

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

August 8, 2019

Ms. Ursula Margazano, Administrator Menig Nursing Home 215 Tom Wicker Lane Randolph Center, VT 05061

Dear Ms. Margazano:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **July 10, 2019**. 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

Jamela MCotaRN

Licensing Chief

PRINTED: 07/18/2019 FORM APPROVED OMB NO. 0938-0391

STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		CONSTRUCTION	COMPLETED
	**************************************	475059	B. WING	; .		07/10/2019
		475058	D. THIT		REET ADDRESS, CITY, STATE, ZIP CODE	
NAME OF P	ROVIDER OR SUPPLIER				5 TOM WICKER LANE	
MENIG N	URSING HOME				ANDOLPH CENTER, VT 05061	
(X4) ID PREFIX TAG	VEACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAC		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DÉFICIENCY)	JLD BE COMPLETION
	0			1	Preparation and/or execution	of this
E 000	Initial Comments		E	000	plan of correction does not	
FOOO	miliai commenta				constitute the providers admi	ssion
ĺ	An unannounced	onsite Emergency			of/or agreement with the alle	ged
	Prenaredness sun	vev was conducted in		İ	violations or conclusions set f	orth in
	conjunction with th	ne annual re-certification survey		ĺ	this statement of deficiencies	. The
	from 7/8/19 - 7/10	/19. There were no regulatory fied related to Emergency		-	plan of correction is prepared	and/or
	Preparedness.	ned related to Emergency	1		executed as required by State	and
F 000		NTS	, F	000	Federal law.	
	A consisted broad areas and				Federal law.	1
	The Division of Li	censing and Protection	1		F041	(
	conducted an una	innounced onsite annual			1. Resident #9, 13, 19,	and 27
	recertification sun	vey 7/8/18 - 7/10/19. The ry deficiencies were identified	ì		had no negative effe	
	as a result;		3		result of the alleged	1
F 641	Accuracy of Asset	ssments .	. F	641	practice.	SECTION CONTRACTOR CON
SS=E)	Į.		2. All residents with M	DS
	0.100.00/-> 0.000	acy of Assessments.		•	assessments have th	
	The assessment	must accurately reflect the			potential to be affect	
	resident's status.		*		the alleged deficient	
		ENT is not met as evidenced				1
	by:	ration, interview and record			3. Re-education will be to Certified MDS Co.	
	review, the facilit	y failed to ensure that the			1	
	Minimum Data Se	et (MDS) assessments	•		and DNS using RAI g	
	accurately reflect	s the resident's status for 4 of 1	3		for accurate diagnos	
	sampled resident	ts (Residents #9, #13, #19 and g includes the following:			and reviewing LTC F	
V 1	#ZI). THE IIIIIII	g moiddes the renowing.			Residents #9, 13, 19	
	1. Per medical re	ecord review, Resident #13 has			will be corrected on	C Section Committee
	a documented di	agnosis of Advanced Dementia			next MDS assessme	
	and Hypertension	n with physician orders to treat 10 milligrams (mg.) by mouth			Moving forward all	other
	(PO) daily for de	pression and Losartan 50 mg.			resident MDS assess	sments
	PO daily for hype	ertension. The MDS assessmen	t		will be reviewed and	d revised
	dated 5/18/19 (S	ection I Active Diagnosis) does			re diagnosis coding	per RAI
	not include the a	ctive diagnoses of hypertension Section N of the assessment			guideline.	
		OVIDER/SUPPLIER REPRESENTATIVE'S	SIONATI IT)C	TITLE	, (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.

Facility ID: VT475058

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 07/18/2019 FORM APPROVED OMB NO. 0938-0391

CENTER	S FOR MEDICARE	& MEDICAID SERVICES			- WALLEY OF THE STATE OF THE ST	(X3) DATE SURVEY
STATEMENT AND PLAN O	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		CONSTRUCTION	COMPLETED
		475058	B. WING			07/10/2019
7 - E	PROVIDER OR SUPPLIER		7	21	TREET ADDRESS, CITY, STATE, ZIP CODE 15 TOM WICKER LANE ANDOLPH CENTER, VT 05061	H
(X4) ID PREFIX TAG	(EACH DEFICIENC	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DÉFICIENCY)	JLD BE COMPLETION
TAG	Continued From patitled Medications, Antipsychotic and administered 7 day Federally mandate completed on all rehome. The MDS 0 7/10/19 at approxi #13 is receiving mypertension but on the assessment of the CMS (Center Services) manual instructions, direct have a documented have a direct current medical tractions with phy 300 mg PO daily for major Zolpidem Tartrate The MDS assessing Active Diagnoses of hypothypothypothypothypothypothypothypot	age 1 identifies administration of Antidepressant medications ys a week. The MDS is a ed assessment that is to be esidents residing in a nursing Coordinator confirmed on mately 9:45 AM, that Resident edication for depression and lid not include either diagnosis at completed 5/8/19. Per review er's for Medicare/Medicaid dated 10/2018 coding as staff to code diseases that ed diagnosis in the last 60 days relationship to the resident's	F	641	4. Audits will be conducted weekly X 12 wks by the or designee to monitor effectiveness of the interventions. 5. Results of the audits we reported to the QAPI committee at which time committee will evaluate make recommendation needed. 6. Corrective action to be completed by 8/2/201.	ed e DNS r fill be me the te and ns as
	7/9/2019 at 1:25 diagnoses of hyp	PM, that Resident #9 has active perlipidemia, hypothyroidism, bety, and insomnia and is	!			

Facility ID: VT475058

DEPARTMENT OF HEALTH AND HUMAN SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MUL A. BUILD	TIPLE CC	(X3) DATE SURVEY COMPLETED				
AND PLAN OF	CORRECTION	# # # # # # # # # # # # # # # # # # #					07	10/2019
	ROVIDER OR SUPPLIER	475058	B, WING	STRE 215 T	ET ADDRESS, CITY, STA OM WICKER LANE DOLPH CENTER, V		, 07	10/2013
(X4) ID PREFIX	ŞUMMARY ST	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF	IX :	PROVIDER'S PLA (EACH CORRECTIV CROSS-REFERENCE	AN OF CORRECTION SHOULD TO THE APPRO	D BE	(X5) COMPLETIO DATE
TAG	REGULATORY OR I	SCIDENTIL TING IN GIAM MIGH			DEFI	CIENCY)		
F 641	insomnia but did n	ons for depression and ot include those diagnoses on	F	641				
	the assessment co	ompleted 4/25/19. ord review Resident #19 has						
	deficiency, GERD disease), atrial fib depression, and h orders include; Tri insomnia, Vitamin Vitamin D deficier twice daily for GE	noses of insomnia, Vitamin D (gastroesophageal reflux rillation (A-Fib), hypertension, ypomagnesemia. Physician azodone 50 mg PO daily for D 3 2000 units PO daily for ncy, Omeprazole 20 mg PO RD, Xarelto 15 mg PO daily for			u.			
-	A-Fib, Metoprolol hypertension, Ser depressed mood, daily for hypomac assessment date Diagnoses) does of insomnia, Vitar hypertension, dep	50 mg PO twice daily for traline 200 mg PO daily for and Magnesium 400 mg PO pesemia. The MDS d6/6/2019 (Section I Active not include the active diagnose min D deficiency, GERD, A-Fib, pression, and hypomagnesemia	s S					
	Section N of the a identifies administ Anticoagulant me week. The MDS confirmed on 7/1 #19 is receiving revitamin D deficie	assessment titled Medications, stration of Antidepressant and edication administered 7 days a Coordinator and the DON 0/19 at 9:17 AM that Resident medications for insomnia, ncy, GERD, A-Fib, hypertension		1 3				
2	depression, and	hypomagnesemia but did not gnoses on the assessment						
	documented diag glaucoma, macu hypomagnesemi	cord review Resident #27 has gnoses of, hypertension, lar degeneration, a, hyperlipidemia, osteoporosis art failure. The MDS assessme	ent	e		· .		

STATEMENT C AND PLAN OF	OF DEFICIENCIES CORRECTION	(XI) THOUBERROOT FEBRUARY	(X2) MULTIF A. BUILDIN	0.90 50	ONSTRUCTIO	N ————	COMPL	
		475058	B. WING _				07/10	0/2019
NAME OF PROVIDER OR SUPPLIER MENIG NURSING HOME			215 7	TOM WICKE	ENTER, VT 05061			
(X4) ID : PREFIX : TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	3 3 3	(EACH C	(IDER'S PLAN OF CORRECTI CORRECTIVE ACTION SHOUL EFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
· ·			F.04	1				
	not include the act glaucoma, macula hypomagnesemia, mild diastolic hear assessment titled administration of E administered 7 dar Coordinator and E approximately 9:1 diagnoses include macular degenera hyperlipidemia, os	ction I Active Diagnoses) does live diagnoses of hypertension, in degeneration, hyperlipidemia, osteoporosis, it failure. Section N of the Medications identifies Diuretic medication ys a week. The MDS ION confirmed on 7/10/19 at 7 AM the Resident #27 active hypertension, glaucoma, lition, hypomagnesemia, liteoporosis, and mild diastolic mey were not included on the	F 64	1	F657	Resident #22, 26, an	d 27 had	
F 657 SS=E	Care Plan Timing CFR(s): 483.21(b) Comp §483.21(b)(2) A comprehensive (ii) Prepared by an includes but is not (A) The attending (B) A registered not resident. (C) A nurse aide of resident. (D) A member of	and Revision (2)(i)-(iii) rehensive Care Plans comprehensive care plan must ain 7 days after completion of the assessment in interdisciplinary team, that t limited to	F 6	57	3.	no negative effects a of the alleged deficie practice. All residents with ca have the potential to affected by the alleg deficient practice. Resident #22, 26, an Plans reviewed and on by DNS Completed: Re-education will be to DNS and RN designed.	re plans to be ged ad 27 Care signed off 7/25/19 e provided	
	the resident and the An explanation madical record if and their resident	the resident's representative(s). The participation of the resident to the participation of the resident to the representative is determined or the development of the	8			Care Plan review pro Care Plans will be re and signed for accur DNS and/or RN designed Completed:	viewed acy by gnee.	

	OF DESICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPLE (CONSTRUC	TION	(3	X3) DATE	SURVEY
	OF DEFICIENCIES F CORRECTION	IDENTIFICATION NUMBER:	A. BUILD	ING	-			COMP	
		475058	B. WING			V		07/1	0/2019
	ROVIDER OR SUPPLIER			215	TOM WIC	ESS, CITY, STATE, ZII KER LANE CENTER, VT 05 ÓVIDER'S PLAN OF (061		(X5)
(X4) ID PREFIX TAĞ	VEACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		IFAC	H CORRECTIVE ACT REFERENCED TO T DEFICIENC	ION SHOULD I HE APPROPR	3E	COMPLÉTION DATE
••,	disciplines as determined or as requested by (iii) Reviewed and team after each as comprehensive arrangements. This REQUIREME by: Based on observiewed the facility resident's person reviewed and #27). The first a Federal/State in completed on 6/1 on 6/11/19. The identifies various attendance, but in person-centered Licensed Practice staff in the development of the person-centered there is no docurridentifying that arrangement accepted the person-center of the person-cente	ate staff or professionals in armined by the resident's needs of the resident. The revised by the interdisciplinary seessment, including both the ad quarterly review. ENT is not met as evidenced ation, interview and record failed to ensure that the centered care plan was sed by the interdisciplinary team of a Registered Nurse (RN), for esidents, (Residents #22, #26 adding includes the following: Ecord review, Resident # 22 had andated assessment 0/19 and a Care plan meeting attendance sign in sheet members of the IDT in no RN presence. Review of the care plan identifies initials of the all Nurse (LPN) and the Activity opment of the plan. However, mentation in the medical record in RN reviewed, revised or son-centered care plan. Is made by the Director of Nurse to present for the meeting that 1/19 nor is there documentation cord identifying the royal of the care plan for June	s	657	 7. 	Audits will be weekly X 4 wk designee to meffectiveness interventions. Results of the reported to the committee at committee wimake recommeded. Corrective act completed by	s by the DI onitor of the audits will be QAPI which time all evaluate nendations ion to be 8/2/19	be e the and	2d/Pmc
	the care plan are	so confirms that the initials on e of an LPN and the Activity staff							
	On 7/2/19, confir	mation was made by the Direct	ог						

DEPARTMENT OF HEALTH AND HUMAN SERVICES NOADE & MEDICAID SERVICES

STATEMENT (S FOR MEDICARE OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		ONSTRUCTION	(X3) I	(X3) DATE SURVEY COMPLETED	
		475058	B. WING				07/10/2019	
	ROVIDER OR SUPPLIER	4,000	_	215 T	EET ADDRESS, CITY, STATE, ZIP CODE TOM WICKER LANE NDOLPH CENTER, VT 05061			
(X4) ID PREFIX TÁĞ	TACH DECICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 657	meeting that took documentation in the the acceptance plan.	t S/he was not present for the place on 6/11/19, nor is there the medical record identifying e/approval of the recent care		657				
	a Federal/State m completed on 6/2 on 7/2/19. The a various members RN presence. Ro care plan identified Practical Nurse (I development of the	ecord review, Resident # 26 had nandated assessment 7/19 and a Care plan meeting ttendance sign in sheet identifier of the IDT in attendance, but no eview of the person-centered signitials of the Licensed LPN) and the Activity staff in the one plan. However, there is no the medical record identifying wed, revised or accepted the care plan.	s o					
	RN that s/he was took place on 7/2 in the medical re acceptance/appr	s made by the Director of Nurses not present for the meeting the 2/19 nor is there documentation cord identifying the roval of the recent care plan. The that the initials on the care pland the Activity staff.	ė	1				
	Federal/State m on 6/29/19 and a The Care Plan S the LPN, Social Licensed Nursin and the Daught there is no docuidentifying the a	ecord review, Resident #27 had andated assessment completed a Care plan meeting on 7/2/19. Sign in Sheet lists signatures of Worker, Registered Dietician, and Assistant, the Resident #27, er of Resident #27. However, amentation in the medical record in RN reviewed, revised, or erson centered care plan.	3					
*		as made by the Director of Nurs	ses	*	X * II		sian shoot Dage f	

STATEMENT (OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	97 151	LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING			
	4.:	475058	B. WING			07/10/2019
	CACH DEELCIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		215 TOM WICKI RANDOLPH C	ER LANE ENTER, VT 05061 VIDER'S PLAN OF CORRECT CORRECTIVE ACTION SHOL REFERENCED TO THE APPRI	JED BE COMPLETION
				1		
F 757	s/he was not preseplace on 7/2/19 not medical record ideacceptance/approace RN also confirms are of an LPN and Drug Regimen is CFR(s): 483.45(d). §483.45(d) Unnecessary drug when used-	at approximately 10:45 AM that ent for the meeting that took or is there documentation in the entifying the wal of the recent care plan. The that the initials on the care plan d the Activity staff. Free from Unnecessary Drugs (1)-(6) Cessary Drugs-General. rug regimen must be free from gs. An unnecessary drug is any	F 65	57 F757 1.	Resident #15 had no adverse effects rela alleged deficient pr Residents with med order with parame the potentially of b affected by this alle	ated to the ractice. dication ters have being
	§483,45(d)(3) Williams §483,45(d)(4) Williams (d)(5) In consequences with reduced or disconstated in paragrasection. This REQUIREM by: Resert on staff	r excessive duration; or ithout adequate monitoring; or ithout adequate indications for it the presence of adverse which indicate the dose should be ontinued; or my combinations of the reasons aphs (d)(1) through (5) of this MENT is not met as evidenced interview and record review, the	à	3.	deficient practice. Resident #15 alerts the medication administration reconotified of past low sugar results that woutside the notific parameter.	ord. MD w blood were sation ed: 7/24/19 provided to monitoring meter and
	(Pacident #15)	ensure 1 applicable resident was free from unnecessary reat diabetës. Findings include:				¥

PRINTED: 07/18/2019 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO	(X3) DATE SURVEY COMPLETED	
a a	475058	B. WING		07/10/2019
NAME OF PROVIDER OR SUPPLIER MENIG NURSING HOME	473030	STREE 215 T	ET ADDRESS, ÇÎTY, STATE, ZIP CODE OM WICKER LANE DOLPH CENTER, VT 05061	
ACACH DEELCIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE COMPLETION
a diagnosis of diable order dated 6/3/19 Resident's blood significant blood support of the property of the pro	admitted to the facility and has betes. There is a physician to notify the the provider if the ugar levels were above 400 or irector of Nurses (DON) stated notified the provider via fax of ugar levels. After review of d Resident # 15's clinical evidence that the provider was sugar levels less than 100 17/6/19. This was confirmed by	F 757	 5. Audits will be conduct weekly X 4 wks by the designee to monitor effectiveness of the p 6. Results of the audits reported to the QAPI committee at which to committee will evaluate make recommendation needed. 7. Corrective action to completed by 8/2/20 	e DNS or plan. will be time the late and lons as lbe D19

Event ID: 28YW11