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

September 25, 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 **September 4, 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

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 09/04/2019

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 self-reports and a confidential complaint was conducted on 09/03/19 and completed on 09/04/19 by the Division of Licensing and Protection. The following regulatory violation was identified:	F 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 689 SS=E	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to ensure that 2 of 2 applicable residents, were adequately supervised to prevent accidents and/or intrusion of others, (Resident #1 and #2). The findings include the following: 1. Per medical record review, Resident #1 has a diagnosis of Alzheimer's Disease and major Depression. Medical record identifies the following inappropriate behaviors since May 2019: -05/17/19 at approximately 2:35 PM, Resident #1 was standing in the hall and was smacked and grabbed by Resident #2. Resident #1 sustained fingernail marks on the left wrist. -06/13/19 at approximately 5:30 PM, Resident #1	F 689	F689 1. Resident #1 & #2 had no negative effects as a result of the alleged deficient practice. 2. All residents in Res:Res incident have the potential to be affected by the alleged deficient practice. 3. Re-education will be provided to Nurses and LNAs regarding documented use of interventions as sighted in the Care Plan. Residents #1 & #2 interventions reviewed and updated if appropriate. 4. Audits will be conducted weekly X 12 wks by the DNS or designee to monitor effectiveness of the interventions.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Administrator/ED 6KC 9/23/19

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 689	Continued From page 1 was sitting on the couch, in front of the main team station when with Resident #2 pulled Resident #1's shirt. Resident #1 retaliated by pushing Resident #2 on the arm. -07/28/19 at approximately 11:17 AM at the entrance of the facility, Resident #1 reached for Resident #2's pencils. Resident #2 responded by slapping the right forearm of Resident #1. Medical record identifies the following falls since February 2019: -02/22/19 at approximately 10 PM, Resident #1 was found lying on the floor at the entrance door. Resident complained of pain and was transported to the emergency room for evaluation. -04/04/19 at approximately 11:30 PM, Resident #1 was found on the floor in his/her bedroom. -08/15/19 at approximately 3:45 PM, Resident #1 was witnessed by a visitor falling to the floor at the nurses' station. -08/21/19 at approximately 11:10 AM, Resident #1 had an unwitnessed fall, found resident on the floor at the nurses' station. Per review of the resident centered care plan, identifies problems with difficult communication, takes psychotropic medications because of anxiety, confusion, with times of feeling scared, sad and angry. Nursing staff are directed to monitor vital signs, ensure medication administration and to provide diversional activities, offer the resident snacks, take for a walk outside, 1:1, offer the resident the pet cat and provide the resident a quiet environment. The care plan also identifies falls, since Resident #1 is unaware of when s/he is tired. Staff are directed to monitor and to encourage the resident to rest.	F 689	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 10/3/2019 F689 POC accepted 9/25/19 MBertrand RN/PM	

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F 689	Continued From page 2	F 689		

Per review of resident centered care plan, identifies the resident as a resident who wanders, has been found in other resident's space/room, has slapped others, grabbed others and has pushed others away. The facility's interventions to help mitigate these tendencies are to monitor, redirect, provide diversional activities (offering the pet cat), provide 1:1, ambulate the resident outdoors and to relocate to a quiet environment.

During the investigation, the Surveyor observed Resident #1 ambulating independently throughout the facility, and approaching residents in the hall. There was no observation of ambulating the resident outdoors, providing 1:1, offering the resident the pet cat and/or assisting the resident a quiet environment.

Confirmation is made by the Director of Nurses (DNS) on 09/04/19 at approximately 9:15 AM that the above information has been accurately obtained from the Electronic Medical Record.

2. Per medical record review, Resident #2 has a diagnosis of Advanced Dementia with behavioral disturbances.
During the past 3 months the following inappropriate behaviors, a fall and an elopement have occurred:
-05/17/19 at approximately 2:35 PM, Resident #1 was standing in the hall and was smacked and grabbed by Resident #2. Resident #1 sustained fingernail marks on the left wrist.
-05/29/19 at approximately 10:10 AM, Resident #2 was in the dining room eating lunch, when another resident reached for condiments that were being held by Resident #2. This resulted in Resident #2 physically pushing the other resident away with a closed fist;

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F 689	Continued From page 3 -06/13/19 at approximately 5:30 PM, Resident #1 was sitting on the couch, in front of the main team station when with Resident #2 pulled Resident #1's shirt. Resident #1 retaliated by pushing Resident #2 on the arm. -07/12/19 at approximately 2 PM, Resident #2 pushed against the secure entrance sliding doors, dislodging the doors from the tracks and eloped from the building. The resident was seen in the facility parking lot, by a staff member who was in the dining room. The resident was returned to the building. The facility has had an alarm installed to the doors; -07/28/19 at approximately 11:17 AM at the entrance of the facility, Resident #1 reached for Resident #2's pencils. Resident #2 responded by slapping the right forearm of Resident #1. -08/07/19 at approximately 10 AM, Resident #2 was observed on the floor in his/her room. The resident had two legs in one leg of his/her pants. Per review of resident centered care plan, identifies the resident as a resident who wanders, has been found in other resident's space/room, has slapped others, grabbed others and has pushed others away. The facility's interventions to help mitigate these tendencies are to monitor, redirection, likes to go for walks. Per observation during the two-day investigation the surveyor observed the resident ambulating about the facility independently. S/He spends time sleeping and/or in and out of various spaces through-out the facility. The resident spends time in his/her bedroom with the door closed. The resident was not observed with staff in close proximity unless the resident was in the dining room. Confirmation is made by the Director of Nurses (DNS) on 09/04/19 at approximately 9:15 AM that	F 689		

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F 689	Continued From page 4 the above information has been accurately obtained from the Electronic Medical Record.	F 689		

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER #	MULTIPLE CONSTRUCTION	DATE SURVEY COMPLETE
	475058	A. BUILDING: _____ B. WING _____	9/4/2019

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

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 842	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State;

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The above isolated deficiencies pose no actual harm to the residents

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F 842	Continued From Page 1

(v) Physician's, nurse's, and other licensed professional's progress notes; and
(vi) Laboratory, radiology and other diagnostic services reports as required under §483.50.
This REQUIREMENT is not met as evidenced by:
Based on staff interview and record review the facility failed to ensure that 1 of 4 sampled residents had medical records accurately documented related to allergies (Resident #2). The findings include the following:

Per medical record review, Resident #2 has a diagnosis of Advanced Dementia and is a poor historian. The medical record has an alert identifying an allergy to Flu Vaccine. The history documented by a Nurse Practitioner dated 12/12/17, identifies an active allergy to Flu Vaccine.

Per Influenza Vaccine 2018-2019 consent form dated 9/21/18, identifies permission by Resident #2's guardian, to administer the flu vaccine. The vaccine was administered by the Licensed Practical Nurse (LPN) on 10/10/18.

Per review of the nurses' progress notes dated 10/10/18 through 10/13/18 there is no documentation identifying a flu vaccine allergy, nor is there any documentation identifying that the resident demonstrated with any adverse reaction to the vaccine that was administered on 10/10/18.

Confirmation was made by the LPN on 09/04/19 at approximately 9:15 AM, who did not acknowledge the Flu Vaccine allergy but does recall a conversation with the attending physician claiming the resident was not allergic to the vaccine. However, there is no documentation confirming the discussion. The LPN and the Director of Nurses confirm at this time that the chart does have the allergy alert present.