

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

April 29, 2015

Ms. Linda Minsinger, Administrator
Menig Extended Care
44 South Main Street
Randolph, VT 05060-1381

Dear Ms. Minsinger:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **March 31, 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,

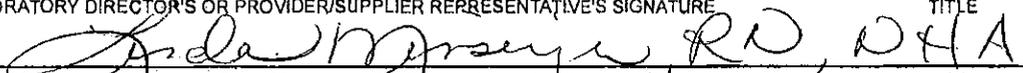


Pamela M. Cota, RN
Licensing Chief

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

PRINTED: 04/07/2015
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 03/31/2015
NAME OF PROVIDER OR SUPPLIER MENIG EXTENDED CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 44 SOUTH MAIN STREET RANDOLPH, VT 05060		
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F 000	INITIAL COMMENTS	F 000			
F 225 SS=D	<p>An unannounced onsite annual recertification survey and investigation of a self-reported incident were conducted by the Division of Licensing and Protection on 3/30 and 3/31/15. The findings include the following:</p> <p>483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS</p> <p>The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.</p> <p>The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.</p> <p>The results of all investigations must be reported to the administrator or his designated</p>	F 225	<p>F225</p> <ol style="list-style-type: none"> <u>Current Resident Corrective action:</u> DON went with Surveyor and immediately called Adult Protective Services Line to report recent incident with Residents #22 and #33. DON then completed and documented investigation on the incident and developed action plan to try to prevent further resident to resident altercation. <u>Prevent reoccurrence with other potential residents:</u> DON revised current process to ensure all future resident to resident altercations are - First called to Adult Protective Services phone line and then a thoroughly investigation is completed within defined guidelines. Documentation as appropriate in Resident Medical record. The Investigation results are kept in file in DON office. <u>Process improvement for prevention:</u> <ol style="list-style-type: none"> All Staff educated on reporting of resident to resident incidents by reading the State Regulation and Menig updated policy and sign after completion. Expect 100% Compliance of Staff. See attached Policy update Reporting Resident to Resident Incidents Process reviewed at monthly staff meeting each month for 3 months (April/May/June) Each staff member will be provided with a copy of the updated abuse policy Each occurrence that is reported will be discussed with the medical director and administrator monthly and trended. 		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE:  TITLE: R.D., DHA (X6) DATE:

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 225	<p>Continued From page 1</p> <p>representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p> <p>This REQUIREMENT is not met as evidenced by: Based on staff interview and medical record review, the facility failed to report an allegation of physical abuse and verbal abuse for 1 of 2 residents in the Stage 2 sample, Resident #22 and failed to have evidence that the incident was thoroughly investigated.. Findings include:</p> <p>1. During record review on 3/30/15, for Resident #22, a progress note dated 3/28/15 stated that a resident was yelling out and when Licensed Nursing Assistant entered the room s/he witnessed Resident #33 slap resident #22 across the face. At 3:11 PM, the charge nurse stated that if there is an incident, it is placed on the report log and when the log was reviewed, there was documentation that indicated an altercation had occurred. At 3:13 PM per the Director of Nursing (DON), s/he investigates an incident first and insures that care plans are up to date and if s/he feels that it is needed to be reported s/he then does so. S/he confirmed at this time that the incident had not been reported. Further review of the medical record on 3/31/15 at 9:00AM presented with nurse progress notes dated 2/15/15 that Resident #22 had pushed Resident #33 in the chest to keep him/her from entering a room and a note dated 3/5/15 indicated that Resident #22 had a verbal altercation with another resident and Resident #22 got up from</p>	F 225	<p>4. <u>Monitoring plan:</u></p> <p>a) The Administrator will monitor that each Resident incident was reported within appropriate time frame and the investigation was fully completed.</p> <p>b) At the Quarterly Quality meeting the Resident to Resident incidents trends will be reviewed and discussed.</p> <p>5. <u>Date Corrective Action Completed:</u></p> <p>a) Staff education and Policy review- Completed April 20, 2015</p> <p>b) Staff meeting- July 1, 2015 <i>by 4-30-2015 per T/C L. de M. 4-24-15</i></p> <p>c) Administrator monitoring- Ongoing</p> <p>d) Quarterly Quality Review - Ongoing</p> <p><i>Account 4-24-15 for</i></p>		

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F 225	Continued From page 2 the table and "got in the face of the elder and made threats to punch [other resident] in the face." On 3/31/15 at 1:10 PM, the DON confirmed that these incidents were not reported per regulation. 2. On 3/31/15 at 1:10 PM, review of the internal investigations for 2/15/15 and 3/5/15 incidents conducted by the facility, they did not provide evidence that the incidents were thoroughly investigated and the Director of Nurses (DON) confirmed that s/he had only spoke to Resident #22 in regards to the inappropriate behaviors of yelling at others or touching others. S/he further stated that statements had not been obtained by witnesses and that an attempt to determine the cause for the behaviors, which are relatively new for the resident, had not been investigated.	F 225			
F 253 SS=B	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observation and confirmed by staff interview the facility failed to ensure that ventilation ducts located in resident care areas are adequately maintained in a sanitary and orderly manner. The findings include the following: Per room to room tour with the Director of Nurses (DNS) on 3/30/15 at 3:30 PM, the following resident room bathrooms were found to have	F 253	F253 1. <u>Current Corrective action:</u> Air ventilation ducts in bathrooms and whirlpool room will be cleaned. 2. <u>Prevention reoccurrence:</u> Bathroom air ventilations units will be visually assessed during Environmental rounds. These will be added to the already occurring monthly multidisciplinary environmental rounds. 3. <u>Process improvement for prevention:</u> a) Air Ventilation Ducts will be added to the Preventive maintenance List for routine cleaning. b) If not completed each quarter, maintenance will contact DON who will follow up with Housekeeping. 4. <u>Monitoring plan:</u> Monitor through Environment rounds monthly 5. <u>Date Corrective action Completed</u> a) Identified Duct work has been cleaned as of April 23, 2015 b) Monthly Environmental rounds will assess cleanliness air ventilation units- ongoing <i>Account 4.24.15 gal</i>		

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F 253	Continued From page 3 ventilation ducts to be heavily caked with dust and debris: Rooms #1, 2, 3, 4, 10, 13, 15, 16, 17, and 18. Both whirl-pool rooms also had ventilation ducts in the same condition. Confirmation was made by both the DNS and the Director of Environment at 4 PM that the vents needed attention and that it has been some time since they had been cleaned.	F 253			
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe 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 §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on observation, record review and	F 279	F279 1. <u>Current Resident Corrective action:</u> Residents #9 and #22 Care plans that were identified by surveyors have been updated and current with resident's conditions. 2. <u>Prevent Recurrence:</u> Developed a new check list for care planning meetings to be used with all residents to ensure any changes will be captured for additions to care plan devised to keep care plans up to date and accurate. See Attached Checklist and care plan policy 3. <u>Process improvement for prevention:</u> a) MDS nurse, Staff nurse and DON reviewed and updated all 29 resident care plans. b) Care plan team will utilize the new checklist at each resident care plan review. 4. <u>Monitoring plan:</u> a) DON, or designee, will randomly review 5 care plans / month to ensure up to date accuracy		

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F 279	<p>Continued From page 4</p> <p>confirmed by staff interview the facility failed to develop comprehensive plans of care for 2 of 11 applicable residents in the Stage 2 sample, for Residents # 9 and #22. The findings include the following:</p> <p>1. Per medical record review on 3/31/15 at approximately 2:PM, Resident #9 admitted on 4/7/14 with diagnoses to include overflow incontinence. Per physician's progress note dated 7/24/14 identifies that the resident has frequency in voiding and has to go to the bathroom every two (2) hours. S/he has had infections in the past. The attending physician ordered the catheterization after dinner every night on 7/24/14. On 8/5/14, Resident #9 was seen by a Urologist, who documents through bladder scanning, post residual voiding evidences urine retention up to 280 milliliters. The specialist suggested catheterizing the resident after dinner every night in an attempt to assist Resident #9 to sleep through the night. On 3/19/15 the attending physician ordered a medication adjustment and advised nursing staff to hold evening catheterization for two (2) weeks, call the physician if any changes worsen or changes in urinary situation occur.</p> <p>Per review of the initial and current comprehensive care plans on 3/31/15, there is no evidence that Resident #9's urinary problems or the need for catheterization were ever included. Confirmation was made by the Director of Nurses and the Charge Nurse on 3/31/15 at approximately 3:30 PM.</p> <p>2. On 3/31/15, during record review for Resident #22, the nurse progress notes presented with s/he had been slapped by another resident on 3/28/15. Nurse note dated 1/13/15 stated that</p>	F 279	<p>b) Randomly review 5 Completed Checklists, kept in MDS care planning notebook, per month to ensure effectiveness of the checklist document</p> <p>5. <u>Date Corrective action Completed</u></p> <p>a) Care plans identified (#9 & #22) were updated for accuracy - April 2, 2015</p> <p>b) All resident Care plans were reviewed for current accuracy - April 17, 2015</p> <p>c) Monitoring of ongoing accuracy of care plans by DON-ongoing</p>		

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F 279	Continued From page 5 resident was pulling on the arm of another resident and yelling at them. Physician progress notes dated 2/9/15 present that the resident was ebbing and flowing in regards to her interactions with staff and other residents. A 2/15/15 nurse note states that resident pushed another resident in the chest to keep them from entering a room. Numerous notes written since 12/1/14 indicate that the Resident # 22 had verbal outbursts and was being overly concerned of what other residents were doing and needed to be redirected. A 3/5/15 nurse note states that resident had a verbal altercation with another resident and got up from their table and, 'got in [his/her] face and made threats to punch them in the face'. There was no evidence that a care plan had been developed regarding behaviors and altercations until 3/4/15. Confirmation was made at 1:10 PM by the Director of Nursing that a care plan had not been developed to represent the behaviors of the resident.	F 279			
F 280 SS=D	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	F 280			

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F 280	<p>Continued From page 6</p> <p>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 2 of 11 applicable residents (Residents # 30 and 21). Findings include:</p> <p>1. Per record review on 3/31/15 at 2:48 PM, the care plan for Resident # 30 was not revised to reflect a pressure ulcer. Per record review, Resident # 30 developed a stage 1 pressure ulcer to the left ischial area and a stage 2 pressure ulcer to the right ischial area on 11/3/14. There is a care plan in place for risk of skin breakdown but no care plan for the actual pressure ulcers. This was confirmed by the Director Of Nursing (DON) on 3/31/15 at 3:08 PM. The DON who stated that the care plan should have been revised to reflect the actual ulcers.</p> <p>2. Per observation and record review on 3/31/15 at 12:10 PM, Resident # 21's care plan was not revised to reflect that a floor mat in the resident's room was no longer needed. Per review of the falls risk care plan, there was to be an anti-slip mat at the resident's bedside. During interview with the DON on 3/31/15 at 1:12 PM, the DON stated that the mat was removed from the resident's room as it was deemed a tripping hazard. The DON confirmed that the care plan had not been revised to remove the mat.</p>	F 280	<p>F280</p> <p>1. <u>Current Resident Corrective action:</u> Residents #30 and #21 Care plans that were identified by surveyors have been updated and current with resident's conditions.</p> <p>2. <u>Prevent Reoccurrence:</u> Developed a new check list for care planning meetings to be used with all residents to ensure any changes will be captured for additions to care plan devised to keep care plans up to date and accurate.</p> <p>3. <u>Process improvement for prevention:</u></p> <p>a) MDS nurse, Staff nurse and DON reviewed and updated all 29 resident care plans.</p> <p>b) Care plan team will utilize the new checklist at each resident care plan review.</p> <p>4. <u>Monitoring plan:</u></p> <p>a) DON , or designee, will randomly review 5 care plans / month to ensure up to date accuracy</p> <p>b) Randomly review 5 Completed Checklists, kept in MDS care planning notebook , per month to ensure effectiveness of the checklist document</p> <p>5. <u>Date Corrective action Completed</u></p> <p>a) Care plans Identified (#9 & #22) were updated for accuracy – April 2, 2015</p> <p>b) All resident Care plans were reviewed for current accuracy -April 17, 2015</p> <p>c) Monitoring of ongoing accuracy of care plans by DON-ongoing</p> <p><i>DOC [Signature] 4-24-15</i></p>		

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F 281 SS=D	<p>483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS</p> <p>The services provided or arranged by the facility must meet professional standards of quality.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to adhere to professional standards regarding medication administration for 1 of 11 residents (Resident # 11). Findings include:</p> <p>Per record review on 3/31/15 at 1:23 PM, Resident # 11 had a physician's order for Nitrotab (a heart medicine) 0.4 milligrams (mg) tablet, use as directed as needed. Resident # 11 has a diagnosis of Arterial Occlusive Disease. There are no indications for use or parameters for administration in the physicians order or on the Medication Administration Record (MAR). In addition, per observation with a unit nurse, the medication was not available in either of two medication carts and the nurse was unaware where the medication was kept. Per observation with the Director of Nursing (DON), the medication was kept in a sealed emergency drawer in the medication room. There were no indications for use as directed on the medication container. This was confirmed by the DON on 3/31/15 at 1:51 PM.</p> <p>Reference: Lippincott Manual of Nursing Practice (9th Edition). Wolters Kluwer Health/Lippincott Williams and Wilkins.</p>	F 281	<p>F281</p> <p>1. <u>Current Resident Corrective action:</u> Immediately clarified order with Physician for Residents #11. Medication was moved to right medication cart and labeled appropriately. Spoke with Pharmacy about improperly written order with no parameters for administration.</p> <p>2. <u>Prevent Reoccurrence:</u></p> <p>a) DON reviewed all Residents MARS for properly written medication orders</p> <p>b) All medications provided by pharmacy are properly labeled with patient name and administration parameters.</p> <p>3. <u>Process improvement for prevention:</u></p> <p>a) Educate Nursing staff on properly written medication orders</p> <p>b) Ensure Pharmacists reviews orders written for appropriate parameters</p> <p>c) Nursing staff/pharmacy will check that all emergency medications for residents are in the correct cart and labeled appropriately.</p> <p>4. <u>Monitoring plan:</u></p> <p>a) Pharmacy will check all medication orders are written with clear administration requirements.</p> <p>b) The Pharmacy will contact Provider and DON of any orders found not be meet the standard</p> <p>c) Periodic medication cart/area checks by Pharmacy and document findings</p> <p>d) Pharmacy will report at Quarterly Quality meetings any findings</p> <p>5. <u>Date Corrective action Completed</u></p> <p>a) Educate Nursing staff on properly written medication orders- Completed April 1, 2015</p> <p>b) All resident MARS were reviewed for accuracy of written orders- Completed April 24, 2015</p> <p>c) Periodic medication cart/area checks by Pharmacy - ongoing</p> <p>d) Quarterly Quality Meetings- Pharmacy will report any findings- ongoing</p> <p><i>Account 4-24-15</i></p>		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN	F 282			

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F 282	<p>Continued From page 8</p> <p>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review and confirmed by staff interview the facility failed to implement the comprehensive care plan for 1 of 11 applicable residents in the Stage 2 sample for Resident #9. The findings include the following:</p> <p>Per medical record review on 3/31/15 at approximately 3 PM, Resident #9 admitted on 4/7/14 with diagnoses to include Spinal Stenosis, Osteoporosis, Artherosclerotic Cardiovascular Disease with stent placements, Anxiety Disorder and overflow incontinence.</p> <p>Physician orders prescribed Resident #9, to receive Clonazepam 0.25 milligrams (mg) daily by mouth (po) at 8 AM and 0.50 mg at hours of sleep (hs). May have Clonazepam 0.25 mg po as needed every 12 hours for anxiety. Clonazepam is classified as an anticonvulsant medication indicated for residents with panic disorders, seizures and Bipolar Disease. The medication has risks for adverse side effects such as difficulty speaking, tremor, ataxia, abnormal coordination and psychosis. Monitoring is necessary to ensure the need for the medication and/or dose adjustment.</p> <p>Per review of the comprehensive care plan, a problem identifies that the resident is receiving psychotropic medication (Clonazepam) with the initiative to monitor for changes in mood and</p>	F 282	<p>F282</p> <p>1. <u>Current Resident Corrective action:</u> Order Clarified with Provider for Resident #9. Immediately monitored side effects of psychoactive medication for this resident.</p> <p>2. <u>Prevent Reoccurrence:</u></p> <ul style="list-style-type: none"> a) DON reviewed all Residents MARS for properly written medication orders b) All medications provided by pharmacy are properly written with clear administration parameters. c) Developed AIMS policy <p>3. <u>Process improvement for prevention:</u></p> <ul style="list-style-type: none"> a) Educate Nursing staff on properly written medication orders and new AIMS policy b) Ensure Pharmacists reviews orders written for appropriate parameters and AIMS monitoring compliance c) See attached AIMS policy <p>4. <u>Monitoring plan:</u></p> <ul style="list-style-type: none"> a) Pharmacy will check all medication orders are written with clear administration requirements. They will also monitor compliance to AIMS assessment with dosage changes. b) The Pharmacy will contact Provider and DON of any orders found not be meet the standard c) Pharmacy will contact DON of any findings and report at Quarterly Quality meetings 		

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

PRINTED: 04/07/2015
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 03/31/2015
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 282	Continued From page 9 behaviors. On 4/16/14 an Abnormal Involuntary Movement Scale (AIMS) evaluation was conducted. An AIMS evaluation is a tool used to monitor for side effects of antipsychotic medications. Per monthly summary dated 5/2014 through 3/2015 identifies that Resident #9, receives antidepressant and anxiety medication, however the side effect question on all summaries is left blank. Nurses notes do not identify any evidence that monitoring for side effects of medication have been conducted. Per interview on 3/31/15 at approximately 4 PM with the Director of Nurses and the Charge Nurse, confirmation is made that there is no evidence that nursing staff have monitored for side effects for the use of Clonazepam. The care plan has not been followed and physician orders dated 3/19/15 identify that the hs dose of the medication was increased. The DNS is unable to locate a policy or procedure that identifies how side effects of specific medications are to be evaluated.	F 282	5. <u>Date Corrective action Completed</u> a) All resident MARS were reviewed for accuracy of written orders- Completed April 24, 2015 b) Pharmacy review monthly - ongoing <i>Account 4.24.15 - el</i>		
F 329 SS=D	(See F329) 483.25(i) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.	F 329			

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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 329	<p>Continued From page 10</p> <p>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review and confirmed by staff interview the facility failed to comprehensively assess and adequately monitor for the presence of adverse consequences for 1 of 11 applicable residents in the Stage 2 Sample for Resident #9. The findings include the following:</p> <p>Per medical record review on 3/31/15 at approximately 3 PM, Resident #9 admitted on 4/7/14 with diagnosis to include Spinal Stenosis, Osteoporosis, Artherosclerotic Cardiovascular Disease with stent placements, Anxiety Disorder and overflow incontinence.</p> <p>Physician orders prescribed Resident #9, to receive Clonazepam 0.25 milligrams (mg) daily by mouth (po) at 8 AM and 0.50 mg at hours of sleep (hs). May have Clonazepam 0.25 mg po as needed every 12 hours for anxiety. Clonazepam is classified as an anticonvulsant medication</p>	F 329	<p>F329</p> <p>1. <u>Current Resident Corrective action:</u> Order Clarified with Provider for Resident #9. Immediately monitored side effects of psychoactive medication for this resident.</p> <p>2. <u>Prevent Reoccurrence:</u></p> <p>c) DON reviewed all Residents MARS for properly written medication orders</p> <p>d) All medications provided by pharmacy are properly written with clear administration parameters.</p> <p>e) Developed AIMS policy</p> <p>3. <u>Process improvement for prevention:</u></p> <p>d) Educate Nursing staff on properly written medication orders and new AIMS policy</p> <p>e) Ensure Pharmacists reviews orders written for appropriate parameters and AIMS monitoring compliance</p> <p>4. <u>Monitoring plan:</u></p> <p>a) Pharmacy will check all medication orders are written with clear administration requirements. They will also monitor compliance to AIMS assessment with dosage changes.</p> <p>b) The Pharmacy will contact Provider and DON of any orders found not be meet the standard</p> <p>c) Pharmacy will contact DON of any findings and report at Quarterly Quality meetings</p>		

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NAME OF PROVIDER OR SUPPLIER MENIG EXTENDED CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 44 SOUTH MAIN STREET RANDOLPH, VT 05060		
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F 329	<p>Continued From page 11</p> <p>indicated for residents with panic disorders, seizures and Bipolar Disease. The medication has risks for adverse side effects such as difficulty speaking, tremor, ataxia, abnormal coordination and psychosis. Monitoring is necessary to ensure the need for the medication and/or dose adjustment.</p> <p>Per review of the comprehensive care plan, a problem identifies that the resident is receiving psychotropic medication (Clonazepam) with the initiative to monitor for changes in mood and behaviors. On 4/16/14 an Abnormal Involuntary Movement Scale (AIMS) evaluation was conducted. An AIMS evaluation is a tool used to monitor for side effects of antipsychotic medications. Per monthly summary dated 5/2014 through 3/2015 identifies that Resident #9, receives antidepressant and anxiety medication, however the side effect question on all summaries is left blank. Nurses notes do not identify any evidence that monitoring for side effects of medication have been conducted.</p> <p>Per interview on 3/31/15 at approximately 4 PM with the Director of Nurses and the Charge Nurse, confirmation is made that there is no evidence that nursing staff have monitored for side effects for the use of Clonazepam. The care plan has not been followed and physician orders dated 3/19/15 identify that the hs dose of the medication was increased. The DNS is unable to locate a policy or procedure that identifies how side effects of specific medications are to be evaluated.</p> <p>(See F 282)</p>	F 329	<p>5. <u>Date Corrective action Completed</u></p> <p>a) All resident MARS were reviewed for accuracy of written orders- Completed April 24, 2015</p> <p>b) Pharmacy review monthly - ongoing</p> <p><i>pc wnt 4.24.15</i></p>		



CONFIDENTIAL

Title:	Adult Abuse and Reporting	Effective Date:	2015-04-21	Policy #:	MEC-106
Applies to:	<input type="checkbox"/> Gifford Health Care <input type="checkbox"/> Gifford Medical Center <input checked="" type="checkbox"/> Gifford Retirement Community				
Division:	<input type="checkbox"/> Primary Care <input type="checkbox"/> Hospital <input type="checkbox"/> Surgical <input type="checkbox"/> Operations <input type="checkbox"/> Administrative Svcs.				
Contact:	Director of Nursing Menig Nursing Home				

Purpose/Policy Statement: Each resident has the right to be free from abuse, corporal punishment and involuntary seclusion. (See State of Vermont Memo 4/13/2013)

Each resident has the right to be free from abuse, corporal punishment and involuntary seclusion. Residents must not be subjected to abuse by anyone including facility staff, other residents, consultants, volunteers, and staff of other agencies serving the residents, family members or legal guardians, friends or any other individuals.

Each resident has the right to be free from mistreatment, neglect and misappropriation of property. This includes the identification of patients and residents whose personal histories render them at risk for abusing other residents, and development of intervention strategies to prevent occurrences, monitoring for changes that would trigger abusive behavior, and reassessment of the interventions on a regular basis.

DEFINITIONS: "Abuse" means the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish." This also includes the deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental, and psychosocial well-being. This presumes that instances of abuse of all residents, even those in a coma, cause physical harm, or pain or mental anguish.

"Verbal abuse" is defined as the use of oral, written or gestured language that willfully includes disparaging and derogatory terms to residents/patients or their families, or within their hearing distance, regardless of their age, ability to comprehend, or disability. Examples of verbal abuse include, but are not limited to: threats of harm; saying things to frighten a resident/patient, such as telling a resident/patient he/she will never be able to see his/her family again.

"Sexual abuse" includes, but is not limited to, sexual harassment, sexual coercion, or sexual assault.

"Physical abuse" includes hitting, slapping, pinching and kicking. It also includes controlling behavior through corporal punishment.

"Mental abuse" includes, but is not limited to, humiliation, harassment, threats of punishment or deprivation.

"Neglect" means failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness.

"Misappropriation of resident/patient property" means deliberate misplacement, exploitation, or wrongful, temporary or permanent use of a resident's/patient's belongings or money without the resident's consent.

"Involuntary seclusion" is defined as separation of a resident/patient from other residents/patients or from her/his room or confinement to his/her room (with or without roommates) against the resident's/patient's will, or the will of the resident's/patient's legal representative. Emergency or short term monitored separation from other residents/patients will not be considered involuntary seclusion and may be permitted if used for a limited period of



time as a therapeutic intervention to reduce agitation until professional staff can develop a plan of care to meet the resident's/patient's needs.

Gifford has developed and implemented policies and procedures that include the seven components: screening, training, prevention, identification, investigation, protection and reporting or responding to abuse.

Screening

Gifford screens potential employees for a history of abuse, neglect or mistreating residents or patients. This includes obtaining information from previous employers and/or current employers, and checking with the appropriate licensing boards and registries. Gifford will not employ individuals who have been:

- Found guilty of abusing, neglecting, or mistreating residents/patients by a court of law; or
- Have had a finding entered into the State registry concerning abuse, neglect, mistreatment of residents/patients or misappropriation of their property; and
- Report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse, aide, or other facility staff to the State registry or licensing authorities.

Training

Gifford trains employees through orientation and on-going in-services on issues related to abuse prevention practices:

- Appropriate interventions to deal with aggressive and/or inappropriate reactions of residents;
- How staff should report their knowledge related to allegations without fear of reprisal;
- How to recognize signs of burnout, frustration and stress that may lead to abuse; and;
- What constitutes abuse, neglect and misappropriation of resident property.

Prevention

Gifford has procedures to provide residents, families and staff information on how and to whom they report concerns, incidents and grievances without the fear of retribution; and feedback regarding concerns when they are expressed. Identify, correct and intervene in situations in which abuse, neglect and/or misappropriation of property is more likely to occur. This includes:

- Features of the physical environment that may make abuse and/or neglect more likely to occur, such as secluded areas of the facility;
- The deployment of staff on each shift in sufficient numbers to meet the needs of the residents and assure that the staff assigned have knowledge of the individual patients care needs;
- The supervision of staff to identify inappropriate behaviors, such as using derogatory language, rough handling, or ignoring residents while giving care.
- The assessment, care planning, and monitoring of residents with needs and behaviors which might lead to conflict or neglect, such as residents with a history of aggressive behaviors, self-injurious behaviors, communication disorders and those who require heavy nursing care or are totally dependent on staff.

All alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the DON or Administrator, the State Licensing Agency and to other officials in accordance with State law within 24 hours of the incident. If the alleged violation is verified, appropriate corrective action shall be instituted. All alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.



Identification

Gifford has procedures to identify events, such as suspicious bruising of residents, occurrences, patterns and trends that may constitute abuse; and to determine the direction of the investigation.

Investigation

Gifford will:

- Investigate different types of incidents; and
- Identify the staff member responsible for the initial reporting, investigation of alleged violations and reporting of results to the proper authorities.

Protection

Gifford will protect residents from harm during an investigation.

Reporting/Response

Gifford will Report all alleged violations and all substantiated incidents to the State Licensing Agency and to all other agencies as required, and take all necessary corrective actions depending on the results of the investigation; Report to the State nurse aide registry or licensing authorities any knowledge it has of any actions by a court of law which would indicate an employee is unfit for service; and analyze the occurrences to determine what changes are needed, if any, to policies and procedures to prevent further occurrences.

PROCEDURES:

1. Anyone who witnesses an incident of resident abuse, neglect and exploitation is required to report it to the nurse in charge, the Director of Nursing, or the Administrator.
 - o Events such as suspicious bruising of residents, injuries of unknown source, misappropriation of resident property, occurrences, patterns, and trends that may constitute abuse should be reported as above.
2. Gifford will make available information to provide residents, families and staff information on how and to whom they may report concerns, incidents and grievances without fear of retribution; and provide feedback regarding the concerns that have been expressed.
3. When a person reports any allegation or suspects an incident of abuse, neglect or exploitation involving residents of Menig, the Administrator or Director of Nursing will be immediately notified.
4. Appropriate steps will be taken to protect the resident from further abuse, neglect or exploitation.
5. The employee is immediately removed from duty.
6. A thorough investigation is conducted
7. All alleged or suspected incidents of abuse, neglect or exploitation involving residents or patients to Adult Protective Services within 24 hours of facility personnel receiving the information.

Telephone: 802-871-3317 or web site reporting on DAIL website

TRAINING OF EMPLOYEES

Menig will provide in-service to train employees, through orientation and annually related to abuse prohibition practices such as:

- o Appropriate interventions to deal with aggressive reactions of residents;
- o How staff should report their knowledge related to allegations without fear of reprisal;
- o How to recognize signs of burnout, frustration and stress that may lead to abuse; and
- o What constitutes abuse, neglect and misappropriation of resident property.
- o How to report abuse, neglect and misappropriation of resident property.



Key Words: Adult abuse, residents

All Staff (non-providers): A policy is intended to clarify expected practice and commit the organization/staff to a specific course of action. Any temporary requests or decisions to modify an expected course of action as outlined in a policy must be approved by Senior Management or the Administrator-on-Call.

Providers: Not all patient situations will fit the policy as written. Patient care is individualized based on professional judgment and a patient's condition may require a change in the care provided. Deviation from the written, adopted policy should be clearly documented in the patient's medical record along with the rationale for such deviation.

Standard or Statute:	<input type="checkbox"/> N/A <input type="checkbox"/> CAH Standard <input checked="" type="checkbox"/> NH Standard <input type="checkbox"/> FQHC	<input type="checkbox"/> Labor Statute <input type="checkbox"/> VT State Statute <input type="checkbox"/> Compliance/HIPAA <input type="checkbox"/> Other	Standard or Statute Details:	F151, F156, F223, F224, F225, F226, C382-C385
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Careplan Checklist

		YES	No	Added to CP
Neurological				
	change in mental status			
Cardiac				
	changes in status?			
	New or med changes			
Respiratory needs				
	Change in resp status			
	Change in O2 requirements?			
	Change in nebs/treatments?			
genitourinary needs				
	Changes in bladder?			
	Any infections?			
	Require cathing?			
Bowel				
	Changes in bowel habits?			
	Incontinence?			
Mobility status				
	New DME			
	PT/OT/ST needs?			
	Any falls last quarter?			
Nutritional status				
	Weight gain/loss?			
	Dentition needs?			
	Dentures?			
	Last dental exam?			
Skin integrity				
	Any PU			
	Any tears/bruising?			
	Any wounds?			
Medication management				
	Any new medications last quarter?			
Emotional Needs				
	Psychosocial changes			
Activities				
	spiritual needs			
	Participate in activities?			
Refferal to Specialist				
Review End of Life paperwork				
Review Family contact information				



CONFIDENTIAL

Title:	Resident Care Planning	Effective Date:	2015-04-10	Policy #:	MEC-110
Applies to:	<input type="checkbox"/> Gifford Health Care <input type="checkbox"/> Gifford Medical Center <input checked="" type="checkbox"/> Gifford Retirement Community				
Division:	<input type="checkbox"/> Primary Care <input type="checkbox"/> Hospital <input type="checkbox"/> Surgical <input type="checkbox"/> Operations <input type="checkbox"/> Administrative Svcs.				
Contact:	Director of Nursing Menig Nursing Home				

Purpose/Policy Statement: To develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.

An interdisciplinary team, in conjunction with the resident, resident's family surrogate or representative as appropriate, shall develop quantifiable objectives to attain the highest level of functioning the resident may be expected to attain, based on the comprehensive assessment.

Evidence shall exist in the CAA (Comprehensive Annual assessment) summary and clinical record of the following:

- The resident's status in triggered CAA areas;
- The rationale for deciding whether to proceed with care planning; and
- Evidence of the development of care planning interventions for all Raps triggered by the MDS.

The Care plan shall describe:

- Services to be furnished to attain or maintain the highest practicable physical mental and psychosocial well-being
- Any services that would otherwise be required but are not provided due to the resident's exercise of rights (including the right to refuse treatment).

The Comprehensive care plan will be:

- Developed within 7 days after the completion of the comprehensive assessment;
- Prepared by an interdisciplinary team that includes the: attending physician; Staff nurse; Other appropriate staff in disciplines as determined by the resident's needs and, to the extent practical, with participation of the resident, the resident's family or the resident's legal representative.
- Periodically reviewed and revised by the Care Plan Team after each assessment.

Procedure:

The plan of care is initiated 24 hours after admission and fully developed within 7 days after the completion of the comprehensive assessment.

- Resident Care Plans are initiated by a registered nurse. Licensed practical nurses and ancillary professionals add to the plan of care after initiation.
- Following multidisciplinary team conferences, which occur 21, 30 and every 90 days thereafter unless there is a significant change in the resident's condition. The nurse coordinates the Resident Care Plan for all disciplines by updating goals and actions that were discussed.
- Between multidisciplinary team conferences, each discipline contributes to the Resident Care Plan as indicated, which initiated and discontinues activities when completed.
- Each discipline is responsible for following established format for care planning in the long-term care facility.
- The Resident's Care Plans are kept on the unit. (They may be located in the Kardex for nursing assistant use during the resident's stay).



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- A readmission to the long-term care facility has their previous plans of care available for review. However, if the resident is out of the facility longer than 48 hours, then a totally new Care Plan is completed.
1. Assessment
 - a. A functional nursing assessment is conducted using MDS 3.0 Assessment form (Minimum Data Set).
 2. Diagnosis
 - a. Resident needs are discussed and prioritized by resident, family, and nurse.
 - b. Problems/Needs/Concerns are developed and placed in the Resident's Care Plan.
 3. Planning and Setting Goals
 - a. Planning and setting goals are a team effort by health care personnel, resident, and family.
 - b. Goals are realistic for the individual involved.
 - c. Goals also must be stated in terms of behavior that is specific and measurable within a given time.
 - d. Small or enabling steps may be defined in reaching a short-term goal.
 - e. Long-term goals must be individualized and realistic for resident involved; potential for discharge is considered from day of admission.
 4. Implementation
 - a. Action of nursing intervention is specific and relates to each stated short-term goal.
 - b. Times and actions are stated so caregivers can carry out care with complete continuity.
 - c. Notations about implementation of care are made in progress notes to verify progress, or lack of, in relation to each goal.
 5. Evaluation
 - a. Progress on goal achievement is evaluated on the date set in the given time; status of the goal is recorded in the progress notes.
 - b. If the goal has been achieved, the problem goal and action are placed in brackets and a date documented indicative of resolution and so indicated in the progress notes as well.
 - c. If progress is slow, a new time may be established and actions adjusted to meet resident needs more adequately; information is recorded in the progress notes.
 - d. The goal may be determined to be unworkable. In this instance, it is crossed off the Resident Care Plan, and progress notes contain the reason or discontinuing the goal.

Interdisciplinary Care Plan:

An Interdisciplinary Care Plan Conference exists to identify resident needs and establish obtainable goals. An appropriate plan of action is designed to ensure optimal levels of activity and independence for all residents. Documentation is done on the Interdisciplinary Care Plan.

- The MDS Coordinator or designee conducts all Resident Care Plan reviews.
- Conferences are held within 21 days following admission, at intervals of 30, 90 and every 90 days thereafter unless there is a condition change.
- Residents are invited to participate, and if they grant permission, other family members (or the responsible party) are invited and documented in their Resident's Care Plan.
- Included are representatives from nursing, dietary, care management, rehabilitation as needed and activities. Other disciplines participate as needed.
- The person that chairs the Interdisciplinary Conference moderates differences of opinions among team members.
- Resident Care Plans are written in ink or computerized. Discontinued items are crossed out with ink using brackets and the date or discontinued.



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- Discontinued Resident Care Plans are filed in the resident's thinned active health record in the Health Information Department.

PROCEDURE

1. The MDS Nurse sends a list of residents to be reviewed to all disciplines at least two weeks in advance of the conference.
2. The Care plan checklist is started and reviewed
3. An invitation to the resident's legal representative is sent with the scheduled conference date.
4. Residents attend if desired.
5. Attendance, including the resident and legal representative, is placed on the Interdisciplinary Care Plan Signature Sheet.
6. The MDS Nurse or designee leads the discussion and summarizes at the end of each case.
7. The Care plan check list is completed and all aspects are discussed at the Care planning meeting. The checklist is saved by the MDS Coordinator.
8. Resident's Care Plan is updated by the MDS Coordinator or designee at each Conference.
9. Between Interdisciplinary Care Plan Conferences, all disciplines update Resident Care Plans using the proper procedure for entering and discontinuing items.
10. Disciplines involved in Resident Care Plan reviews, and unable to attend the Interdisciplinary Conference, provide the MDS Coordinator or designee with relevant information before the Interdisciplinary Conference.
11. Scheduled evaluation of Resident Care Plans by the Interdisciplinary Conference occurs: For new admissions, the Resident Care Plan is reviewed within 21 days after admission, 30 and 90 days after admission, and every 90 days thereafter unless there has been a condition change.
12. Activities of the Interdisciplinary Team:
 - a. The fourteen-day review includes, at a minimum:
 - A review of established long term and short term goals.
 - Completion and review of the Minimum Data Set (MDS) form.
 - Rehabilitation potential noted on the History and Physical Examination Form.
 - Assurance that all reports of admission required are in the health record.
 - b. The 30-day, 90 day and annual reviews include:
 - A review of current long term and short term goals.
 - Resident care problems, goals and approaches with appropriate time frames.
 - MDS form

Key Words: Care Planning, MDS, Interdisciplinary care plan

All Staff (non-providers): A policy is intended to clarify expected practice and commit the organization/staff to a specific course of action. Any temporary requests or decisions to modify an expected course of action as outlined in a policy must be approved by Senior Management or the Administrator-on-Call.

Providers: Not all patient situations will fit the policy as written. Patient care is individualized based on professional judgment and a patient's condition may require a change in the care provided. Deviation from the written, adopted policy should be clearly documented in the patient's medical record along with the rationale for such deviation.

Standard or Statute:	<input type="checkbox"/> N/A	<input type="checkbox"/> Labor Statute	Standard or Statute Details:	F279, F280
	<input type="checkbox"/> CAH Standard	<input type="checkbox"/> VT State Statute		
	<input checked="" type="checkbox"/> NH Standard	<input type="checkbox"/> Compliance/HIPAA		
	<input type="checkbox"/> FQHC	<input type="checkbox"/> Other		



CONFIDENTIAL

Title:	Assessment of Involuntary Movements (AIMS) Testing	Effective Date:	2015-04-02	Policy #:	MEC-163
Applies to:	<input type="checkbox"/> Gifford Health Care <input type="checkbox"/> Gifford Medical Center <input checked="" type="checkbox"/> Gifford Retirement Community				
Division:	<input type="checkbox"/> Primary Care <input type="checkbox"/> Hospital <input type="checkbox"/> Surgical <input type="checkbox"/> Operations <input type="checkbox"/> Administrative Svcs.				
Contact:	Director of Nursing, Menig				

Purpose/Policy Statement:

To provide assessment to any resident receiving anti-psychotic medications without adverse reactions.

Responsibilities:

Monitor any involuntary movements upon admission and every six months for side effects of anti-psychotic medications using the AIMS testing tool. If any dosage change is indicated, assess the resident and re-assess the resident again in six months for side effects/effectiveness. Utilize the pharmacy as needed for medication regime.

All residents on psychoactive medication will be reviewed monthly and documented on the resident summary.

All Staff (non-providers): A policy is intended to clarify expected practice and commit the organization/staff to a specific course of action. Any temporary requests or decisions to modify an expected course of action as outlined in a policy must be approved by Senior Management or the Administrator-on-Call.

Providers: Not all patient situations will fit the policy as written. Patient care is individualized based on professional judgment and a patient's condition may require a change in the care provided. Deviation from the written, adopted policy should be clearly documented in the patient's medical record along with the rationale for such deviation.

Standard or Statute:	<input type="checkbox"/> N/A	<input type="checkbox"/> Labor Statute	Standard or Statute Details:	
	<input type="checkbox"/> CAH Standard	<input type="checkbox"/> VT State Statute		
	<input type="checkbox"/> NH Standard	<input type="checkbox"/> Compliance/HIPAA		
	<input type="checkbox"/> FQHC	<input type="checkbox"/> Other		