Division of Licensing and Protection HC 2 South, 280 State Drive Waterbury, VT 05671-2060 <u>http://www.dail.vermont.gov</u> 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

April 29, 2022

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 recertification survey conducted on **April 6, 2022.** 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,

Jamela M Cota RN

Pamela M. Cota, RN Licensing Chief

## DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY **IDENTIFICATION NUMBER:** COMPLETED AND PLAN OF CORRECTION A. BUILDING 475058 B. WING 04/06/2022 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 215 TOM WICKER LANE MENIG NURSING HOME RANDOLPH CENTER, VT 05061 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5) COMPLETION DATE ID (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) E 000 Initial Comments E 000 The Division of Licensing and Protection conducted a survey of the facility's emergency preparedness program as part of an onsite, Preparation and/or execution of this unannounced recertification survey on 4/6/2022, The following regulatory deficiencies were plan of correction does not identified: constitute the providers admission E 022 E 022 Policies/Procedures for Sheltering in Place of/or agreement with the alleged CFR(s): 483.73(b)(4) SS=C violations or conclusions set forth in §403.748(b)(4), §416.54(b)(3), §418.113(b)(6)(i), this statement of deficiencies. The §441.184(b)(4), §460.84(b)(5), §482.15(b)(4), plan of correction is prepared and/or §483.73(b)(4), §483.475(b)(4), §485.68(b)(2), §485.625(b)(4), §485.727(b)(2), §485.920(b)(3), executed as required by State and §491.12(b)(2), §494.62(b)(3). Federal Law. (b) Policies and procedures. The [facilities] must develop and implement emergency preparedness E022 policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk 1. No Residents had negative assessment at paragraph (a)(1) of this section. and the communication plan at paragraph (c) of Effects as a result of the this section. The policies and procedures must alleged deficient practice. be reviewed and updated at least every 2 years 2. All Residents, Staff and [annually for LTC facilities]. At a minimum, the policies and procedures must address the Volunteers have the potential following:] ŧ, to be affected by the alleged [(4) or (2),(3),(5),(6)] A means to shelter in place deficient practice. for patients, staff, and volunteers who remain in 3. Develop and implement the [facility]. policy and procedure specific \*[For Inpatient Hospices at §418.113(b):] Policies to sheltering in place. and procedures. 4. Education provided to Menig (6) The following are additional requirements for employees regarding new p hospice-operated inpatient care facilities only. The policies and procedures must address the policy and procedure. following: ABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE 1da h Qr. Lelo -VP Services 10 LNHA Any deficiency statement ending with a sterisk (\*) 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.

PRINTED: 04/18/2022

TATEMENT	RS FOR MEDICARE &	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTI	PLE CO	NSTRUCTION	(X3) DAT	0,0938-039 5 SURVEY
nd plan o	F CORRECTION	IDENTIFICATION NUMBER:	a, Buildin	G	· · · · · · · · · · · · · · · · · · ·	COM	PLETED
		475058	B. WING			04	/06/2022
NAME OF F	PROVIDER OR SUPPLIER				ET ADDRESS, CITY, STATE, ZIP CODE		
MENIG N	URSING HOME				OM WICKER LANE DOLPH CENTER, VT 05061		
(X4) ID Prefix Tag	(EACH DEFICIENC)	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 APPR DEFICIENCY)	ULD BE	(X5) GOMPLETION DATE
E 022 E 039 SS=C	This REQUIREMENT by: Based on staff intervi facility failed to develd a means to shelter in and volunteers who re an emergency. Findin 1. Per record review, preparedness policies contain a policy outlin sheltering in place dur which the policy may Per interview on 4/6/2 AM, the Administrator have a policy outlining residents, staff, and vi EP Testing Requiremen CFR(s): 483.73(d)(2) §416.54(d)(2), §482.1 §460.84(d)(2), §482.1 §483.475(d)(2), §484. §485.625(d)(2), §484. §485.625(d)(2), §484. §491.12(d)(2), §494.6 *[For ASCs at §416.54 "Organizations" under §485.920, RHCs/FQH Facilities at §494.62]: (2) Testing. The [faciliti	in place for patients, tho remain in the hospice. is not met as evidenced ew and record review, the op policies or procedures for place for residents, staff, emain in the facility during gs include: the facility's emergency e and procedures did not ing procedures for ring any emergency for apply. 022 at approximately 10:00 confirmed that they do not g procedures for sheltering olunteers in place. ents 13(d)(2), §441.184(d)(2), 5(d)(2), §483.73(d)(2), 102(d)(2), §485.68(d)(2), 727(d)(2), §485.920(d)(2), 2(d)(2). 4, CORFs at §485.68, OPO, §485.727, CMHCs at Cs at §491.12, and ESRD y] must conduct exercises plan annually. The [facility]	EO	<b>T</b> 4	<ol> <li>Monitoring of Emergy Preparedness Policie Procedures to occur Quarterly QAPI meet</li> <li>Corrective Action to completed by 5/20/2</li> <li>CAG E 022 POC Accepter V28/22 by K. Ruffe/P. Co</li> <li>No Residents had not Effects as a result of alleged deficient pra</li> <li>All Residents have th potential to be affect the alleged deficient</li> <li>Schedule and execut least 2 exercises to t emergency plan ann</li> </ol>	egative at ings. be 22 ed on ta egative the actice. he cted by t practice. te at eest the	

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7 1. Facility ID: VT475058

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	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER;		PLE CONSTRUCTION		e survey Pleted
		475058	B. WNG_		04	/06/2022
NAME OF P	ROVIDER OR SUPPLIER		_	STREET ADDRESS, CITY, STATE, ZIP CODE		
MENIG N	JRSING HOME			215 TOM WICKER LANE RANDOLPH CENTER, VT 05061		
(X4) 1D PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	COMPLETION DATE
E 039	accessible, conduct a exercise every 2 years (B) If the [facility] natural or man-made activation of the emer exempt from engaging community-based or ii functional exercise fol actual event. (ii) Conduct an additio years, opposite the yea functional exercise un this section is conduct not limited to the follow (A) A second full-scale community-based or ii functional exercise; or (B) A mock disaster dr (C) A tabletop exercise a facilitator and Includ a narrated, clinically-re scenario, and a set of directed messages, or designed to challenge (iii) Analyze the [facility maintain documentatio exercises, and emerge [facility's] emergency p *[For Hospices at 418. (2) Testing for hospice patient's home. The he exercises to test the e	scale exercise that is any 2 years; or ty-based exercise is not facility-based functional s; or experiences an actual emergency that requires gency plan, the [facility] is g in its next required ndividual, facility-based lowing the onset of the nal exercise at least every 2 ear the full-scale or der paragraph (d)(2)(i) of ted, that may include, but is wing: a exercise that is ndividual, facility-based ifli; or a or workshop that is led by es a group discussion using elevant emergency problem statements, prepared questions an emergency plan. y's] response to and on of all drills, tabletop ency events, and revise the olan, as needed. 113(d):] es that provide care in the	EC	<ul> <li>4. Monitoring of Emerge Preparedness exercise drills to occur at quart QAPI meetings.</li> <li>5. Corrective Action to be completed by 5/20/22</li> <li>TAG E 039 POC Accept 4/28/22 by K. Ruffe/P.</li> </ul>	s and erly	

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TATEMENT	S FOR MEDICARE &	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	IPLE CC	DNSTRUCTION	(X3) DA	<u>NO. 0938-039</u> Te survey
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	√G		CO	MPLETED
		475058	B. WING			c	4/06/2022
NAME OF P	ROVIDER OR SUPPLIER			STRE	ET ADDRESS, CITY, STATE, ZIP CODE		
MENIG NU	JRSING HOME				TOM WICKER LANE IDOLPH CENTER, VT 05061		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	<	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	DBE	(X5) COMPLETION DATE
E 039	Continued From page	e 3	E	039			
	community based ev						
		ity based exercise is not					
	accessible, conduct a	an individual facility based					
	functional exercise every 2 years; or (B) If the hospice experiences a natural or						
	-	by that requires activation of					
	engaging in its next r	the hospital is exempt from					
	community-based ex						
		nal exercise following the					
	onset of the emergen						
		ional exercise every 2 years,					
		full-scale or functional					
		raph (d)(2)(i) of this section					
		y include, but is not limited					
	to the following: (A) A second full-sca	le evercise that is					
		a facility based functional					
	exercise; or	a laonity bacca lancional					
	(B) A mock disaster (	drill; or					
	(C) A tabletop exerci	se or workshop that is led by					
		les a group discussion using					
	a narrated, clinically-						
	scenario, and a set of	•					
	directed messages, o designed to challenge						
	designed to challenge	e an emergency plan.					
	(3) Testing for hospic	es that provide inpatient					
	care directly. The hose						
ſ		emergency plan twice per					
	year. The hospice m						
		nnual full-scale exercise that					
	is community-based;	or ty-based exercise is not					
	accessible, conduct a						
	facility-based function						
	(B) If the hospice exp						
1	man-made emergenc		1				1

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Facility ID: VT475058

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		ID HUMAN SERVICES MEDICAID SERVICES				FOR	D: 04/18/2022 MAPPROVED D. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		475058	B. WING			04	/06/2022
NAME OF P	ROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE		
MENIG NU	JRSING HOME				15 TOM WICKER LANE ANDOLPH CENTER, VT 05061		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	DBE	(X5) COMPLETION DATE
E 039	engaging in its next re based or facility-base following the onset of (ii) Conduct an additi may include, but is no (A) A second full-sca community-based or a exercise; or (B) A mock disaster of (C) A tabletop exercis facilitator that includes narrated, clinically-rel and a set of problem s messages, or prepare challenge an emerger (iii) Analyze the hosp maintain documentati exercises, and emerg hospice's emergency *[For PRFTs at §441.* §482.15(d), CAHs at § (2) Testing. The [PRT conduct exercises to f twice per year. The [I do the following: (i) Participate in an at is community-based; of (A) When a communit accessible, conduct a facility-based function (B) If the [PRTF, Hosp actual natural or man- requires activation of [facility] is exempt fror	the hospice is exempt from equired full-scale community d functional exercise the emergency event. onal annual exercise that onal annual exercise that it limited to the following: le exercise that is a facility based functional drill; or se or workshop led by a s a group discussion using a evant emergency scenario, statements, directed ad questions designed to ney plan. ice's response to and on of all drills, tabletop ency events and revise the plan, as needed. 184(d), Hospitals at §485.625(d):] F, Hospital, CAH] must test the emergency plan PRTF, Hospital, CAH] must mual full-scale exercise that or y-based exercise is not n annual individual, al exercise; or oital, CAH] experiences an made emergency that the emergency plan, the	E	039			

Facility ID: VT475058

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Sector Sector

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					e survey Ipleted
		4 <b>7</b> 5058	B. WING			04/06/2022	
NAME OF P	ROVIDER OR SUPPLIER			STRE	EET ADDRESS, CITY, STATE, ZIP CODE		
MENIG N	URSING HOME				TOM WICKER LANE IDOLPH CENTER, VT 05061		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
E 039	facility-based function onset of the emergen (ii) Conduct an [a and that may include, following: (A) A second full-sca community-based or i functional exercise; of (B) A mock of (C) A tabletop ex led by a facilitator and discussion, using a na emergency scenario, statements, directed r questions designed to plan. (iii) Analyze the [1 maintain documentati exercises, and emerg [facility's] emergency *[For PACE at §460.8 (2) Testing. The PACE exercises to test the e annually. The PACE of following: (i) Participate in an an is community-based; (A) When a community accessible, conduct a facility-based function (B) If the PACE experi- man-made emergency the emergency plan, the based or individual, fat	al exercise following the cy event. additional] annual exercise or but is not limited to the le exercise that is individual, a facility-based r lisaster drill; or ercise or workshop that is d includes a group arrated, clinically-relevant and a set of problem messages, or prepared o challenge an emergency facility's] response to and on of all drills, tabletop ency events and revise the plan, as needed. 4(d):] E organization must conduct emergency plan at least organization must do the nnual full-scale exercise that or y-based exercise is not n annual individual,	EC	039			

Facility ID: VT475058

If continuation sheet Page 6 of 17

	S FOR MEDICARE &						10. 0938-0 <u>3</u> 9
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			DNSTRUCTION		TE SUR <b>V</b> EY MPLETED
		475058	B. WING			0	4/06/2022
NAME OF P	ROVIDER OR SUPPLIER			STRE	EETADDRESS, CITY, STATE, ZIP CODE		
MENIG NU	URSING HOME				TOM WICKER LANE IDOLPH CENTER, VT 05061		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CORRECTIO PREFIX (EACH CORRECTIVE ACTION SHOULD TAG CROSS-REFERENCED TO THE APPROP DEFICIENCY)		OULD BE	(X5) COMPLETION DATE
E 039	<ul> <li>(ii) Conduct an additional exercise every 2 years opposite the year the full-scale or functional exercise under paragraph (d)(2)(1) of this section is conducted that may include, but is not limited to the following:</li> <li>(A) A second full-scale exercise that is community-based or individual, a facility based functional exercise; or</li> <li>(B) A mock disaster drill; or</li> <li>(C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.</li> <li>(iii) Analyze the PACE's response to and</li> </ul>		E	039			
	maintain documentati exercises, and emerg PACE's emergency p *[For LTC Facilities at	on of all drills, tabletop lency events and revise the lan, as needed. §483.73(d):]					
	test the emergency pl including unannounce emergency procedure ICF/IID] must do the f	ollowing: nnual full-scale exercise that					
	<ul><li>(A) When a communit accessible, conduct a facility-based function</li><li>(B) If the [LTC facility]</li></ul>	ty-based exercise is not n annual individual,					
	requires activation of	the emergency plan, the from engaging its next ommunity-based or					

Facility ID: VT475058

If continuation sheet Page 7 of 17

(X3) DATE SURVEY COMPLETED 04/06/2022
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DF CORRECTION (X5) CTION SHOULD BE COMPLETIC O THE APPROPRIATE DATE INCY)

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Facility ID: VT475058

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	MENT OF HEALTH AN S FOR MEDICARE &	D HUMAN SERVICES MEDICAID SERVICES				FC	TED: 04/18/2022 DRM APPROVED NO. 0938-0391	
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) Mul A. Build			(X3) D.	ATE SURVEY DMPLETED	
		475058	B. WING				04/06/2022	
NAME OF PI	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE			
MENIG NU	IRSING HOME		215 TOM WIGKER LANE RANDOLPH CENTER, VT 05061					
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) Completion Date	
E 039	a facilitator and includ using a narrated, clinis scenario, and a set of directed messages, or designed to challenge (iii) Analyze the ICF/II maintain documentatio exercises, and emerge ICF/IID's emergency p *[For HHAs at §484.10 (d)(2) Testing. The HH to test the emergency least annually. The HH (i) Participate in a full- community-based; or (A) When a comm accessible, conduct an facility-based function or. (B) If the HHA ex or man-made emergency of the emergency plan engaging in its next re community-based or in functional exercise foll emergency event. (ii) Conduct an additio opposite the year the exercise under paragr is conducted, that limited to the following (A) A second full-	rill; or e or workshop that is led by es a group discussion, cally-relevant emergency problem statements, r prepared questions a nemergency plan. D's response to and on of all drills, tabletop ency events, and revise the olan, as needed. D2] IA must conduct exercises plan at IA must do the following: scale exercise that is nunity-based exercise is not n annual individual, al exercise every 2 years; periences an actual natural ncy that requires activation i, the HHA is exempt from quired full-scale ndividual, facility based owing the onset of the nal exercise every 2 years, full-scale or functional aph (d)(2)(i) of this section may include, but is not : scale exercise that is n individual, facility-based	E	035	2			

Facility ID: VT475058

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TATEMENT	OF DEFICIENCIES F CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 · ·		CONSTRUCTION	OMB NO, 093 (X3) DATE SURVE COMPLETED	
		4 <b>7</b> 5058	B. WNG				)4/06/2022
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
MENIG NU	URSING HOME				15 TOM WICKER LANE ANDOLPH CENTER, VT 05061		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
E 039	led by a facilitator and discussion, using a na emergency scenario, statements, directed r questions designed to plan. (iii) Analyze the HHA's documentation of all of emergency events, ar emergency plan, as n *[For OPOs at §486.3 (d)(2) Testing. The OF to test the emergency following: (i) Conduct a paper-ba workshop at least ann led by a facilitator and discussion, using a na emergency scenario, a statements, directed n questions designed to plan. If the OPO expe man-made emergency the emergency plan, t engaging in its next re following the onset of (ii) Analyze the OPO's documentation of all ta emergency events, an OPO's] emergency plan *[ RNCHIs at §403.744 (d)(2) Testing. The RN	ercise or workshop that is l includes a group arrated, clinically-relevant and a set of problem nessages, or prepared o challenge an emergency a response to and maintain lrills, tabletop exercises, and of revise the HHA's eeded. 60] PO must conduct exercises plan. The OPO must do the ased, tabletop exercise or ually. A tabletop exercise is includes a group irrated, clinically relevant and a set of problem nessages, or prepared challenge an emergency riences an actual natural or y that requires activation of he OPO is exempt from quired testing exercise the emergency event. response to and maintain abletop exercises, and d revise the [RNHCI's and an, as needed. 3]: IHCI must conduct mergency plan. The RNHCI	E	039			

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Facility ID: VT475058

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TATEMENT (	OF DEFICIENCIES	MEDICAID SERVICES	(X2) MUL	TIPLE CO	ONSTRUCTION		<u>D. 0938-039</u> E SURVEY
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:					PLETED
		475058	B. WING			04	/06/2022
NAME OF P	ROVIDER OR SUPPLIER	ł		STR	EET ADDRESS, CITY, STATE, ZIP CODE		
MENIG NU	IRSING HOME				TOM WICKER LANE NDOLPH CENTER, VT 05061		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	OULD BE COMPLE	
E 039	Continued From page	e 10	E	039			
	least annually. A table	etop exercise is a group					
	•	acilitator, using a narrated,					
	clinically-relevant emergency scenario, and a set						
	of problem statements, directed messages, or prepared questions designed to challenge an						
	emergency plan.	esigned to enalionge an					
	(ii) Analyze the RNH0						
		ion of all tabletop exercises,					
	emergency plan, as n	ts, and revise the RNHCI's					
		ieeueu. is not met as evidenced					
	by:						
	based on staff intervi	ew and record review, the					
	•	ict a second full-scale or					
		t meets the requirements of e to test the emergency plan					
	at least annually. Find						
	1. Per record review,						
	•	a second exercise to test the e last year that met the					
		cond full-scale exercise or a		ł			
	-	t uses a clinically-relevant					
	emergency scenario I	ed by a facilitator.		Í			
	Per interview on AIGI2	2022 at approximately 12:00					
		ursing confirmed that the					
1		cted a second full-scale or					
	tabletop exercise that	- ·					
	-	an exercise within the last					
F 000	year. INITIAL COMMENTS		F	000			
1 000							
	The Division of Licen	sing and Protection					
		unannounced recertification					
	survey and staff vacci	nation requirement review	ŀ				
	from 4/3/2022 through	n 4/6/2022. The following					

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Facility ID: VT475058

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## DEPARTMENT OF HEALTH AND HUMAN SERVICES

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PRINTED: 04/18/2022 FORM APPROVED

CENTEF	RS FOR MEDICARE &	MEDICAID SERVICES				DMB N	O. 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION		E SURVEY IPLETED
t.		475058	B. WING			04	/06/2022
NAME OF F	ROVIDER OR SUPPLIER			s	STREET ADDRESS, CITY, STATE, ZIP CODE		
					215 TOM WICKER LANE		
MENIG N	URSING HOME				RANDOLPH CENTER, VT 05061		
			1 15		1		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ITEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	BE	(X5) Completion Date
	CFR(s): 483.15(c)(3)- §483.15(c)(3) Notice I Before a facility transf resident, the facility m (i) Notify the resident a representative(s) of th the reasons for the mail language and manner facility must send a co representative of the C Long-Term Care Omb (ii) Record the reasons discharge In the reside accordance with parage and (iii) Include in the notic paragraph (c)(5) of thi §483.15(c)(4) Timing of (c)(8) of this section, the discharge required una made by the facility at resident is transferred (ii) Notice must be made before transfer or disc (A) The safety of indivi- be endangered, under this section; (B) The health of indivi- be endangered, under this section; (C) The resident's heal allow a more immediat under paragraph (c)(1) (D) An immediate transfer	before transfer. ers or discharges a ust- and the resident's e transfer or discharge and ove in writing and in a they understand. The opy of the notice to a Diffice of the State udsman. s for the transfer or ent's medical record in graph (c)(2) of this section; the the items described in s section. of the notice. in paragraphs (c)(4)(ii) and ne notice of transfer or der this section must be least 30 days before the or discharged. de as soon as practicable harge when- duals in the facility would paragraph (c)(1)(i)(C) of duals in the facility would paragraph (c)(1)(i)(D) of th improves sufficiently to e transfer or discharge, (i)(B) of this section; sfer or discharge is t's urgent medical needs,	F	623	<ol> <li>Resident #27 and #380 no negative effects as a of the alleged deficient practice. Verbal communication regard urgent medical transfer documented.</li> <li>All residents that are transferred due to an u medical need have the potential to be affected the alleged deficient pr</li> <li>Policy &amp; procedure rela Transfer/Discharge revi and updated to include written communication resident and/or residen representative, as well Ombudsman. Developr and implementation of letter template for use i written communication urgent medical transfer</li> <li>Re-education provided to Care Manager and Nurs the need for written notification of transfer a form utilization.</li> </ol>	result ng the was rgent by actice. ted to to to t's sent form n of o es re:	

FORM CMS-2567(02-99) Previous Versions Obsolete

Facility ID: VT475058

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STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	(X3) DATE	D, 0938-039 SURVEY PLETED	
		475058	B. WING		04/	/06/2022	
	rovider or supplier J <b>rsing home</b>			STREET ADDRESS, CITY, STATE, ZIP COE 215 TOM WICKER LANE RANDOLPH CENTER, VT 05061			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL & LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X6) COMPLETION DATE	
F 623	days. §483.15(c)(5) Conte notice specified in pa must include the foll (i) The reason for tra- (ii) The offective data (iii) The location to w transferred or dischar (iv) A statement of th including the name, and telephone number receives such reque to obtain an appeal f completing the form hearing request; (v) The name, addre telephone number of Long-Term Care Om (vi) For nursing facili and developmental co disabilities, the mailing telephone number of the protection and acc developmental disab C of the Developmental codified at 42 U.S.C. (vii) For nursing facili disorder or related di email address and te agency responsible f	ot resided in the facility for 30 Ints of the notice. The written aragraph (c)(3) of this section owing: ansfer or discharge; e of transfer or discharge; /hich the resident is arged; ne resident's appeal rights, address (mailing and email), per of the entity which sts; and information on how form and assistance in and submitting the appeal ss (mailing and email) and f the Office of the State budsman; ty residents with intellectual lisabilities or related ng and email address and f the agency responsible for Avocacy of individuals with illities established under Part ntal Disabilities Assistance of 2000 (Pub. L. 106-402, 15001 et seq.); and ity residents with a mental isabilities, the mailing and dephone number of the for the protection and als with a mental disorder e Protection and Advocacy fuals Act.	F 62	<ul> <li><sup>23</sup> 5. Audits will be coweekly X 12 wks Manager &amp;/or dmonitor and enscommunication was provided.</li> <li>6. Results of the aureported to the committee at which committee at which committee will emake recommenneeded.</li> <li>7. Corrective action completed by 5/</li> <li>TAG F 623 POC Accord/28/22 by K. Ruffe/</li> </ul>	by the Care esignee to for transfers udits will be QAPI hich time the evaluate and ndations as n to be '13/22.		

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	S FOR MEDICARE &					10.0938-039	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 475058 NAME OF PROVIDER OR SUPPLIER		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED 04/06/2022	
		B. WING	0				
		STF	REET ADDRESS, CITY, STATE, ZIP CODI	E			
MENIG NU	IRSING HOME			TOM WIGKER LANE			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COM (EACH CORRECTIVE ACTION) CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) Completion Date	
F 623	Continued From page	ə 13	F 623				
	effecting the transfer must update the recip as practicable once the becomes available. §483.15(c)(8) Notice In the case of facility the administrator of the written notification pri	ne notice changes prior to or discharge, the facility pients of the notice as soon ne updated information in advance of facility closure closure, the individual who is ne facility must provide or to the impending closure					
	State Long-Term Care the facility, and the re well as the plan for th relocation of the resid 483.70(I). This REQUIREMENT by:	gency, the Office of the e Ombudsman, residents of sident representatives, as e transfer and adequate lents, as required at § <sup>.</sup> is not met as evidenced iews and record review the					
	facility failed to notify resident's represental transfer/discharge; ar to the Ombudsman (p investigate complaints government and/or pu	the resident and/or ive in writing of a id send a copy of the notice public official appointed to s people make against ublic organizations) for 2 of 2 in the sample (Resident #27					
	a change in mental st the hospital on 3/17/2 admitted back to the f was no evidence in th and/or their represent Ombudsman was not transfer/discharge. P	acility on 3/18/22. There e record that the resident ative; and/or the					

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Facility ID: VT475058

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	MENT OF HEALTH AN S FOR MEDICARE & I					FOF	ED: 04/18/2022 RM APPROVED IO. 0938-0391
STATEMENT OF DEFICIENCIES ( AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING				ESURVEY IPLETED
		475058	B. WING			04	4/06/2022
NAME OF PI	ROVIDER 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 PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPR DEFICIENCY)	ILD BE	(X5) COMPLETION DATE
F 623	Worker also confirmed providing these notice	never given a written cility "always accepts ng that time, the Social d that the facility was not s to any residents, their r Ombudsman when a	F	623	3		
F 656 SS=D	family representative of revealed that the reside an acute care hospital returning later the sam representative denied notification of the tran- record review there is record that the resider representative, or the in writing of the transfe 16, 2022 at approxima the Social Service Der written notification had Develop/Implement C CFR(s): 483.21(b)(1) §483.21(b) Comprehe §483.21(b)(1) The fac Implement a compreh care plan for each res resident rights set fort §483.10(c)(3), that inco objectives and timefra medical, nursing, and needs that are identified	tent had been transferred to I on March 24, 2022, ne day. The resident receiving written sfer to the hospital. Per no evidence in the clinical nt, the resident's Ombudsman were notified er to the hospital. On April ately 9:20 AM a member of partment confirmed no d been provided. omprehensive Care Plan nsive Care Plans illity must develop and ensive person-centered ident, consistent with the h at §483.10(c)(2) and	F	656	<ul> <li>F656</li> <li>1. Resident #5 had no effects as a result of alleged deficient pra</li> <li>2. All residents that hav nutrition care plan h potential to be affect the alleged deficient</li> </ul>	the ctice, /e a ave the ced by	

Facility ID: VT475058

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475058	215	EETADDRESS, CITY, STATE, ZIP CODE TOM WICKER LANE	04/	06/2022
Y MUST BE PRECEDED BY FULL	215 - RAN	TOM WICKER LANE		
Y MUST BE PRECEDED BY FULL	RAN			
Y MUST BE PRECEDED BY FULL		NDOLPH CENTER, VT 05061		
	PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETIO DATE
e 15 g - are to be furnished to attain ent's highest practicable I psychosocial well-being as 24, §483.25 or §483.40; and would otherwise be required .25 or §483.40 but are not esident's exercise of rights ding the right to refuse 3.10(c)(6). ervices or specialized a the nursing facility will PASARR a facility disagrees with the RR, it must indicate its ent's medical record. h the resident and the tive(s)- als for admission and eference and potential for ilities must document s desire to return to the ssed and any referrals to s and/or other appropriate ose. n the comprehensive care in accordance with the n in paragraph (c) of this <sup>-</sup> is not met as evidenced In, staff interviews, and lity failed to implement a 1 applicable resident tops include:	F 656	<ul> <li>to Food Services, Nur and activities staff re dysphagia diets and t importance of impler the nutrition care pla Format change to me to enhance visibility a ensure correct theray modifications to the meal service are implemented for deli</li> <li>4. Audits will be conduct twice weekly X 4 wee weekly Xs 8 weeks by DNS &amp;/or designee to monitor the distribut meals to ensure correct therapeutic service de</li> <li>5. Results of the audits or reported to the QAPI committee at which to committee will evaluate make recommendation needed.</li> <li>6. Corrective action to b</li> </ul>	rses, LNA garding the menting an. eal ticket and to peutic resident very. cted 2 eks then v the p ion of ect elivery. will be ime the ate and pns as	
	g - are to be furnished to attain ent's highest practicable I psychosocial well-being as 24, §483.25 or §483.40; and would otherwise be required .25 or §483.40 but are not esident's exercise of rights ding the right to refuse 3.10(c)(6). ervices or specialized a the nursing facility will PASARR a facility disagrees with the RR, it must indicate its ent's medical record. h the resident and the tive(s)- als for admission and efference and potential for ilities must document s desire to return to the ssed and any referrals to s and/or other appropriate ose. n the comprehensive care in accordance with the n in paragraph (c) of this is not met as evidenced n, staff interviews, and lity failed to implement a 1 applicable resident togs include: I on 4/4/22 at 12:10 PM, erved eating half of a grilled	g - are to be furnished to attain ent's highest practicable I psychosocial well-being as 24, §483.25 or §483.40; and would otherwise be required .25 or §483.40 but are not esident's exercise of rights ding the right to refuse 8.10(c)(6). ervices or specialized a the nursing facility will PASARR a facility disagrees with the RR, it must indicate its ent's medical record. h the resident and the tive(s)- als for admission and efference and potential for illities must document s desire to return to the ssed and any referrals to s and/or other appropriate ose. n the comprehensive care in accordance with the n in paragraph (c) of this is not met as evidenced n, staff interviews, and lity failed to implement a 1 applicable resident rogs include: I on 4/4/22 at 12:10 PM, erved eating half of a grilled	g -to Food Services, Nu and activities staff re dysphagia diets and dysphagia diets and dysphagia diets and dysphagia diets and importance of implet the nutrition care play Format change to me asident's exercise of rights ding the right to refuse s 10(c)(6).to Format change to me to enhance visibility a ensure correct therap modifications to the meal service are a facility disagrees with the the resident and the tive(s)- als for admission andto Food Services, Nu and activities staff re dysphagia diets and importance of implet the nutrition care play format change to me to enhance visibility a ensure correct therap modifications to the meal service are a facility disagrees with the RR, it must indicate its on's medical record.the resident and the twice weekly X 4 wee weekly X 4 wee weekly X 8 8 weeks by DNS &/or designee to monitor the distribut meals to ensure correct therapeutic service ds desire to return to the see.s and/or other appropriate is a cordance with the n in paragraph (c) of this5. Results of the audits reported to the QAPI committee at which to completed by 5/13/2.' is not met as evidenced ings include:6. Corrective action to b completed by 5/13/2.	g -to Food Services, Nurses, LNA and activities staff regarding dysphagia diefs and the importance of implementing the nutrition care plan.2.5 or §483.40; and would otherwise be required 2.5 or §483.40; and would otherwise be required 2.5 or §483.40; and to refuse a facility will PASARR a facility will PASARR a facility disagrees with the RR, it must indicate its nifs medical record. h the resident and the tive(s)- als for admission and ofference and potential for illities must document s ead and any referrals to s and/or other appropriate ise.to Food Services, Nurses, LNA and activities staff regarding dysphagia diefs and the importance of implementing the nutrition care plan. Format change to meal ticket to enhance visibility and to ensure correct therapeutic modifications to the resident meal service are implemented for delivery.4. Audits will be conducted 2 twice weekly X 4 weeks then weekly X 8 weeks by the DNS &/or designee to monitor the distribution of meals to ensure correct therapeutic service delivery.5. Results of the audits will be reported to the QAPI committee at which time the committee at which time the committee at which time the committee at the time the committee at the time the committee at the time the completed by 5/13/226. Corrective action to be completed by 5/13/22

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Facility ID: VT475058

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		ID HUMAN SERVICES MEDICAID SERVICES				FOR	D: 04/18/2022 MAPPROVED D: 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		475058	B, WING			04/	06/2022
NAME OF PROVIDER OR SUPPLIER					TREET ADDRESS, CITY, STATE, ZIP CODE		
MENIG NURSING HOME			215 TOM WICKER LANE RANDOLPH CENTER, VT 05061				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	id Prefi TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)		(X5) COMPLETION DATE
F 656	ASING HOME SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 16 cheese sandwich with crust on the bread. Over the course of the lunch period, the resident proceeded to eat the second half of the sandwich which also contained crust on the bread. Per record review Resident #5 has a diagnosis of Alzheimer's disease (A progressive disease that destroys memory and other important mental functions.) and celiac disease (An immune reaction to eating gluten, a protein found in wheat, barley, and rye.), and a history of unintended weight loss. Per a dietitian's note from 4/1/22, it states "sip eval res swallowing funct. this past quarter and downgraded diet". The resident's care plan dated $3/2/22$ states, "Diet to include ground meats with extra molsture, add extra moisture to breads or muffins, cut crusts off bread, avoid particulates such as rice, corn, or peas. avoid straws alternate sips and bites during meals". Per review of Resident #5's diet ticket from $4/1/22$ it states, "Grilled Cheese on Gluten Free Bread-1 Ea extra gravy/moisture no crust". Per interview on $4/5/22$ at 3:35 PM with the Director of Nursing (DNS), S/He confirmed that Resident #5's care plan was not being followed and that the resident should not be given bread with crust at any time.		F	656	TAG F 656 POC Accepted 4/28/22 by K. Ruffe/P. Cot		

Event ID; BDCO11

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## Gifford Retirement Community

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

4/26/2022

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 recertification survey on April 3, 2022. Please let me know if you have any additional questions or concerns.

Sincerely,

Visila ( Margo sport

Ursula Margazano, LNHA VP of Senior Services GRC 215 Tom Wicker Lane Randolph Center, VT 05061 Email: <u>umargazano@giffordmed.org</u> Direct Phone 802-728-7887 |Fax 802-728-7886 giffordhealthcare.org