VERMONT

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

October 22, 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 plans of correction for the complaint investigation conducted on **September 28, 2026.** 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: 475050	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 09/28/2026

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 The Division of Licensing and Protection conducted an unannounced, onsite investigation of 2 facility reported incidents, including reports #3188112 and #3203380, on 9/28/2026 to determine compliance with 42 CFR Part 483 requirements for Long Term Care Facilities. The following regulatory deficiency was identified:	F0000	**Plans to address immediate concern:** Education will be distributed to direct care staff related to Abuse, Neglect, Exploitation/ Misappropriation, and mandated reporting expectations. Staff will complete the education by 11/6/26 All current staff will complete attestations related to their obligations as Mandated Reporters Staff will attest by 11/6/26 **Ensuring future compliance:** The facility will add to its new-hire orientation process including updated information and examples on Abuse, Neglect, Exploitation/ Misappropriation, and injury of unknown origin, as well as mandated reporting. The new orientation process will be created by 10/23/26	
F0609 SS = D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is NOT MET as evidenced by: Based on interview and record review, the facility	F0609		

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
	Administrator	10/22/26

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F0609 SS = D	Continued from page 1 failed to ensure that an allegation of resident physical abuse for 1 of 3 residents in the applicable sample (Resident #1), was reported to the Administrator of the facility within the required timeframe. Findings include: Per review of a facility summary of an internal investigation submitted to the licensing agency on 9/17/2026, on 9/13/2026 at a little after 1:00 PM Resident #1 was witnessed by a Licensed Practical Nurse stating that s/he had been "beaten up" by their roommate. During the facility internal investigation administration learned that Resident #1 had made similar comments to a Licensed Nursing Assistant (LNA) regarding being "beaten up" on 9/14/2026 around 7:00 AM. Per facility policy titled Abuse, Neglect, Mistreatment, Exploitation or Misappropriation of Resident Funds Reporting/Investigation Procedure it states under the heading Procedure: ALL STAFF MEMBERS OF THIS NURSING COMMUNITY ARE MANDATED REPORTERS. You must report the following: a. The resident is making an allegation of abuse, neglect, or exploitation.... Immediately take steps to ensure the resident is protected from abuse. Report the incident to your immediate supervisor, or charge nurse, and Administrator or DNS [Director of Nursing] immediately. During an interview with the facility Administrator on 9/28/2026 at 1:20 PM she confirmed that the LNA had not reported the allegation of abuse timely per facility policy and per regulatory requirements.	F0609	Thompson House will update its employee handbook to outline disciplinary action associated with employees who fail to report. Policy effective 10/23/26 Identifying residents with potential to be effected: Administrator, DON, Executive Director, and/or ADON will audit resident diagnoses and care plans of all current residents to determine if the resident has factors that put them at risk for abuse. If deemed necessary and not already present, care plans will be updated accordingly to indicate resident at risk of abuse with individualized interventions. This project will be complete by 11/6/26 Measure of success: DON or designee to audit risk management and clinical progress report weekly for 4 weeks then monthly for 2 months to ensure any documented concerns have been appropriately reported. If compliance not achieved by end of this period, project to transition to QAPI committee To start week of 10/26/26 **Tag F0609 POC accepted on 10/22/26 by S. Freeman/S. Stem**	