 AM and that hygiene care was then provided and Resident #2 was compliant with care given at 6:00 AM. There is no evidence that staff attempted toileting or incontinence care at the next 2 hour interval (at 3:00 AM), as required by the care plan, prior to the fall occurring. A progress note dated 12/1/25 at 9:36 AM states that staff were reeducated on the care plan intervention placed on 2/10/25 and that Resident #2 is incontinent at night and should be checked and changed Q2 (every two hours) hours at minimum to ensure Resident #2 is comfortable and dry. It also states to offer toileting opportunities when rounding to prevent incontinence and provide supervision when walking to the bathroom at night. A progress note dated 12/1/25 at 14:33 states that Resident #2 denies pain but has a bruise noted on skin check from fall. Per interview with LNA #5 on 12/1/25 at 5:31 PM, she initially stated she had assignment list #1, but confirmed she was actually assigned to assignment list #3 after being informed that a different staff member stated they had list #1. When asking about how to tell if residents are on fall precautions or have fall interventions, she reported the way to tell if a resident is on fall precautions and has fall interventions is if they have a mat on the floor, a motion sensor, or if they have wedges used to secure them in bed. When asked about how she knows if other residents require additional supervision, she stated that it would be communicated to her via other LNA's and nursing staff at the beginning of the shift. She reported not being aware of any residents recently on hourly checks in the past week or any who were actively on them. When asked how often she views the care plan, she stated that she views it as she deems it necessary, and that she reviews them monthly. When asked if she knew about any specific interventions for Resident #2, she was only able to mention that s/he had a motion sensor in their room. LNA #5 was not able to identify nonvisual resident specific interventions. She was not able to identify that Resident #2 was care planned for utilizing "wheelchair follow during evening ambulation and extended distances due to increased fatigue and decreased gait stability" (Fall intervention 10/23/25) or Fall intervention 11/20/25 "Offer toileting after	F0689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 475050	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 12/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Thompson House Nursing Home	**80 Maple Street , Brattleboro, Vermont, 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
F0689 SS = SQC-J	Continued from page 17 resident finishes each meal", or Fall intervention 2/10/25 "Resident is incontinent at night and should be checked and changed Q2 hours at minimum to ensure [s/he] is comfortable and brief is dry. Offer toileting opportunities when rounding to prevent incontinence and provide supervision when walking to the bathroom at night." Additionally, she was not able to identify the Fall intervention dated 3/11/25 that states, utilize wheelchair for transfers when [Resident #2] is experiencing episodes of weakness." Per interview with the Charge Nurse who is a Registered Nurse on 12/1/25 at 3:18 PM, she reported she had south and east end of the hall. She stated that she wasn't aware of anyone on hourly checks or who required additional supervision currently or over the past couple of weeks. The Charge Nurse had Resident's #2 and Resident #3 in her assignment, all were residents who had required additional supervision and had been on the hourly checks on 11/24/25. Per interview with a Licensed Practical Nurse (LPN) on 12/1/25 at 3:02 PM, she stated that she was not aware of anyone who required additional supervision or scheduled checks and that they have a paper for 15 minute neuro checks after a fall, or 15 minute checks for residents with suicidal ideation. 3. Per record review, Resident #3 has medical diagnosis of Parkinson's disease, tremor, Traumatic Fracture, Generalized Anxiety Disorder, Chronic Pain Syndrome, Muscle Weakness, Presence of Right Artificial Hip Joint, Overactive Bladder, and Bladder Neck Obstruction. Per Resident #3's Fall Assessment dated 9/7/25, they have a fall risk score of 11 indicating that they are at a high risk of falls. Per Resident #3's care plan, they have fall interventions of using a motion sensor dated 5/28/25, when resident is showing signs of being uncomfortable and restless in bed, staff to provide 30 minute checks dated 6/20/25, offering the resident toileting assistance as frequently as they will tolerate dated 7/9/25, and they had been care planned for ensuring needs are met every hour when in unsupervised areas dated 5/21/25, which was changed on 11/25/25 to ensuring that Resident #3 needs are met regularly when in unsupervised areas. Per record review of facility incident reports provided via email communication on 12/3/25 at 10:01 AM , Resident #3 had 11 unwitnessed falls on 5/21/25, 5/25/25, 5/28/25, 6/3/25, 6/4/25, 6/6/25, 6/19/25, 6/23/25, 7/14/25, 7/22/25, and 9/26/25. The Administrator confirmed that Resident #3 had these falls and that the Resident #3 had hip surgery.	F0689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 475050	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 12/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Thompson House Nursing Home	**80 Maple Street , Brattleboro, Vermont, 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
F0689 SS = SQC-J	Continued from page 18 Per record review of progress notes dated 5/21/25, Resident #3 had a fall around 12:20 AM and then was later sent out at 1:56 PM via emergency services to the hospital for evaluation of their right groin pain and low blood pressure. A progress note later that day at 4:35 PM states that Resident #3 had fractured their hip and would be admitted to the hospital. Per interview with the Administrator on 12/8/25 at approximately 5 PM, she confirmed that Resident #3 had a fall between 5/15/25 and 5/16/25 and that the care plan was not updated after this fall and that the facility did not complete an incident report for this fall. Per interview on 12/9/25 at 11:40 AM, the Administrator and ADON confirmed they were not documenting or monitoring the effectiveness of the hourly checks. Per interview on 12/8/25 at 12:29 PM, the Administrator confirmed that they that don't have a policy for untimely death, for what to do when a resident is found on the floor deceased, and that they don't have a supervision policy, or a call light policy relating to maintenance. Per review of the facilities "Bowel Protocol" policy, no date, it does not identify a timeframe to monitor the resident after being given bowel meds.	F0689		
F0919 SS = K	Resident Call System CFR(s): 483.90(g)(1)(2) §483.90(g) Resident Call System The facility must be adequately equipped to allow residents to call for staff assistance through a communication system which relays the call directly to a staff member or to a centralized staff work area from- §483.90(g)(1) Each resident's bedside; and §483.90(g)(2) Toilet and bathing facilities. This REQUIREMENT is NOT MET as evidenced by: Based on observation and interview, the facility failed to ensure an effective, functioning resident call system was accessible to all 32 residents on the first floor. Specifically, the facility failed to maintain a	F0919	**Tag F0919-K: Call Bell System** *While the Facility does not agree with all aspects of the survey findings for this tag, the Facility has implemented the following actions to ensure continued compliance with §483.90(g).* • In August 2025, the Facility installed a new resident call bell system that provides both an audible alarm and a visual notification at the central nurses' station when a call cord is activated or disconnected, including a brown "ERROR" ribbon and room number display when a device is pulled from the wall. • On August 20, 2025, staff were trained on the functions of the new call bell system, including recognition of the "ERROR" ribbon and the requirement to respond promptly to all audible and visual alerts relayed to the nurses' station or other staffed locations.	01/07/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 475050	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 12/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Thompson House Nursing Home	**80 Maple Street , Brattleboro, Vermont, 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
F0919 SS = K	Continued from page 19 system that effectively alerted staff when a call light was disconnected from the wall at the bedside, which occurred in Resident #1's room and was confirmed through sampling in Resident #4's room. On 11/8/25, Resident #1—who was at high risk for falls and was receiving laxatives—was found deceased on the floor with the call light detached and unalarmed at the nurses' station. The facility failed to implement any policies or routine testing procedures to ensure the call system's audible and visual indicators remained operational. These failures resulted in an Immediate Jeopardy due to the outcome of death for Resident #1 and potentially left all other residents without a reliable means of calling for assistance during an emergency, if their call bell fails to alarm adequately to alert staff when accidentally disconnected. Findings Include: 1. Per record review of Resident #1's medical record, Resident #1 had end stage heart failure, chronic kidney disease, hypertension, and was placed on hospice care on 12/13/24. Resident #1 required substantial to maximum assistance for his/her toileting and hygiene needs per his/her Minimum Data Set (a tool used to identify resident abilities) dated 9/16/25. Resident #1 was at a high risk for falls, with his/her most recent fall assessment dated 9/13/25 with a score of 13. The Fall Risk Evaluation form states that a "Score 10 or higher indicated the resident is at high risk of fall." Per Resident #1's care plan reviewed 9/18/25, they were care planned on 4/17/25 for "Q1hr [every hour] checks in resident while in bed to ensure all needs are met" as a fall intervention due to Resident #1's risk for falls due to "impaired mobility and incontinence." Additionally, Resident #1 was care planned for "Toilet use: The resident requires substantial/maximal assistance" dated 12/15/24 stating "The resident has an ADL self-care performance deficit r/t [due to] terminal prognosis, impaired mobility, pain and incontinence." Resident #1 also had a motion sensor as a fall intervention on 10/31/25. Resident #1 has the call light intervention of having a pad style call light being in reach at all times, dated 4/16/25. Resident #1 had a history of five falls identified in their care plan since 3/10/25 with their sixth fall occurring on 11/8/25. Resident #1 had been given scheduled Senna Docusate Sodium Oral tablet 8.6-50 MG "Give 2 tablet by mouth every morning and at bedtime for bowel management" with a start date of 10/09/25 (a medication used to help alleviate constipation) on 11/7/25 at 9:00 AM and again at 9:00 PM. Additionally, Resident #1 was given a PRN Senna Tablet 8.6 MG with a start date of 12/13/24 "Give	F0919	**Systemic Changes** • On December 3, 2025, the audible alert volume at the nurses' station was increased to ensure the call system is clearly audible to staff working in the area, followed by a Facility wide (whole house) audit of the call bell system was completed to verify that all resident rooms and common areas have functional call devices that properly annunciate at the nurses' station. • The audit found that all call bells tested were functioning as intended. **Monitoring / QAPI** • The Maintenance Department has incorporated inspection and testing of the call bell system into its routine quarterly safety checks, including verifying both audible and visual alerts at the nurses' station. Any call system failures or delays in response will be treated as incidents, reviewed through QAPI, and result in corrective actions as indicated; Maintenance is responsible for ongoing inspections **Date of Completion: 01/07/26** **Tag F 919 POC accepted on 2/17/26 by S. Stem**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 475050	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 12/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Thompson House Nursing Home	**80 Maple Street , Brattleboro, Vermont, 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
F0919 SS = K	Continued from page 20 2 tablet by mouth as needed for constipation give 2 tablets = total dose of 17.2 mg for constipation. Bowel Protocol step 1, PRN for no BM in 72 hours..." The PRN Senna was given on 11/7/25 at 9:31 AM. Per the documented survey report for the month of 11/25, Resident #1 had not had a bowel movement for approximately 72 hours with the last bowel movement dated 11/4/25 at 10:57 PM. Per record review of Resident #1's progress notes on 11/8/25 at 2:30 AM, Resident #1 was found unresponsive and without a pulse and had expired. The medical record does not reveal the circumstances surrounding Resident #1's death. Per interview with Registered Nurse #1 (RN #1) on 12/2/25 at 12:38 PM, she stated that she found Resident #1 on the ground deceased on 11/8/25 at 2:30 AM, the basin was on his/her bed with feces in it, the call light was detached from the wall on the ground by Resident #1's feet at the head of the bed, and that Resident #1 was lying on his/her right lateral side and there was feces on the floor. RN #1 stated that she thinks the call light is supposed to alarm when it is detached from the wall, and it alarms at the nursing station, but that there was no indicator that the call light was detached or that Resident #1 had been moving in his/her room as she did not hear anything at the nurses station. 2. Per observation of how the call light system functions on 12/1/25 at 6:29 PM, the Director of Nursing (DON) went to sample disconnected call lights from the wall. The DON disconnected the call light from the wall in the room that Resident #1 had been in. A soft and quiet beep could just barely be heard coming from the facilities call light system at the nurses' station. When sampling a second room, Resident #4's room, the call light system again, did not effectively notify nursing staff that the call light was disconnected. There was no visual indicator over either Resident #1's room or Resident #4's room to notify staff that the call light was detached from the wall. Per interview with a Licensed Nursing Assistant (LNA) at the nurse's station on 12/1/25 at 6:31 PM, she initially confirmed that she could not hear the call light making a noise when it was disconnected, and then she stated that she could barely hear the beeping from the call light after pausing and listening closely. Per interview with a RN #2 at the nurse's station on 12/1/25 at 6:32 PM, she stated that she could not hear the call light alarming when it was disconnected from	F0919		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 475050	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 12/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Thompson House Nursing Home	**80 Maple Street , Brattleboro, Vermont, 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
F0919 SS = K	Continued from page 21 the wall, and that they must do frequent checks in the hallways to make sure they do not miss anything. Per interview with the DON on 12/1/25 at approximately 6:38 PM, he confirmed that the call light is supposed to make a loud noise when disconnected from the wall and that it is only making a soft beeping noise. Per interview with the DON on 12/1/25 at approximately 7 PM, he stated that the call lights are easy to pull out of the wall and that residents do it all the time. Per interview with the Administrator on 12/1/25 at 7:02 PM, she confirmed that they do not have a policy or procedure for maintaining their call lights or a system in place to ensure that they are functioning effectively. Per phone interview with the Administrator on 12/2/25 at 1:32 PM, she confirmed that the call light does not alarm above the room when the call light is disconnected from the wall. Per email correspondence with the Administrator and Executive Administrator on 12/2/25 at 4:37 PM, she confirmed that they don’t regularly test the call light system.	F0919		