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

December 20, 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 **November 25, 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 11/25/2019

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 two facility self-reported incidents was conducted on 11-25-19 by the Division of Licensing and Protection. The following regulatory violations were a result of the investigation.	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 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and	F 656	F656 1. Resident #1 had no negative effects as a result of the alleged deficient practice. 2. All residents that refuse medications have the potential to be affected by the alleged deficient practice. 3. Re-education will be provided to Nurses re medication refusal and its influence on behavior, as well as Policy on Change of Condition. MD for Resident #1 is aware of resident #1 chronic behaviors. 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
[signature]	ED GKC (Administrator	12/13/19

ny deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that her safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days llowing 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 ays following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued ogram participation.

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F 656	Continued From page 1 desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based upon interview and record review, the facility failed to ensure 1 resident [Res. #1] of 3 sampled residents' Care Plan interventions were implemented regarding receiving their physician' prescribed medications as ordered. Findings include: A review of the medical record for Res. #1 reveals the resident was admitted to the facility on 10/17/18. Res. #1's diagnoses include vascular dementia of acute onset with behavioral disturbance, major depressive disorder, and a history of a stroke. Per review of Res. #1's Care Plan, dated 8/28/19; "I need to have staff give me my medications as ordered by my provider. While I'm here: I want to [be] safe, comfortable, and have my needs met by the staff." A review of Physician Orders regarding medications for Res. #1 was conducted on 11/25/19. Nine medications were ordered for Res. #1 including: Remeron: an antidepressant medication ordered for the resident in September 2019 Lamictal: a medication used to treat bipolar disorder	F 656	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 12/20/2019 F-656 POC accepted 12/19/19 D. Wideawake RN/ S Rumpf	

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F 656	Continued From page 2	F 656		

Zoloft: an antidepressant medication
Metoprolol: used to treat Res. #1's high blood pressure [a risk for stroke]
Xarelto: a 'blood thinner' medication used to help prevent stroke

Per review of Res. #1's Medication Administration Record [MAR], along with Nursing Notes and behavior notes from September 17th through November 25, 2019, reveal Res. #1 did not receive at least one of her prescribed medications on approximately 62 of 70 days.

An Interview was conducted with Licensed Practical Nurse [LPN] 'A' and LPN 'B' on 11/25/19 at 2:50 PM. Staff stated that Res. #1 could have very difficult behaviors, that the resident refuses medication "almost every day" and "More often than she takes them". Staff stated the Physician "should" be notified regarding a resident refusing medication. Physicians are notified via phone or fax. Staff stated they "sometimes forget" to notify the physician. Staff also stated that they "should" document that the physician was notified of medication refusals but "sometimes" they do not document this.

An interview was conducted with the Director of Nursing Services [DNS] on 11/25/19. The DNS stated that the facility did not have a policy regarding about when a physician should be notified, including if a resident is refusing or not receiving ordered medications. The DNS stated that "generally", if a resident was refusing medications for 2 or 3 days the physician would be notified. The DNS confirmed Res. #1 had refused medications for more than 2 or 3 days. The DNS also confirmed that there was no documentation in Res. #1's medical chart until a

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F 656	Continued From page 3 fax on 10/20/19 that demonstrated Res. #1's Physician was notified, despite the resident continuing to have behaviors and refusing medications including behavioral and antidepressant medications almost daily. Further review of Res. #1's MAR documents after a fax to the Physician on 11/6/19, where the Physician asks "Is she not taking them? Let me know" [if the resident is not receiving her medications]. Res. #1 refused the antidepressant Remeron 4 more times, and the antidepressant Zoloft 8 more times, including 4 days in a row. There is no documentation in Res. #1's medical record that the Physician was notified of the resident not receiving these doses of her ordered medications.	F 656		
F 744 SS=D	Treatment/Service for Dementia CFR(s): 483.40(b)(3) §483.40(b)(3) A resident who displays or is diagnosed with dementia, receives the appropriate treatment and services to attain or maintain his or her highest practicable physical, mental, and psychosocial well-being. This REQUIREMENT is not met as evidenced by: Based upon interview and record review, the facility failed to ensure that 1 of 3 sampled residents diagnosed with dementia, [Res. #1] received the appropriate treatment and services to attain or maintain his or her highest practicable physical, mental, and psychosocial well-being. Findings include: A review of the medical record for Res. #1 reveals the resident was admitted to the facility on 10/17/18. Res. #1's current diagnoses include vascular dementia of acute onset with behavioral	F 744	F744 1. Resident #1 had no negative effects as a result of the alleged deficient practice. 2. All residents who have chronic behaviors have the potential to be affected by the alleged deficient practice. 3. All resident charts reviewed specific to medication refusals. Re-education will be provided to Nurses re updated policy on Change of Condition to include MD notification of medication refusal.	

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F 744	Continued From page 4 disturbance and major depressive disorder. A review conducted of Nurses Notes for Res. #1 for September 2019 lists almost daily behaviors by the resident. For a single day, on 9/10/19, Nurses Notes record: 'Chronic behavior: Cursing at others, screaming at others, Verbal threatening: "This is my house, get out of here you asshholes". Behavior status has not changed since last assessment.' 'Placed on [one to one observation] due to abusive behavior. Abusive behavior: kicking hitting, pinching, scratching, pushing, grabbing, Self-propelling wheelchair into staff, Punching, hitting staff. Cause of behavior: none apparent.' 'New behavior: threw activity board off easel onto floor. "This is my home".' 'Wrapped hands around TV and VCR cords trying to pull it off TV stand onto floor ...Took 3 nurses to unwrap cords from her hands, Redirected. Behavior status has deteriorated since the last assessment.' 'Elder was trying to run staff down with her wheelchair so I followed her to make sure no one got hurt ... She moved every wastepaper basket in the hall she came to and threw them across the floor. She went into her room and tried to pull the call light out of the wall, then she threw her waste basket across the room." Nurses Notes for the next day, 9/11/19, continue 'Chronic behavior: cursing at others, screaming at others, Verbally threatening when LNA [Licensed Nursing Aide] answered call light. Also tried to spit at LNAs. Outcome: unchanged.' Nurses Notes dated 9/20/19 include 'Won't release call bell, Constantly ringing. "This is my house. Get out" and kicked LNA out trying to	F 744	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 12/20/2019 F 744 POC accepted 12/19/19 D.Widenmoth RN/S.Lunyou	

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F 744	Continued From page 5	F 744		

answer call bell. Outcome: unchanged, Call bell constantly ringing since she won't let go. Elder threw medicine cup twice at nurse and stated, "I am not taking these, I only want my Tylenol.'"

On 9/23/19, behavior notes record an incident where behaviors affected another resident when Res. #1 was 'tipping over computer screen at team station. Throwing things at staff. Trying to grab keyboard for computer at team station. Trying to throw door opener on the floor. Threw movies on the floor. Threw a mechanical cat at another [resident], also threw chocolate milk at another [resident]'. Facility notes record the physician 'was notified of the occurrence'. Further review of Nursing Notes and behavior notes for October through November 2019 reveal Resident #1 continued to have behaviors on an almost daily basis.

Nursing Notes dated 10/8/19 record "Elder more restless than baseline. Had been wheeling herself back and forth more than baseline. Shutting door then opening it, then coming down the hall. LNA reports that after supper [Res. #1] went up to LNA pushing another [resident] down the hall and rammed her wheelchair into the wheelchair of another [resident]. "There. See how you like it! Don't you ever hit me again". [Res. #1] redirected, but ineffective.'
A faxed communication was sent to Res. #1's Primary Physician on 10/20/19. The fax noted 'increased behaviors, new behaviors' and was 'refusing medications, getting out of bed, breakfast, lunch and nourishment, can be verbally and physically abusive.' The fax records a situation where the resident expressed to her daughter 'that she wants to die.'

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F 744	Continued From page 6	F 744		

An Interview was conducted with Licensed Practical Nurse [LPN] 'A' and LPN 'B' on 11/25/19 at 2:50 PM. Staff stated that Res. #1 could have very difficult behaviors, that the resident refuses medication "almost every day" and "More often than she takes them". Staff stated the Physician "should" be notified regarding a resident refusing medications. Physicians are notified via phone or fax. Staff stated they "sometimes forget" to notify the physician. Staff also stated that they "should" document that the physician was notified of medication refusals but "sometimes" they do not document this.

Per record review, a Care Plan meeting was held with the resident's daughter on 10/29/19. Notes from the meeting include "Daughter asked if we could talk to [Res. #1's Physician] about maybe cutting back on some more of her medications because she gets so upset when staff bring them to [him/her]. We will talk to [Res. #1's Physician] about this ..." A week later, on 11/6/19, a faxed communication was sent to Res. #1's Primary Physician The physician's response signed and dated on 11/12/19 reads "I cannot read writing above. Are you saying, "not wanting her meds?" Is she not taking them? Let me know". A note at the bottom of the fax records it was refaxed on 11/15/19 with the note 'She at times refuses her meds. Again FYI'.

A review of Res. #1's medical record from September 17th through November 25th 2019 revealed one record where it was stated 'the Doctor will be notified' about refusing medications, with no follow up note, and the two faxes, the second where the Physician asks "Is she not taking them? [Medications]. Let me know".

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F 744	Continued From page 7	F 744		

A review of Physician Orders regarding medications for Res. #1 was conducted on 11/25/19. Nine medications were ordered for Res. #1 including:
Zoloft: an antidepressant medication ordered for the resident in July 2019
Remeron: an antidepressant medication ordered for the resident in September 2019
Lamictal: a medication used to treat bipolar disorder ordered for the resident on 11/8/19
Per review of Res. #1's Medication Administration Record [MAR], along with Nursing Notes and behavior notes from September 17th through November 25, 2019, reveal Res. #1 refused at least one of her prescribed medications on approximately 62 of 70 days.

An interview was conducted with the Director of Nursing Services [DNS] on 11/25/19. The DNS stated that the facility did not have a policy regarding about when a physician should be notified, including if a resident is refusing or not receiving ordered medications. The DNS stated that "generally", if a resident was refusing medications for 2 or 3 days the physician would be notified. The DNS confirmed Res. #1 had refused medications for more than 2 or 3 days. The DNS also confirmed that there was no documentation in Res. #1's medical chart until the fax on 10/20/19 that demonstrated Res. #1's Physician was notified despite the resident continuing to have behaviors and refusing medications including behavioral and antidepressant medications almost daily. Further review of Res. #1's MAR records after the fax to the Physician on 11/6/19, where the Physician asks to "let me know" if the resident is refusing her medications, Res. #1 refused the

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F 744	Continued From page 8	F 744		

antidepressant Remeron 4 more times, and the antidepressant Zoloft 8 more times, including 4 days in a row. There is no documentation in Res. #1's medical record that the Physician was notified of the resident not receiving these doses of her ordered medications.

Gifford Retirement Community

215 Tom Wicker Lane, Randolph Center, Vermont 05061
802-728-7887 • *fax* 802-728-7886

12/9/2019

Pamela Cota, RN – Licensing Chief
HC 2 South, 280 State Drive
Waterbury, VT 05671-2060

Dear Mrs Cota:

Enclosed is the signed 2567 and the Plan of Correction related to the deficiencies sited during the investigation survey on November 25, 2019.

Please let me know if you have any additional questions or concerns.

Sincerely,

Ursula Margazano, LNHA
Executive Director GRC

215 Tom Wicker Lane
Randolph Center, VT 05061
Email: umargazano@giffordmed.org
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