

Division of Licensing and Protection
103 South Main Street, Ladd Hall
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

May 29, 2014

Ms. Linda Minsinger, Administrator
Menig Extended Care
44 South Main Street
Randolph, VT 05060

Dear Ms. Minsinger:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **May 6, 2014**. 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

PC:jl

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

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 05/06/2014
NAME OF PROVIDER OR SUPPLIER MENIG EXTENDED CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 44 SOUTH MAIN STREET RANDOLPH, VT 05060		
(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 F 280 SS=D	<p>INITIAL COMMENTS</p> <p>An unannounced on-site re-certification survey was conducted by the Division of Licensing and Protection from 5/5 - 5/6/14. The following regulatory violation was found.</p> <p>483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE GP</p> <p>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.</p> <p>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 each assessment.</p> <p>This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility failed to revise care plans for 1 of 2 applicable residents, Resident #22. Findings include: Per record review on 5/6/14, Resident #22 had</p>	F 000 F 280	<p>C -(a) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP</p> <p>Concerns Identified: Based on staff interview and record Review, the facility failed to revise care plans for 1 of 2 applicable residents.</p> <p>Corrective Action: MDS Coordinator / DNS shall review all Care plans for accuracy, sign and date before 5/25/14. When problems are entered in care plan, goals and/or approaches will be updated as needed. Then at each Quarterly Care planning meeting each resident's plan of care will be reviewed to ensure accuracy. Each quarter the DNS or designee will sign and date for accuracy. We will check this process for 1 year.</p> <p>Monitoring: Will be reported at each quarter at the Quality Nursing Home meeting.</p> <p>Completion Date: Phase 1- May 25, 2014 Phase 2 -May 2015</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____

Spide M... RN, BSN, MED, MS, DHA

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. (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.

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

PRINTED: 05/07/2014
FORM APPROVED
OMB NO. 0938-0391

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F 280	Continued From page 1 been assessed upon admission to the facility, on 10/11/13, to be at risk for falls. The Initial care plan dated 10/13/13 states as a problem that resident is at risk for falls with a goal for falls with no injury for 90 days and the intervention is to monitor for unsteady gait. The Care plan was reviewed and revisions made on 2/23/14 and 4/23/14, with no changes being made to the falls risk. The review of LNA kardexes (care plans) did not present with interventions to address falls risk interventions. Progress notes present that resident was found on floor next to bed on 3/28/14 and presented with a small abrasion on right outer knee that was red without broken skin. Progress notes further indicate that Resident #22 was found sitting on the floor in the dining room on 4/19/14 and was found to be with no injuries. There is no evidence that the facility put in place interventions or made changes to the care plan in an attempt to further prevent resident from having falls. Per interview with the Director of Nursing (DNS), at 11:34AM, regarding the fall on 3/28/14, Resident #22 was found on the floor, tangled in bed sheets and indicated that the resident does get in and out of bed independently. H/she confirmed that there were no interventions put into place to evaluate the current plan of care or interventions put into place to prevent further falls from bed. The DNS stated that the fall in the dining room on 4/19/14 was unwitnessed and there were no evaluations made as to the cause of the fall and no interventions have been made to the care plan in an attempt to address the fall. The DNS stated that Resident #22 was placed on the Falling Star Program, which is the facility's way to alert staff that a resident is at a higher risk for falls, and participation of the program is indicated by a Gold Star on the outside of the bedroom door. When looking at Resident #22	F 280			

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F 280	Continued From page 2 bedroom door, it was confirmed by the DNS that there is no Gold Star and h/she stated that the resident may have removed it. The DNS confirmed that without the Gold Star, there is no other way to indicate the resident is a fall risk. The DNS stated that h/she alerts staff to interventions that need to be in place, but has not written them down.	F 280		