

Division of Licensing and Protection
103 South Main Street
Waterbury, VT 05671-2306
<http://www.dail.vermont.gov>
Voice/TTY (802) 871-3317
To Report Adult Abuse: (800) 564-1612
Fax (802) 871-3318

July 15, 2015

Ms. Linda Minsinger, Administrator
Menig Nursing Home
3075 Route 66
Randolph Center, VT 05061

Dear Ms. Minsinger:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **June 22, 2015**. Please post this document in a prominent place in your facility.

We may follow-up to verify that substantial compliance has been achieved and maintained. If we find that your facility has failed to achieve or maintain substantial compliance, remedies may be imposed.

Sincerely,



Pamela M. Cota, RN
Licensing Chief



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

PRINTED: 06/29/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 475058	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/22/2015
NAME OF PROVIDER OR SUPPLIER MENIG NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 3075 ROUTE 66 RANDOLPH CENTER, VT 05061	
(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
F 000	INITIAL COMMENTS	F 000		
F 250 SS=D	<p>An unannounced on-site complaint investigation of two self report was conducted on 6/22/15 by the Division of Licensing and Protection. The findings include the following:</p> <p>483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE</p> <p>The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and medical record review the facility failed to ensure that medically related social services were provide to attain or maintain the highest practicable physical, mental and psychosocial well-being for 2 of 3 applicable residents (#1 and #2) reviewed. The findings include the following:</p> <p>1. Resident #1 who is developmentally delayed, has been identified as being involved in two resident to resident altercations, (both of which s/he is the victim), since March of 2015. Care Manger progress note dated 4/10/15 evidences an episode of being hit by another resident with no injury. There is also evidence of other changes occurring in the resident's personal life that may be impacting the resident's quality of life at the facility. Progress note dated 6/16/15 evidences Resident #1's recent sadness.</p> <p>Per interview with the Care Manager at 11:40 AM,</p>	F 260	<p>F250</p> <p>1. <u>Current Resident Corrective action:</u> Care Manager has assessed and documented her observations on Resident #1 and #2. Completed</p> <p>2. <u>Prevant reoccurrence with other potential residents:</u> First part of the week leadarship meetings will discuss all residents that have changes or concerns since the previous week. Leadership meetings include DNS, MDS coordinator, Care Manager, Activities coordinator. Care Manager will ansure documentation with each identified resident by week-and. The laadarship team will huddle at the end of the week to touch base that all expected documentation has been completed.</p> <p>3. <u>Process improvement for prevention:</u> a. Education on Nursing Homa ragulations for Care Manager. b. Davalop Care Manager network within the state to have local resources/supports to ask questions for new social workers. c. Orientation for Social workars new to Long term care.</p> <p>4. <u>Monitoring plan:</u> a. Tha DNS will monitor that all residents identifies with changas and have an appropriata social service note.</p> <p>5. <u>Date Corrective Action Completed:</u> a. Care Management documantation complated by July 2, 2015. b. DNS monitoring - Ongoing</p>	

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

TITLE

(X6) DATE

[Signature] *[Signature]*

7/14/15

F250 POC accepted 7/14/15 mBetranan/Pme

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 250	Continued From page 1 confirmation was made that there has not been an ongoing plan to assist Resident #1 with any of the resident to resident altercations that have transpired, Resident #1's inability to cope with her/his family's issues that have resulted in decreased visits by the guardian and Resident #1's lack of coping skills to assist with the transition of moving from one facility to the other.	F 250			
F 280 SS=D	2. Resident #2 who has a diagnosis of Dementia with Agitation has been identified as being involved in three resident to resident altercations since March of 2015 of which s/he has been the perpetrator. Per interview with the Care manger at 11:40 AM, confirmation was made that there has not been an ongoing plan to assist Resident #2 with any of the three altercations that have transpired. 483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after	F 280	F280 1. <u>Current Resident Corrective action:</u> Resident #3 care plan that was identified by surveyor has been updated and current with resident's conditions. 2. <u>Prevent Reoccurrence:</u> Develop a check list for all new Provider orders to ensure any new provider orders will be captured for the care plan, keeping them up-to-date and accurate. 3. <u>Process Improvement for prevention:</u> a. Educate Nursing staff about their responsibility to ensure each residents plan of care is up to date with any new orders. b. Educate all staff to review care plans as a safety tool for resident care.		

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F 280	<p>Continued From page 2 each assessment.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and medical record review for 1 of 3 sampled residents, the facility failed to update the Interdisciplinary Care Plan for Resident #3, to meet current needs. The findings include the following:</p> <p>Per medical record review at 9:45 AM, Resident #3 developed a fracture of the right tibia while falling out of a wheel chair during a leave of absence on 4/11/15. A cast was applied to the right leg. On 6/9/15 Resident #3 was evaluated by the Physician Assistant (PA), the cast was removed, x-rays to the proximal tibia identified healing and a hinged knee brace was applied. PA directed staff to have the resident wear the brace during transfers and rolling. May be removed for hygiene and bath. The progress note was noted by a Registered Nurse on 6/19/15. Licensed Nurse Aide Care plan identifies that Resident #3 has a cast in place status post (S/P) fall. Interdisciplinary Care Plan identifies a problem dated 4/11/15 fell at home has fracture. Approaches to care are to lift transfers with 2 assist, Physical Therapy Consult PRN, Electric Wheel Chair, Falling Star on door and cast checks every shift for circulation/moistness/sensitivity/touch (CMST). A second problem identified as altered pain/comfort S/P fall 4/11/15 cast in place. Initiatives for care include medication as ordered, monitor pain every shift, cast in place and reposition for</p>	F 280	<p>4. <u>Monitoring plan:</u></p> <p>a. The DNS, or designee, will receive all new check lists from the Nursing staff – these will be checked for completeness by using the check-off list.</p> <p>b. DNS, or designee, will randomly check 5 new orders/week to ensure that they are appropriately added to care plan.</p> <p>5. <u>Date Corrective Action Completed:</u></p> <p>a. Care plan identified (#3) was updated for accuracy – June 22, 2015.</p> <p>b. Nursing Staff meeting – reviewed care plan updating responsibilities – July 2, 2015.</p> <p>c. Staff meeting – reviewed care plan expectations and everyone's role into keeping them up to date – July 8, 2015.</p> <p>d. Monitoring of ongoing accuracy of care plans by DON – Ongoing</p> <p><i>F280 POC accepted 7/14/15 M.Bertrand pvl/mme</i></p>		

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F 280	Continued From page 3 comfdr.	F 280			
F 323 SS=D	<p>Per interview with the Director of Nurses (DNS) at approximately 12:30 PM, Resident #3 no longer has a cast in place, a consult has been requested for right knee range of motion noted on 6/19/15, the resident is non-weight bearing. DNS confirms that the LNA care plan and the Interdisciplinary care plan have not been updated to reflect the change in care and management of the healing fractured tibia.</p> <p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES</p> <p>The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.</p> <p>This REQUIREMENT is not met as evidenced by: Based on medical record review and confirmed by staff interview, the facility failed to ensure that 1 of 3 applicable residents were adequately supervised to prevent resident to resident altercations perpetrated by Resident #2. The findings include the following:</p> <p>1. Per medical record review at 1 PM, Resident #2 has a diagnosis of Dementia with Agitation. Nurses progress notes identify that the resident has been the perpetrator in 3 resident to resident altercations since March of 2015. Progress notes also identify that Resident #2 is combative with</p>	F 323	<p>F323</p> <p>1. <u>Current Resident Corrective action:</u> Leadership team will identify interventions for this resident to try to stop resident to resident altercations. MDS coordinator will document in residents care plan the prevention plan.</p> <p>2. <u>Prevent Reoccurrence:</u> Weekly Leadership meetings will review and identify any trends in resident to resident incidents. A prevention plan for any identified resident will be developed. The prevention plans will be implemented and reviewed regularly to assess that the interventions were successful.</p>		

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F 323	<p>Continued From page 4 care, assaultive to staff and wanders into other resident rooms.</p> <p>Licensed Nurses Aide (LNA) care plan dated 9/2/14, identifies that Resident #2 has Problem Behaviors of wandering, can be verbally and physically abusive with care, hits staff and other residents, does not like loud noises and every (q) 15 minute checks when awake. Interdisciplinary Care Plan updated on 4/16/15 and 5/29/15 identifies a problem behaviors, resistive to care and hits staff/residents and spits. Approaches to manage are 1-2 with care, speak in a soft voice, approach in quiet calm manner, step away and reproach in a few minutes, monitor whereabouts q 15 minutes when awake and redirect from other residents room/space. Per interview with LNA assigned to Resident #2 on 6/22/15, confirmation is made that LNA staff visually check on Resident #2 in between assigned tasks and in between providing care to other residents.</p> <p>Per medical record review for Resident #1 who is developmentally delayed, progress notes identifies on 4/10/15 during the 3-11 shift, Resident #1 was sitting in wheelchair when Resident #2 was attempting to enter the room. Resident #2 hit Resident #1 in the right eye. Per interview with the Director of Nurses (DNS) at 10:45 AM, confirmation was made that the incident occurred as documented.</p> <p>Per medical record review for Resident #1, progress notes identify that on 4/29/15 the resident was yelling at Resident #2 because she was in her/his room. As a result of the yelling, staff intervened. Progress notes dated 5/5/15 during the evening shift, identify that Resident #1</p>	F 323	<p>F323</p> <p>3. <u>Process improvement for prevention:</u> All Resident to resident incidents are reviewed for any trends by the leadership team. If a trend is identified – then a prevention plan is developed to try to prevent the behavior that caused the resident to resident incident. The staff will document regularly on the prevention plan and if it is meeting the goal. The interventions will be assessed and changed as needed.</p> <p>4. <u>Monitoring plan:</u> a. DNS, or designee, will review all resident to resident incidents and bring them to the Leadership team to identify trends. b. DNS, or designee, will ensure prevention plans are developed, communicated and followed. c. DNS, or designee, will reassess prevention plans when/at: i. Another incident that occurs that is similar to others. ii. At regular intervals (at least monthly) iii. If a significant health change occurs iv. No longer needed</p>		

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F 323	Continued From page 5 was sitting in her doorway and began yelling at a wandering resident who was attempting to enter the room. Again, as a result of the yelling, staff intervened. Per interview with the Director of Nurses (DNS) at 10:45 AM, confirmation was made that the above incident occurred as documented. Per medical record review, Resident #3, while sitting in her/his room in a wheel chair, was physically hit on the arms by Resident #2. Resident #2 was attempting to remove a blanket from Resident #3's lap. Per interview with the Director of Nurses (DNS) at 1:15 PM, confirmation was made that the above incident occurred as documented.	F 323	5. <u>Date corrective action completed:</u> a. Prevention plan was developed for resident (#2) - July 14, 2015. b. Nursing Staff notified by email - the Prevention plans and importance to implement and monitor results - July 13, 2015. c. Monitoring of ongoing accuracy of prevention plans by DNS - Ongoing		
			F323 Acc accepted 7/14/15 M. Bertrand RN/PMU		

New Doctors orders

Date:

Resident:
Provider:
In Chart: Y N
Faxed to Health Direct: Y N
MAR: Y N
Care Plan: Y N
other
Nurse:

Please return to Brooks

New Doctors orders

Date:

Resident:
Provider:
In Chart: Y N
Faxed to Health Direct: Y N
MAR: Y N
Care Plan: Y N
other
Nurse:

Please return to Brooks

New Doctors orders

Date:

Resident:
Provider:
In Chart: Y N
Faxed to Health Direct: Y N
MAR: Y N
Care Plan: Y N
other
Nurse:

Please return to Brooks

New Doctors orders

Date:

Resident:
Provider:
In Chart: Y N
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MAR: Y N
Care Plan: Y N
other
Nurse:

Please return to Brooks