



Department of Disabilities, Aging and
Independent Living
Division of Licensing and Protection
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AGENCY OF *HUMAN SERVICES*

March 19, 2026

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

Provider ID #: 475050

Dear Ms. Pratt:

The Division of Licensing and Protection completed a recertification survey at your facility on **March 18, 2026**. The purpose of the survey was to determine if your facility was in compliance with Federal participation requirements for nursing homes participating in the Medicare/Medicaid programs.

This survey found that your facility was in substantial compliance with the participation requirements.

Congratulations to you and your staff.

Sincerely,

A handwritten signature in black ink that reads "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: 475050		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 03/18/2026	
NAME OF PROVIDER OR SUPPLIER Thompson House Nursing Home				STREET ADDRESS, CITY, STATE, ZIP CODE 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	
E0000	Initial Comments An unannounced on-site re-certification survey was conducted by the Division of Licensing and Protection on 3/16/26 to 3/18/26 including Emergency Preparedness Requirements for 42 CFR Part 483 requirements for Long Term Care Facilities. The result of the Emergency Preparedness Survey identified no regulatory violations.		E0000				
F0000	INITIAL COMMENTS The Division of Licensing and Protection conducted an unannounced, onsite recertification survey from 3/16/26 through 3/18/26 to determine compliance with 42 CFR Part 483 requirements for Long Term Care Facilities. As a result of this survey, the Facility was determined to be in substantial compliance with these requirements.		F0000				

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
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