

Division of Licensing and Protection

HC 2 South, 280 State Drive

Waterbury, VT 05671-2060

<http://www.dail.vermont.gov>

Survey and Certification Voice/TTY (802) 241-0480

Survey and Certification Fax (802) 241-0343

Survey and Certification Reporting Line: (888) 700-5330

To Report Adult Abuse: (800) 564-1612

April 6, 2016

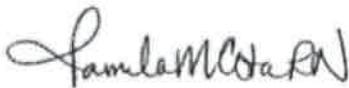
Ms. Linda Minsinger, Administrator
Menig Nursing Home
215 Tom Wicker Lane
Randolph Center, VT 05061

Dear Ms. Minsinger:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on March 9, 2016. 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: 03/22/2016
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 03/09/2016
NAME OF PROVIDER OR SUPPLIER MENIG NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 216 TOM WICKER LANE 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 280 SS=D	<p>An unannounced on-site Recertification survey was conducted by the Division of Licensing and Protection from 3/7/2016 to 3/9/2016. The following issues were identified.</p> <p>483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP</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 observation, record review, and staff interview, the facility failed to ensure that a care plan was revised to reflect current status and possible interventions for 1 of 14 residents sampled (Resident #9). Findings include:</p>	F 280		

*on attached sheet:
Doc accepted on 4/4/16
R Coleman, M.D.*

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE **4/4/16**

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.

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER # 475058	MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	DATE SURVEY COMPLETE: 3/9/2016
NAME OF PROVIDER OR SUPPLIER MENIG NURSING HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 215 TOM WICKER LANE RANDOLPH CENTER, VT	
ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES		
F 428	<p>483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON</p> <p>The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist.</p> <p>The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon.</p> <p>This REQUIREMENT is not met as evidenced by: Based on medical record review and confirmed during staff interview, the facility failed to respond to the recommendations of the pharmacist for 1 of 5 residents (# 3). The specifics are detailed below:</p> <p>Per medical record review, Resident # 3 has Meclizine ordered to be taken 1 hour prior to any outings. On 2/2/2016 the pharmacist recommended, during regular monthly visits and medication reviews that a diagnosis be provided as justification to use this medication. To date there is not a diagnosis given to substantiate the administration of Meclizine. This is confirmed by the nurse during interview on 3/9/2016 at 12:20 PM.</p>		

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

The above isolated deficiencies pose no actual harm to the residents

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F 280	Continued From page 1 Per observation on 3/7/16, Resident #9 was sitting in the dining room with a short sleeved shirt on, and was noted to have a lot of small bruises and multiple skin tears on both arms. The skin tears were covered with a clear dressing to protect them. Review of the nurse's notes showed documentation of treating the wounds and their status. In review of the plan of care, there was no update to the current status of the open wounds, as well as no goals or interventions in place that addressed any possible strategies to prevent further skin tear wounds for this resident. Per interview on 3/8/16, the Director of Nursing confirmed that the plan of care had not been updated to include the actual skin integrity status and possible interventions to prevent further incidents.	F 280		
F 325 SS=D	483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to monitor body weight for a	F 325		

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F 325	Continued From page 2 resident with nutritional concerns for 1 of 14 residents (Resident #9). Findings include: Per record review, Resident #9 had an episode of losing weight in October 2015, when s/he lost over 5 lbs. in a month. The interventions implemented at that time such as supplementation to the diet were successful in regaining weight lost and extra gain. The resident had a diagnosis of depression, was noted to be a very picky eater, and did not always consume enough calories based on a dietician assessment. The resident's last weight recorded on 12/10/15 was 137 lbs. The resident had a fall at the facility, fracturing a hip and was hospitalized in December 2015 for surgical repair and recovery. until a readmission to the nursing home on 12/28/15. Per review of the Dietician note at readmission, they stated that they followed the resident's progress at the hospital, that the resident had lost weight there, and wrote that no admission weight was available. Per further review of the record, there was no evidence that the resident was weighed upon readmission, and the first weight documented was 119.4 lbs. on 1/21/16. The following weights were also recorded: 1/30/16 - 119.4 lbs. On 2/11/16, the resident weighed 115 lbs. On 2/18/16, 116 lbs. The last two weights recorded were 2/25/16 : 113 lbs. and on 3/3/16 the resident weighed 111.4 lbs. There was documentation that the resident was not accepting meals, refusing supplements at times, and was refusing medications also. Per interview with Social Services, the resident had expressed to them many times that they have no appetite, and even with the addition of favorite foods and supplements would choose not to eat. The Social	F 325			

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F 325	<p>Continued From page 3</p> <p>Services director stated that this resident was clear that they did not want to live any more, and was making this choice consciously. There was psychosocial support given to this resident from professionals, depression treatment with medication, and nutritional supplementation, however very little was accepted by the resident.</p> <p>Per interview on 3/9/16, the Director of Nursing (DNS) confirmed that there was no record of the resident being weighed when readmitted on 12/28/15, and that the first weight recorded was on 1/21/16, over three weeks after the resident returned from the hospital. The DNS also confirmed that the resident had a continual weight loss trend since 1/21/16, and the expectation was that Resident #9 would have been weighed upon returning to the facility and weekly after that time.</p>	F 325			

F428

1. Current Resident Corrective action: A diagnosis was obtained for Medication Identified without one.

2. Prevent reoccurrence with other potential residents:

To ensure that each medication provider has ordered has an appropriate diagnosis

1. With our new Electronic Medical Record (American Data), Menig has moved to electronic medication administration records (MAR)
2. To enter any medication orders – each order must have a diagnosis to complete the electronic medication ordering process.
3. We will Start Electronic Medication administration records on April 4th.

3. Process improvement for prevention:

To ensure that each medication provider has ordered has an appropriate diagnosis

1. With our new Electronic Medical Record (American Data), Menig has moved to electronic medication administration records (MAR)
2. To enter any medication orders – each order must have a diagnosis to complete the electronic medication ordering process.
3. We will Start Electronic Medication administration records on April 4th.

4. Monitoring plan:

There is a "hard stop" with the medication ordering process unless a diagnosis is attached to each medication.

5. Date Corrective Action Completed:

April 1, 2016 all medications will be entered and checked into the new computer software.

*accepted 4/6/16
K. Coleman, RN*

F280

1. Current Resident Corrective action: Resident Care plan that was identified by surveyor has been updated and current with resident's condition.

2. Prevent Reoccurrence: 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. Process improvement for prevention:

- 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 the safety tool for resident care.

4. Monitoring plan:

- a) DNS, or designee, will receive all the new checklists from the Nursing staff- these will be checked for completeness of using the check off list
- b) DNS, or designee, will randomly check 5 new orders / week to ensure the appropriate ones are added to care plan

5. Date Corrective action Completed

- a) Care plan Identified was updated for accuracy – March 12, 2016
- b) Staff meeting- reviewed care plan updating responsibilities- March 31, 2016
- c) Monitoring of ongoing accuracy of care plans by DON- ongoing

*Accepted POC 4/06/16
K. Screeman, PA*

F325

1. Current Resident Corrective action: Resident weighed recorded immediately.

2. Prevent reoccurrence with other potential residents: To ensure all residents are weighed regularly.

3. Process improvement for prevention:

- 1. Monthly reports will be obtained on all residents weights through our computerized medical record software system
- 2. Any residents not having a recorded weight will be weighed within 1 week.
- 3. Nurses regularly overseeing the day time care of the resident are responsible to ensure weights are completed. Day Nurses will be educated that this is part of their role.

4. Monitoring plan:

- 1. A report of the resident weights will be completed regularly and any resident not weighed will be completed
- 2. Nursing staff will be educated on their responsibility for monitoring this completion.
- 3. This will be completed each month for 6 months or until compliance is at 100% for 3 months.
- 4. Residents that are end of life will have appropriate orders or an order to stop all vital signs.

5. Date Corrective Action Completed:

April 1, 2016 Education and starting the monthly monitor.

*Accepted POC 4/06/16
K. Screeman, PA*

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 DNS

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 DNS