VERMONT

AGENCY OF HUMAN SERVICES

DEPARTMENT OF DISABILITIES, AGING AND INDEPENDENT LIVING

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

May 3, 2018

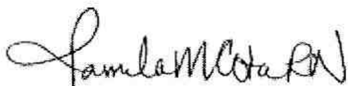
Ms. Kim Campbell, Administrator
Menig Nursing Home
215 Tom Wicker Lane
Randolph Center, VT 05061

Dear Ms. Campbell:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **March 28, 2018.** 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	475058	A. BUILDING ______ B. WING ______	C 03/28/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MENIG NURSING HOME	215 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 An unannounced on-site investigation of 3 facility self-reported incidents was conducted on 3/27/18 through 3/28/18 by the Division of Licensing and Protection. The following regulatory violations were identified:		F 609 1. Resident #1 and #2 had no negative effect as a result of the alleged deficient practice. 2. Residents involved in allegations of abuse have the potential to be affected by the alleged deficient practice. 3. Facility administration has reviewed the requirements related to reporting allegations of abuse and required time frames 4. Education has been done with staff regarding the reporting requirements and timeline for allegations involving abuse 5. Weekly audits will be conducted by the DNS or designee for one month and then monthly for 3 months to monitor effectiveness of the plan 6. Results of the audits will be reported to the QAA committee which will determine further frequency of audits to be done after the 3 months. 7. Corrective action will be completed by 4/20/2018 F609 - POC accepted 5/2/18 D. Wideawake RN / S. Perry, RN	
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Kim Campbell
TITLE: Administrator
(X6) DATE: 4/19/2018

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 609	Continued From page 1 by: Based on interview and record review the facility failed to report an allegation of abuse to the State Survey Agency within the required time frame for 2 of 4 applicable residents in the sample (Resident #1 and Resident #2). Findings include: Per review of the facility investigation for Resident #1 and Resident #2 the alleged abuse occurred on 12/2/17. The alleged abuse was reported to the State Survey Agency on 12/4/17. Per interview on 3/27/18 at 11:29 AM with the Director of Nursing (DNS), s/he confirmed that the alleged abuse was reported to the State Survey Agency on 12/4/17, later than the required time frame for reporting.	F 609		
F 610 SS=D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced	F 610	F 610 1. An investigation summary was completed for the event between resident #1 and resident #3 and submitted to the state survey agency on 4/17/2018 2. Residents involved in allegations of abuse have the potential to be affected by the alleged deficient practice. 3. Facility administration reviewed and are familiar with the requirements for completing a full investigation and submitting an investigation summary to the state survey agency and the required timeline. 4. An audit will be completed by the DNS or designee with any allegations of abuse to ensure compliance with the plan 5. The results of the audits will be reported to the QAA committee for 3 months and the QAA committee will determine further frequency of the audits to be done at that time. 6. Corrective action will be complete 4/20/2018	

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F 610	Continued From page 2 by: Based on interview and record review the facility failed to complete a thorough investigation of an allegation of abuse and report the results of the investigation to the State Survey Agency for 2 of 4 applicable residents in the sample (Resident #1 and Resident #3). Findings include: Per record review on 12/28/18, Resident #1 approached Resident #3 and hit Resident #3 with a clothing protector two times; and then threw the clothing protector over Resident #3's head. Resident #1 then proceeded to hit Resident #3 with a closed finger and open hand. A Staff Nurse intervened and separated the residents. There was no evidence that witnesses to the incident were interviewed and that a summary with the results of the investigation were sent to the State Survey Agency. Per interview on 3/27/18 at 12:18 PM with the DNS, s/he confirmed that the investigation for the incident between Resident#1 and Resident #3 was incomplete and that the results of the investigation were not sent to the State Survey Agency.	F 610	F610 - POC accepted 5/2/18 D. Wideawake RN / S. Perry RN	
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic	F 758		

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F 758	Continued From page 3 Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility	F 758	F758 1. The Lorazepam for resident #1 has been discontinued 2. An initial audit has been completed for any resident with current orders for PRN psychotropic medication, reviewed with physician and changes made as indicated. 3. Residents receiving orders for PRN psychotropic medication have the potential to be affected by the alleged deficient practice. 4. The facility has reviewed the requirements regarding the use of PRN psychotropic medications with the Medical Director to include the requirement for re-evaluation and documented rationale for use beyond 14 days. Education will be provided to other practitioners who provide services to residents at the facility as well. 5. Education has been provided to licensed nurses regarding the requirements related to orders for PRN psychotropic medications. 6. Audits will be conducted weekly by the DNS or designee for one month and then monthly for 3 months to monitor effectiveness of the plan. 7. Results of the audits will be reported to the QAA committee and the committee will determine further frequency of the audits to be completed after 3 months. 8. Corrective action will be complete 4/20/2018	

F758 POC accepted 5/2/18
D. Wideawake RN/S. Perry, RN

PRINTED: 04/12/2018
FORM APPROVED
OMB NO. 0938-0391

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F 758	Continued From page 4 failed to ensure that residents drug regimens were free from unnecessary psychotropic drug use for 1 of 4 residents in the applicable sample (Resident#1). Findings include: Per record review Resident #1 had a physician's order written on 1/30/18 that read, "Lorazepam (medication for anxiety) 1, 0.5 mg (milligram) tablet by mouth every 6 hours as needed for anxiety." There was no evidence in the medical record that the physician provided a rationale for the indication of use of the medication beyond a 14 day period. Per interview on 3/27/18 at 3:54 PM with the DNS, s/he confirmed that the medication order was current and that there was no documented rationale from the physician for the as needed use of the medication beyond a 14 day period.	F 758	F758 POC accepted 5/2/18 D. Widrawaker RN / S. Rimy, RN	

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April 18, 2018

Ms. Kim Campbell, Administrator
Menig Nursing Home
215 Tom Wicker Lane
Randolph Center, VT 05061

Provider #: 475058

Re: **Corrected Letter**

Dear Ms. Campbell:

The Division of Licensing and Protection completed an investigation at your facility on **March 28, 2018**. The purpose of the investigation was to determine if your facility was in compliance with Federal participation requirements for nursing homes participating in the Medicare and Medicaid programs. This investigation found the most serious deficiency in your facility to be isolated deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy as evidenced by the attached CMS-2567 whereby corrections are required. All references to regulatory requirements contained in this letter are found in Title 42, Code of Federal Regulations.

Plan of Correction (POC)

A POC for the deficiencies, which is your allegation of compliance, must be received by **April 24, 2018.** Failure to submit an acceptable POC by **April 24, 2018** may result in imposition of remedies or termination of your provider certification. Your POC must contain the following:

- What corrective action will be accomplished for those residents found to have been affected by the deficient practice;
- How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;
- What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur; and,
- How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place.
- The dates corrective action will be completed.

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The remedies, which will be imposed if substantial compliance has not been achieved by **April 28, 2018**, will include the following:

Denial of Payment for New Admissions effective **June 28, 2018**

An Enforcement Cycle has been initiated based on the citation of deficiencies at a "D" level or greater at your facility. All statutory/mandatory enforcement remedies are effective based on the beginning survey of the Enforcement Cycle. Your Enforcement Cycle began with the **March 28, 2018** survey. All surveys conducted after **March 28, 2018**, with deficiencies at a "D" level or greater become a part of this Enforcement Cycle. The enforcement cycle will not end until substantial compliance is achieved for all deficiencies from all surveys within an enforcement cycle. Facilities are expected to achieve and maintain continuous substantial compliance. If you do not achieve substantial compliance, the CMS Regional Office and/or State Medicaid Agency must deny payments for new admissions. We are also recommending to the CMS Regional Office and/or State Medicaid Agency that your provider agreements be terminated on **September 28, 2018** if substantial compliance is not achieved by that time. A change in the seriousness of the deficiencies on **April 28, 2018** may result in a change in the remedy selected.

Allegation of Compliance

If you believe these deficiencies have been corrected, you may contact Suzanne Leavitt, RN, MS, Assistant Division Director, Division of Licensing and Protection with your written credible allegation of compliance. If you choose and so indicate, the POC may constitute your allegation of compliance. We may accept the written allegation of compliance and presume compliance until substantiated by a revisit or other means. In such a case, the recommended remedy listed above would not be imposed at that time.

If, upon the subsequent revisit, your facility has not achieved substantial compliance, a civil money penalty may be imposed by the CMS Regional Office beginning on the and continue until substantial compliance is achieved. Additionally, the CMS Regional Office will impose the other remedies indicated above or revised remedies, if appropriate.

Informal Dispute Resolution

In accordance with §488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. To be given such an opportunity, you are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to Suzanne Leavitt, RN, MS, Assistant Division Director, Division of Licensing and Protection. **This written request must be received by this office by April 24, 2018**. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

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Opportunity for Independent Informal Dispute Resolution (IIDR)

If you have already requested an Informal Dispute Resolution (IDR) from the State Agency, your request for IIDR will only be allowed if it is made before the State's IDR is completed. If you chose to request an IIDR with an Independent Panel, your written request for an IIDR must be sent to Suzanne Leavitt, RN, MS, State Survey Agency Director. The State Survey Agency will forward your request to the IIDR Panel, and they will inform you when and how the IIDR will be conducted. Your request for IIDR must be made no later than **10 calendar days** from the date of your receipt of this letter.

Sincerely,

Pamela M. Cota, RN
Licensing Chief

Enc.

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April 12, 2018

Ms. Kim Campbell, Administrator
Menig Nursing Home
215 Tom Wicker Lane
Randolph Center, VT 05061

Provider #: 475058

Dear Ms. Campbell:

The Division of Licensing and Protection completed an investigation at your facility on **March 28, 2018**. The purpose of the investigation was to determine if your facility was in compliance with Federal participation requirements for nursing homes participating in the Medicare and Medicaid programs. This investigation found the most serious deficiency in your facility to be isolated deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy as evidenced by the attached CMS-2567 whereby corrections are required. All references to regulatory requirements contained in this letter are found in Title 42, Code of Federal Regulations.

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- What corrective action will be accomplished for those residents found to have been affected by the deficient practice;
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- What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur; and,
- How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place.
- The dates corrective action will be completed.

The remedies, which will be imposed if substantial compliance has not been achieved by **April 20, 2018**, will include the following:

Denial of Payment for New Admissions effective **June 28, 2018**

An Enforcement Cycle has been initiated based on the citation of deficiencies at a "D" level or greater at your facility. All statutory/mandatory enforcement remedies are effective based on the beginning survey of the Enforcement Cycle. Your Enforcement Cycle began with the **March 28, 2018** survey. All surveys conducted after **March 28, 2018**, with deficiencies at a "D" level or greater become a part of this Enforcement Cycle. The enforcement cycle will not end until substantial compliance is achieved for all deficiencies from all surveys within an enforcement cycle. Facilities are expected to achieve and maintain continuous substantial compliance. If you do not achieve substantial compliance, the CMS Regional Office and/or State Medicaid Agency must deny payments for new admissions. We are also recommending to the CMS Regional Office and/or State Medicaid Agency that your provider agreements be terminated on **September 28, 2018** if substantial compliance is not achieved by that time. A change in the seriousness of the deficiencies on **April 20, 2018** may result in a change in the remedy selected.

Allegation of Compliance

If you believe these deficiencies have been corrected, you may contact Suzanne Leavitt, RN, MS, Assistant Division Director, Division of Licensing and Protection with your written credible allegation of compliance. If you choose and so indicate, the POC may constitute your allegation of compliance. We may accept the written allegation of compliance and presume compliance until substantiated by a revisit or other means. In such a case, the recommended remedy listed above would not be imposed at that time.

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Sincerely,

Pamela M. Cota, RN
Licensing Chief

Enc.