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

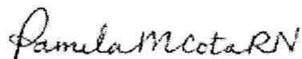
Ms. Ursula Margazano, Administrator
Menig Nursing Home
215 Tom Wicker Lane
Randolph Center, VT 05061

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
Licensing Chief

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

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 ______	07/10/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MENIG NURSING HOME	215 TOM WICKER LANE RANDOLPH CENTER, VT 05061

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E 000	Initial Comments An unannounced onsite Emergency Preparedness survey was conducted in conjunction with the annual re-certification survey from 7/8/19 - 7/10/19. There were no regulatory deficiencies identified related to Emergency Preparedness.	E 000	**Preparation and/or execution of this plan of correction does not constitute the providers admission of/or agreement with the alleged violations or conclusions set forth in this statement of deficiencies. The plan of correction is prepared and/or executed as required by State and Federal law.**	
F 000	INITIAL COMMENTS The Division of Licensing and Protection conducted an unannounced onsite annual recertification survey 7/8/18 - 7/10/19. The following regulatory deficiencies were identified as a result:	F 000		
F 641 SS=E	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure that the Minimum Data Set (MDS) assessments accurately reflects the resident's status for 4 of 13 sampled residents (Residents #9, #13, #19 and #27). The finding includes the following: 1. Per medical record review, Resident #13 has a documented diagnosis of Advanced Dementia and Hypertension with physician orders to treat with Citalopram 10 milligrams (mg.) by mouth (PO) daily for depression and Losartan 50 mg. PO daily for hypertension. The MDS assessment dated 5/18/19 (Section I Active Diagnosis) does not include the active diagnoses of hypertension and depression. Section N of the assessment	F 641	F641 1. Resident #9, 13, 19, and 27 had no negative effects as a result of the alleged deficient practice. 2. All residents with MDS assessments have the potential to be affected by the alleged deficient practice. 3. Re-education will be provided to Certified MDS Coordinator and DNS using RAI guidelines for accurate diagnosis coding and reviewing LTC Ftag 641. Residents #9, 13, 19, and 27 will be corrected on their next MDS assessment. Moving forward all other resident MDS assessments will be reviewed and revised re diagnosis coding per RAI guideline.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature]	Administrator - ED GKC	7/26/19

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 641 Continued From page 1

titled Medications, identifies administration of Antipsychotic and Antidepressant medications administered 7 days a week. The MDS is a Federally mandated assessment that is to be completed on all residents residing in a nursing home. The MDS Coordinator confirmed on 7/10/19 at approximately 9:45 AM, that Resident #13 is receiving medication for depression and hypertension but did not include either diagnosis on the assessment completed 5/8/19. Per review of the CMS (Center's for Medicare/Medicaid Services) manual dated 10/2018 coding instructions, directs staff to code diseases that have a documented diagnosis in the last 60 days and have a direct relationship to the resident's current medical treatments.

2. Per medical record review Resident #9 has documented diagnoses of hyperlipidemia, hypothyroidism, depression, anxiety, and insomnia with physician orders for Wellbutrin XL 300 mg PO daily for depression, Zoloft 200 mg PO daily for major depressive disorder, and Zolpidem Tartrate 5 mg PO daily for insomnia. The MDS assessment dated 4/25/19 (Section I Active Diagnoses) does not include the active diagnoses of hyperlipidemia, hypothyroidism, depression, anxiety, and insomnia. Section N of the assessment titled Medications, identifies administration of Antidepressant and Hypnotic medications administered 7 days a week. The Director of Nursing (DON) confirmed on 7/9/19 at 10:45 AM that Resident #9's active diagnoses included hyperlipidemia, hypothyroidism, depression, anxiety, and insomnia and that the MDS dated 4/25/19 did not reflect these diagnoses. The MDS Coordinator confirmed on 7/9/2019 at 1:25 PM, that Resident #9 has active diagnoses of hyperlipidemia, hypothyroidism, depression, anxiety, and insomnia and is

F 641

4. Audits will be conducted weekly X 12 wks by the DNS or designee to monitor effectiveness of the interventions.
5. Results of the audits will be reported to the QAPI committee at which time the committee will evaluate and make recommendations as needed.
6. Corrective action to be completed by 8/2/2019

F641 POC accepted 7/29/19 RTremblay RN/PML

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F 641	Continued From page 2	F 641		

receiving medications for depression and insomnia but did not include those diagnoses on the assessment completed 4/25/19.

3. Per medical record review Resident #19 has documented diagnoses of insomnia, Vitamin D deficiency, GERD (gastroesophageal reflux disease), atrial fibrillation (A-Fib), hypertension, depression, and hypomagnesemia. Physician orders include; Trazodone 50 mg PO daily for insomnia, Vitamin D 3 2000 units PO daily for Vitamin D deficiency, Omeprazole 20 mg PO twice daily for GERD, Xarelto 15 mg PO daily for A-Fib, Metoprolol 50 mg PO twice daily for hypertension, Sertraline 200 mg PO daily for depressed mood, and Magnesium 400 mg PO daily for hypomagnesemia. The MDS assessment dated 6/6/2019 (Section I Active Diagnoses) does not include the active diagnoses of insomnia, Vitamin D deficiency, GERD, A-Fib, hypertension, depression, and hypomagnesemia. Section N of the assessment titled Medications, identifies administration of Antidepressant and Anticoagulant medication administered 7 days a week. The MDS Coordinator and the DON confirmed on 7/10/19 at 9:17 AM that Resident #19 is receiving medications for insomnia, Vitamin D deficiency, GERD, A-Fib, hypertension, depression, and hypomagnesemia but did not include these diagnoses on the assessment completed on 6/6/19.

4. Per medical record review Resident #27 has documented diagnoses of; hypertension, glaucoma, macular degeneration, hypomagnesemia, hyperlipidemia, osteoporosis, mild diastolic heart failure. The MDS assessment

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F 641	Continued From page 3 dated 6/29/19 (Section I Active Diagnoses) does not include the active diagnoses of hypertension, glaucoma, macular degeneration, hypomagnesemia, hyperlipidemia, osteoporosis, mild diastolic heart failure. Section N of the assessment titled Medications identifies administration of Diuretic medication administered 7 days a week. The MDS Coordinator and DON confirmed on 7/10/19 at approximately 9:17 AM the Resident #27 active diagnoses include; hypertension, glaucoma, macular degeneration, hypomagnesemia, hyperlipidemia, osteoporosis, and mild diastolic heart failure but they were not included on the assessment completed on 6/29/19.	F 641		
F 657 SS=E	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan.	F 657	F657 1. Resident #22, 26, and 27 had no negative effects as a result of the alleged deficient practice. 2. All residents with care plans have the potential to be affected by the alleged deficient practice. 3. Resident #22, 26, and 27 Care Plans reviewed and signed off on by DNS Completed: 7/25/19 4. Re-education will be provided to DNS and RN designees re Care Plan review process. Care Plans will be reviewed and signed for accuracy by DNS and/or RN designee. Completed: 8/2/19	

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F 657	Continued From page 4	F 657		

(F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident.
(iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.
This REQUIREMENT is not met as evidenced by:
Based on observation, interview and record review the facility failed to ensure that the resident's person centered care plan was reviewed and revised by the interdisciplinary team (IDT) that included a Registered Nurse (RN), for 3 of 13 sampled residents, (Residents #22, #26 and #27). The finding includes the following:

1. Per medical record review, Resident # 22 had a Federal/State mandated assessment completed on 6/10/19 and a Care plan meeting on 6/11/19. The attendance sign in sheet identifies various members of the IDT in attendance, but no RN presence. Review of the person-centered care plan identifies initials of the Licensed Practical Nurse (LPN) and the Activity staff in the development of the plan. However, there is no documentation in the medical record identifying that an RN reviewed, revised or accepted the person-centered care plan.

Confirmation was made by the Director of Nurses that s/he was not present for the meeting that took place on 6/11/19 nor is there documentation in the medical record identifying the acceptance/approval of the care plan for June 2019. The RN also confirms that the initials on the care plan are of an LPN and the Activity staff.

On 7/2/19, confirmation was made by the Director

5. Audits will be conducted weekly X 4 wks by the DNS or designee to monitor effectiveness of the interventions.
6. Results of the audits will be reported to the QAPI committee at which time the committee will evaluate and make recommendations as needed.
7. Corrective action to be completed by 8/2/19

F657 POC accepted 7/29/19 RTremblay RN/PMC

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F 657 Continued From page 5 F 657

of Nurses, RN that S/he was not present for the meeting that took place on 6/11/19, nor is there documentation in the medical record identifying the the acceptance/approval of the recent care plan.

2. Per medical record review, Resident # 26 had a Federal/State mandated assessment completed on 6/27/19 and a Care plan meeting on 7/2/19. The attendance sign in sheet identifies various members of the IDT in attendance, but no RN presence. Review of the person-centered care plan identifies initials of the Licensed Practical Nurse (LPN) and the Activity staff in the development of the plan. However, there is no documentation in the medical record identifying that an RN reviewed, revised or accepted the person-centered care plan.

Confirmation was made by the Director of Nurses RN that s/he was not present for the meeting that took place on 7/2/19 nor is there documentation in the medical record identifying the acceptance/approval of the recent care plan. The RN also confirms that the initials on the care plan are of an LPN and the Activity staff.

3. Per medical record review, Resident #27 had a Federal/State mandated assessment completed on 6/29/19 and a Care plan meeting on 7/2/19. The Care Plan Sign in Sheet lists signatures of the LPN, Social Worker, Registered Dietician, Licensed Nursing Assistant, the Resident #27, and the Daughter of Resident #27. However, there is no documentation in the medical record identifying the an RN reviewed, revised, or accepted the person centered care plan.

Confirmation was made by the Director of Nurses

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F 657	Continued From page 6 RN on 7/10/2019 at approximately 10:45 AM that s/he was not present for the meeting that took place on 7/2/19 nor is there documentation in the medical record identifying the acceptance/approval of the recent care plan. The RN also confirms that the initials on the care plan are of an LPN and the Activity staff.	F 657		
F 757 SS=D	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility failed to ensure 1 applicable resident (Resident #15) was free from unnecessary medications to treat diabetes. Findings include:	F 757	F757 1. Resident #15 had no noted adverse effects related to the alleged deficient practice. 2. Residents with medication order with parameters have the potentially of being affected by this alleged deficient practice. 3. Resident #15 alerts built into the medication administration record. MD notified of past low blood sugar results that were outside the notification parameter. Completed: 7/24/19 4. Education will be provided to licensed nurses re monitoring medication parameter and alerting the MD per parameter.	

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F 757	Continued From page 7 Resident # 15 was admitted to the facility and has a diagnosis of diabetes. There is a physician order dated 6/3/19 to notify the the provider if the Resident's blood sugar levels were above 400 or below 100. The Director of Nurses (DON) stated that nursing staff notified the provider via fax of abnormal blood sugar levels. After review of facility fax logs and Resident # 15's clinical record, there is no evidence that the provider was notified of 5 blood sugar levels less than 100 between 6/25/19 - 7/6/19. This was confirmed by the DON on 7/9/19 at 11:05 A.M.	F 757	5. Audits will be conducted weekly X 4 wks by the DNS or designee to monitor effectiveness of the plan. 6. Results of the audits will be reported to the QAPI committee at which time the committee will evaluate and make recommendations as needed. 7. Corrective action to be completed by 8/2/2019 F757 POC accepted 7/24/19 RTremblay RN/PMM	