

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 <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

May 13, 2024

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 complaint investigation conducted on **April 19, 2024.** 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,

famila M Cota RN

Pamela M. Cota, RN Licensing Chief

Enclosure

	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		NSTRUCTION		(X3) DATE SUR COMPLETE	
		475058	B. WING	_			C 04/19/2	2024
	ROVIDER OR SUPPLIER			215 T	ET ADDRESS, CITY, STATE, ZIP CODE 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 PREFI) TAG	×	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD 8		(X5) DMPLETIO DATE
F 000	INITIAL COMMENTS		FC	000				
F 607 SS=C	of 1 facility reported in 4/16//2024, with addit and interviews that er determine compliance requirements for Long	unannounced investigation incident (ACTS #22914) on itional offsite record review issued through 4/19/2024, to e with 42 CFR Part 483 g Term Care Facilities. The eficiencies were identified: buse/Neglect Policies	F 6					
	§483.12(b) The facilit implement written pol §483.12(b)(1) Prohibi neglect, and exploitat misappropriation of re	icies and procedures that: t and prevent abuse, ion of residents and						
	to investigate any suc	sh policies and procedures h allegations, and training as required at						
	QAPI program require §483.12(b)(5) Ensure occurring in federally- facilities in accordance	reporting of crimes funded long-term care e with section 1150B of the procedures must include						
	§483.12(b)(5)(ii) Post	ing a conspicuous notice of efined at section 1150B(d)						
Ath	Mohuan	UPPLIER REPRESENTATIVE'S SIGNATUR	A -V	34	UNIOF WCS	51	(X6) DA	πE
ner safeguard Iowing lhe da	s provide sufficient protec ^l ig le of survey whether or not a he date these documents an	erisk (*) denotes a deficiency which the n to the patients . (See instructions.) Ex a plan of correction is provided. For nur- e made available to the facility. If deficie	cept for nursing sing homes, the	j homes, above fi	the findings stated above are disclose ndings and plans of correction are disc	able 90 da closable 1	ays 14	

TATEMENT	OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	IPLE	CONSTRUCTION	(X3) DATE	
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	IG _			PLETED
							С
		475058	B. WING	07		04	/19/2024
NAME OF PI	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
MENIG NL	IRSING HOME				ANDOLPH 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 CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETIO DATE
F 607	retaliation, as defined (2) of the Act. This REQUIREMENT by: Based on facility polii the facility failed to de procedures that inclue prohibit and prevent a of residents, and misa property, potentially in facility. Findings inclue Facility policy titled "A effective 11/28/2017, required topics related components: Screening. The facility following screening to o Written procedures residents to determine capability and capacit care and services for the facility. Training. The facility p required training topic o Written policies and training new and exist in-service training for topics: -Prohibiting and preven neglect, misappropriat and exploitation; -Identifying what const	hibiting and preventing at section 1150B(d)(1) and is not met as evidenced cy review and staff interview, velop written policies and de all the required topics to abuse, neglect, exploitation appropriation of resident mpacting all residents in the de: dult Abuse and Reporting," does not address the d to the following y policy does not include the pics: for screening prospective e whether the facility has the y to provide the necessary each resident admitted to olicy does not include the s: procedures that include ing nursing home staff and nurse aides in the following nting all forms of abuse, ion of resident property,	F 6	07	Preparation and/or execution of plan of correction does not constitute the providers admiss of/or agreement with the alleg violations or conclusions set for this statement of deficiencies. plan of correction is prepared a executed as required by State a Federal law. F607 Develop/Implement Abuse/Neg Policy was in place but needed modification to include updated regulatory verbiage and guidance 1. Residents had no negative effects as a result of the alleged deficient practice 2. All residents have the potential to be affected the alleged deficient pratice 3. Adult Abuse and Reportive Policy MEC-106 was upd to include more defined verbiage per regulatory update. Re-education specific to updated polic completed with all direct staff.	sion ed th in The nd/or nd ect e. ve e. ve e. by ctice. ng ated	
	property; -Recognizing signs of	abuse, neglect, exploitation			Completed: 4/26	<i>ין 4</i> 7	

Facility ID: VT475058

If continuation sheet Page 2 of 14

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1	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · /				SURVEY
		475058	B. WING				C
		475058	B. WING			04	19/2024
	ROVIDER OR SUPPLIER			2	TREET ADDRESS, CITY, STATE, ZIP CODE 15 TOM WICKER LANE		
				R	ANDOLPH CENTER, VT 05061		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 607	as physical or psycho -Reporting abuse, ne misappropriation of re injuries of unknown s when staff and others knowledge related to fear of reprisal; and -Understanding beha that may increase the and how to respond. Prevention. The facili the required preventio o Written policies and sexual abuse, such a and by whom determ consent to a sexual c where this documenta the resident's right to another individual, wh development of or the sexually intimate rela Identification. The fact the required identifica o Written procedures abuse, neglect, and e misappropriation of re- include identifying the mental/verbal abuse, abuse, and the depri- goods and services. Investigation. The fac- the required investiga o Written procedures	of resident property, such psocial indicators; glect, exploitation, and esident property, including ources, and to whom and a must report their any alleged violation without vioral symptoms of residents e risk of abuse and neglect ty policy does not include on topics: protocols for preventing s the identify when, how, inations of capacity to ontact will be made and ation will be recorded; and establish a relationship with hich may include the e presence of an ongoing tionship. ility policy does not include tion topics: to assist staff in identifying exploitation of residents, and isident property. This would e different types of abuse- sexual abuse, physical vation by an individual of		607	 4. 5 Audits will be conducted weekly X 12 wks by the E &/or designee to evaluate competency and effective utilization. 5. Results of the audits will reported to the QAPI committee at which times committee will evaluate make recommendations needed. Tag F 607 POC accepted on 5/13 S. Stem/P. Cota 	DNS e be the and as	

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

Facility ID: VT475058

		ID HUMAN SERVICES MEDICAID SERVICES				FOR	ED: 05/03/2024 RMAPPROVED O. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION G	(X3) DAT	E SURVEY IPLETED
Automotion		475058	B. WING			04	C 1/19/2024
	Rovider or supplier				STREET ADDRESS, CITY, STATE, ZIP CODE 215 TOM WICKER LANE RANDOLPH 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 CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	DBE	(X5) COMPLETION DATE
F 607	 -Exercising caution in could be used in a crititampering or destroyin -Investigating differen -Identifying and intervincluding the alleged witnesses, and others of the allegations; -Focusing the investigabuse, neglect, exploit has occurred, the exterproviding complete a of the investigation. Protection. The facility required protection top o Written procedures to residents are protecte psychosocial harm du investigation. This mu -Responding immedia victim and integrity of -Examining the alleged injury, including a physic psychosocial assessment -Increased supervision residents; -Room or staffing char protect the resident during and needed. 	onsible for the investigation; handling evidence that minal investigation (e.g., not ng evidence); t types of alleged violations; iewing all involved persons, victim, alleged perpetrator, who might have knowledge vation on determining if itation, and/or mistreatment ent, and cause; and nd thorough documentation of policy does not include the bics: that ensure that all d from physical and ring and after the st include: tely to protect the alleged the investigation; d victim for any sign of sical examination or then if needed; n of the alleged victim and anges, if necessary, to from the alleged ation; and upport and counseling to d after the investigation, as The facility policy does not porting topics:	F	60	77		

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Facility ID: VT475058

If continuation sheet Page 4 of 14

		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	IPLE	CONSTRUCTION		SURVEY
ND PLAN OF		IDENTIFICATION NUMBER:	A. BUILDI	NG			PLETED
		475058	B. WING				C /19/2024
NAME OF P	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		15/2024
				21	5 TOM WICKER LANE		
MENIGNU	IRSING HOME			R	ANDOLPH CENTER, VT 05061		
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F 607	Continued From pa	ge 4	F	507			
	-Immediately report	ing all alleged violations to the					
		agency, adult protective		Í			
		other required agencies (e.g., nen applicable) within required					
	specified timeframe						
	-Assuring that repo	rters are free from retaliation					
	or reprisal;	s notice of employee rights,					
	· ·	o file a complaint with the					
	State Survey Agend	cy if they believe the facility					
١	-	ist an employee or individual					
	who reported a sus such a complaint; a	pected crime and how to file					
		ry actions as a result of the					
	Coordination with C not include the requ	API. The facility policy does					
		nd procedures that define how					
	staff will communica	ate and coordinate situations					
		nisappropriation of resident itation with the QAPI program.					
		v on 4/19/24 at 12:38 PM, the med that while the facility					
	abuse policy and ot						
		pics generally, the policies do cific regulatory requirements e.					
F 609 SS=D	Reporting of Alleged	d Violations	Fe	609	F609	-	
	6400 401 \	waa ka alla aadi da b			Reporting of Alleged Violations w		
		nse to allegations of abuse, n, or mistreatment, the facility			completed but was outside of the	e	
	must:	, or more during the idenity			regulatory timeframe.		
					1. Resident #1 had no nega	tive	
		re that all alleged violations glect, exploitation or			effects as a result of the	-	
	involving abuse, fie	gicer, exploration of			alleged deficient practice		

	S FOR MEDICARE &				OMB NC (X3) DATE	APPRO
	CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO		COMP	
line.		475058	B. WING			19/2024
NAME OF P	ROVIDER OR SUPPLIER			ET ADDRESS, CITY, STATE, ZIP CODE		
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(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 CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLET DATE
F 609		ng injuries of unknown	F 609	2. All residents have the potential to be affecte		
	source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to			the alleged deficient p 3. Re-education regarding updated MEC-106 Adu Abuse & Reporting pro to all direct care staff b	g It wided	
	the administrator of the officials (including to be adult protective service)	use and do not result in serious bodily injury, to administrator of the facility and to other cials (including to the State Survey Agency and ult protective services where state law provides jurisdiction in long-term care facilities) in		&/or designee. Completed: 5, Competency review wi	/10/24 th	
Classic	for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all			direct care staff to ens understanding specific reporting timelines and update by DNS &/or	to	
	designated represent accordance with State Survey Agency, within	Idministrator or his or her ative and to other officials in e law, including to the State n 5 working days of the		designee. Completed: 5/ Weekly communication		
	appropriate corrective	eged violation is verified action must be taken. is not met as evidenced		emails to direct care st included reminders that are all mandated repor	aff ht we	
	failed to ensure that a are reported to the Ad and other officials in a for 1 applicable reside	nd record review, the facility llegations involving abuse ministrator of the facility ccordance with State law ent (Resident #1) and the		please review updated MEC-106, and timely reporting expectations Completed: 5/	policy	
	for ensuring the report	n accordance with section ntially impacting all		 Competency audits will conducted weekly X 12 by the DNS &/or design ensure understanding of 	l be wks nee to	
	allegation of abuse su Agency on 4/9/2024, L	lity investigation report of an bmitted to the State Survey .icensed Practical Nurse #1 staff to resident altercation		policy & expectations o mandated reporter.	fa	

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	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE COMF	SURVEY
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		475058	B. WING			04/	19/2024
NAME OF P	Rovider or supplier			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
	IDRING LIONE			21	15 TOM WICKER LANE		
WENIG NU	JRSING HOME			R	ANDOLPH CENTER, VT 05061		
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F 609	Continued From pag	- F		200	5. Results of the audits wi	llba	
1 003	F-3		F	609		li be	
	1	and Licensed Nursing) that occurred on 4/7/2024.			reported to the QAPI		
	This investigation rep	•			committee at which tin		
		eported to the Administrator,			committee will evaluate	e and	
		, Adult Protective Services,			make recommendation	s as	1
	or local law enforcem two days after the ev	ent agency until 4/9/2024, ent occurred.			needed.		
	explained that s/he h Resident #1 in the ba Resident #1 push an explained that s/he k report the altercation event to the Administ worried it would come negatively.	2/2024 at 2:56 PM, LPN #1 ad heard LNA #1 yelling at athroom and saw LNA #1 and d grab each other. S/He new s/he was supposed to but was afraid to report the rator because s/he was back on him/her			Tag F 609 POC accepted on 5/ S. Stem/P. Cota	I3/24 by	
	Administrator and Dir they had educated Li allegations of abuse leadership within the	ector of Nursing stated that PN #1 about reporting to his/her supervisor or other required timeframes and 1 did not report it during the					
	o Written policies and -Each covered individ Agency and one or m for the political subdiv located any reasonat against any individua receiving care from, t	11/28/2017, does not topics to ensure the able suspicion of a crime: d procedures that include: dual shall report to the State nore law enforcement entities vision in which the facility is ole suspicion of a crime I who is a resident of, or is					

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

Facility ID: VT475058

If continuation sheet Page 7 of 14

		ID HUMAN SERVICES MEDICAID SERVICES				FOR	D: 05/03/2024 MAPPROVED D. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 · ·		E CONSTRUCTION	COMF	SURVEY PLETED
-		475058	B. WING				C /19/2024
NAME OF PI	ROVIDER OR SUPPLIER	I		S	STREET ADDRESS, CITY, STATE, ZIP CODE		
MENIG NL	JRSING HOME				215 TOM WICKER LANE RANDOLPH CENTER, VT 05061		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
1	result in serious bodil hours if the events that not result in serious b -Orienting new and te staff to the reporting r -Assuring that covere notified of their respon- they understand; -Identifying barriers to retaliation or causing implementing interver and promote a culture reporting; -Identifying which cas exploitation may rise to suspicion of crime and and psychosocial indi abuse/neglect/exploita -Working with law enfe determine which crime -Assuring that covered what is reportable as a crime, with competence checks; -Providing in-service to individuals indicate that their reporting respons -Providing periodic dri across all shifts to ass understand the reporting reporting a reasonable	ts that cause the suspicion y injury, or not later than 24 at cause the suspicion do odily injury. mporary/agency/contractor equirements; d individuals are annually nsibilities in a language that oreporting such as fear of trouble for someone, and ntions to remove barriers e of transparency and es of abuse, neglect, and to the level of a reasonable d recognizing the physical cators of ation; orcement annually to es are reported; d individuals can identify a reasonable suspicion of a cy testing or knowledge raining when covered at they do not understand sibilities; and lls across all levels of staff ure that covered individuals ng requirements on 4/17/24 at 11:49 PM, the ed that the abuse policy did d information about	F6	89			
	CFR(s): 483.25(d)(1)(2			09			

S FOR MEDICARE &	MEDICAID SERVICES				DMB NO	D. 0938-0391
	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · ·			1° '	SURVEY PLETED
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ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
IRSING HOME						
			R	RANDOLPH CENTER, VT 05061		
(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL			(EACH CORRECTIVE ACTION SHOULD	BE	(X5) COMPLETION DATE
Continued From page	28	F	689		,	
§483.25(d) Accidents The facility must ensu §483.25(d)(1) The res as free of accident has §483.25(d)(2)Each re supervision and assis accidents. This REQUIREMENT by: Based on observation review, the facility fail supervision for reside aggressive, disruptive 2 applicable residents result, many residents involved in a resident Findings include: 1. Per record review, to the facility on 3/4/2 Alzheimer's dementia states "I may be sad, push others in their w resident for a walk, try do what [s/he] thinks t with feeding another r they are trying to redii residents back or arm Resident #1 include "i those around me." Re plan reveals intervent documenting, and rep	re that - sident environment remains zards as is possible; and sident receives adequate tance devices to prevent is not met as evidenced n, interview, and record ed to provide sufficient nts with a history of e, and intrusive behaviors for a (Resident #1 and #2). As a s are at risk of being to resident altercations. Resident #1 was admitted 024 with a diagnosis of . Resident #1's care plan try to help other residents, heelchairs take another to get another resident to hey should be doing, assist esident hit/slap staff when rect me, rub another s." Care plan goals for nteract appropriately with view of Resident #1's care ions that include monitoring, orting changes in			 Free of Accident Hazards / Supervision/ Devices 1. Resident #1 & #2 had not noted adverse effects retore to the alleged deficient practice. 2. All residents have the potentially of being affeed by this alleged deficient practice. 3. Resident #1 & #2 additional interventions for engaged and prevention were added to their care plans and reviewed with direct care staff during huddle. Completed: 5/ Dining seating changes to encourage and support for a calm & pleasant dining experience Completed: 5/6/24 Re-education regarding flow changes, team communication and situational awareness. 	lated cted onal ement ded e 10/24 o a	
	Continued From page §483.25(d) Accidents The facility must ensu §483.25(d) Accidents The facility must ensu §483.25(d)(1) The res as free of accident ha §483.25(d)(2)Each re supervision and assis accidents. This REQUIREMENT by: Based on observation review, the facility fail supervision for reside aggressive, disruptive 2 applicable residents result, many residents involved in a resident Findings include: 1. Per record review, to the facility on 3/4/2 Alzheimer's dementia states "I may be sad, push others in their w resident for a walk, try do what [s/he] thinks t with feeding another r they are trying to redir resident #1 include "i those around me." Re plan reveals interventif documenting, and rep behaviors, evaluating asking Resident #1 qu and reassuring staterr "check on me" for the	IDENTIFICATION NUMBER: IDENTIFICATION NUMBER: 475058 ROVIDER OR SUPPLIER IRSING HOME SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 8 §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 provide sufficient supervision for residents with a history of aggressive, disruptive, and intrusive behaviors for 2 applicable residents (Resident #1 and #2). As a result, many residents are at risk of being involved in a resident to resident altercations.	DF DEFICIENCIES CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MUL A. BUILDI 475058 ROVIDER OR SUPPLIER 475058 B. WING. IRSING HOME IDENTIFICATION NUMBER: IDENTIFICATION NUMBER: VERSING HOME SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY ORLSC IDENTIFYING INFORMATION) ID PREFI TAG Continued From page 8 F \$483.25(d) Accidents. F \$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 provide sufficient supervision for residents with a history of aggressive, disruptive, and intrusive behaviors for 2 applicable residents (Resident #1 and #2). As a result, many residents are at risk of being involved in a resident to resident altercations. Findings include: 1. Per record review, Resident #1 was admitted to the facility on 3/4/2024 with a diagnosis of Alzheimer's dementia. Resident #1 was admitted to the facility no they other residents, push others in their wheelchairs take another resident for a walk, try to get another resident to do what [s/he] thinks they should be doing, assist with feeding another resident hit/slap staff when they are trying to redirect me, rub another resident shack or arms." Care plan goals for Resident #1 include "interact appropriately with those around me." Review of Resident #1's care plan reveals	DF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPL CORRECTION 475058 B, WING 475058 B, WING I IRSING HOME I I VIDER OR SUPPLIER I I IRSING HOME I I Continued From page 8 I ID Status Continued From page 8 F 689 §483.25(d) Accidents. The facility must ensure that - §483.25(d)(2)Each resident environment remains as free of accident hazards as is possible; and IID §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 provide sufficient supervision for residents with a history of aggressive, disruptive, and intrusive behaviors for 2 applicable residents (Resident #1 and #2). As a result, many residents are at risk of being involved in a resident to resident altercations. Findings include: 1. Per record review, Resident #1 was admitted to the facility on 3/4/2024 with a diagnosis of Alzheimer's dementia. Resident #1's care plan states "1 may be sad, try to help other residents, push others in heir wheelchairs take another resident to do what [s/he] thinks they should be doing, assist with feeding another resident hil/slap staff when they are trying to redirect me, rub another resident to cavelik, try to get another resident to care plan reveals interventi	FFERCIENCIES CORRECTION (*1) PROVIDER/BUPLIER/LLA DENTFICATION NUMBER: A BUILONG (*2) MULTIPLE CONSTRUCTION A BUILONG AT5058 B. WING RONDER OR SUPPLIER STREET ADDRESS, CTV, STATE, ZIP CODE RSING HOME STREET ADDRESS, CTV, STATE, ZIP CODE SUMMARY STATEMENT OF DEFICIENCIES (EACH ORREST FLW OF CORRECTION (EACH DEPICIENCY MUST BE PRECEDED OF YOLL RESULATORY ORLSCIDENTPYNG INFORMATION) ID PRECINE CONCENT & ACTION SHOLD CROSS-REFERENCE TO ENDERCISE (EACH CORRECTIVE ACTION SHOLD CROSS-REFERENCE) TO FUEL RESULATORY ORLSCIDENTPYNG INFORMATION) Continued From page 8 F 689 §483.25(d) (Accidents. The facility must ensure that - §483.25(d)(2)Each resident receives adequate supervision ad assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to provide sufficient supervision for residents with a history of aggressive, disruptive, and intrusive behaviors for 2 applicable resident (T and R2). As a result, many residents are at risk of being involved in a resident to resident attercations. Findings include: 3. Resident #1 & #2 additic interventions for engage and prevention were add to their care plans and reviewed with divise path states 'I may be sad, by to help other residents, push others in their wheichairs take another resident for a wilk, by to getanother resident to completed: 5/6/24 Re-education regarding v flow changes, team communication and situational awareness. Completed: 5/17/24 1. Per record review, Resident #1 was admitted to their care plan goals for Resident back or arms." Care plang goals for Readent #1 include "Interact appr	preference (v1) PROVIDERSUPPLEXCUA DENTIFICATION NUMBER (v2) MULTIFILE CONSTRUCTION A BUILDING (v3) DTT A BUILDING acvider of Suppler RISING HOME 475058 (v3) MULTIFILE CONSTRUCTION A BUILDING (v3) DTT Construction acvider of Suppler RISING HOME 5TREET ADDRESS, CITY, STATE, ZP CODE 215 TOM WICKER LANE RANDOLPH CENTER, VT 05061 (v4) PRETK RANDOLPH CENTER, VT 05061 street acvident devices to percence (CCC) DENTIFYING INFORMATION) PRETK RANDOLPH CENTER, VT 05061 (v4) PRETK RANDOLPH CENTER, VT 05061 Street acvident devices to percence (CCC) DENTIFYING INFORMATION) PRETK RANDOLPH CENTER, VT 05061 (v4) PRETK RANDOLPH CENTER, VT 05061 Continued From page 8 F 689 F 689 \$483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and accidents. This RECURRENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to provide sufficient supervision observation, interview, and record review, the facility failed to provide sufficient supervision for resident with a history of aggressive, disruptive, and intrusive behaviors for 2 applicable residents with a history of aggressive, disruptive, and intrusive behaviors for 2 applicable resident at #1 was admitted to the facility on 3/42024 with a diagnosis of Altheimer's dementia, Resident #1 was admitted to the facility on 3/42024 with a diagnosis of Altheimer's dementia, Resident #1 was admitted to the facility on 3/42024 with a diagnosis of Altheimer's dementia, Resident #1 was admitted to the facility on 3/42024 with a diagnosis of Altheimer's dementia, Resident #1

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DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION COMPLETED IDENTIFICATION NUMBER: A. BUILDING С 475058 B. WING 04/19/2024 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **215 TOM WICKER LANE** MENIG NURSING HOME RANDOLPH CENTER, VT 05061 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (X4) ID ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) 4. Audits will be conducted F 689 Continued From page 9 F 689 weekly X 12 wks by the DNS While the care plan was revised with new interventions on 4/8/2024 and 4/9/2024 to include &/or designee to monitor a list of activities that the resident likes (folding effectiveness of the plan. clothes, reading picture books, and working on 5. Results of the audits will be puzzles), and an increase in their sertaline dose, there are no interventions added to the care plan reported to the QAPI related to supervising Resident #1. committee at which time the committee will evaluate and Per observation on 4/16/2024 at 11:30 AM. make recommendations as Resident #1 is observed in the common area, walking around to multiple residents, touching needed. them on their shoulders and arms and holding onto their wheelchairs. An Activity staff member is Tag F 689 POC accepted on 5/13/24 by in the room facing away from Resident #1. There S. Stem/P. Cota are no other staff in sight of the common area. Resident #1 continues this behavior of touching other residents for 6 minutes until the Activity staff member sits him/her down at a table. On 4/16/2024 at 1:30 PM, Resident #1 is observed in the main hall area near a resident watching TV, Resident #1 began touching this resident on their arms and started to push the wheelchair. There were no staff visible from this main hall area. Record review reveals in multiple nursing notes that Resident #1 has aggressive, disruptive, and intrusive behaviors and interventions that staff are implementing are not working to change Resident #1's behavior so that s/he is interacting appropriately with others as stated in their care plan as a goal. Nursing notes show a pattern of these behaviors as revealed in the summaries below: On 3/13/2024 Resident #1 is noted to wander, go into other resident's rooms, tuck another resident's shirt into [his/her] pants and touch another resident's walker while they were trying to use it. Resident #1 became angry when trying to

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Facility ID: VT475058

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2. Per record review Resident #2 was admitted to		care plan had not beer	n revised since 4/9/2024.					
		2. Per record review R	esident #2 was admitted to					

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

Facility ID: VT475058

	S FUR MEDICARE &	NEDICAID SERVICES					0. 0930-0391
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION		E SURVEY PLETED
							С
		475058	B. WING			04	/19/2024
	ROVIDER OR SUPPLIER J RSING HOME			21	REET ADDRESS, CITY, STATE, ZIP CODE 5 TOM WICKER LANE ANDOLPH CENTER, VT 05061		
						-	1
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREF TAG	1	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 689	# 2 has a care plan for and confusion. Interve behavior changes an monitor whereabouts offer one on one conver- revision on 04/08/202 interventions such as staff one on one when Per record review, Re- involved in several all involving other reside nursing notes reveal to A 3/23/2023 note staft to tell other resident w pushing another reside wheelchair away from and threatening staff A 4/05/2024 note staft another resident by [h staff intervened, and from the situation. Re- threatening staff, thro area, punching tables [his/her] room and slas A 4/10/2024 note staft "attempting to pull an arm into their room." A 4/14/2024 note staft "grabbed another resist turning [her/him] in th [her/him] down the ha- resident grabbed the	nosis of dementia. Resident or forgetfulness, wandering, entions include monitor for d report changes to provider, , redirect out of other rooms, versations. Care plan 24 reveal additional offer outside for a walk and n needed. esident # 2 has been tercations at the facility nts. The following sample of these altercations: es "resident has been trying what to do, and where to go, tent hard in [his/her] n [himself/herself], cussing as well as other residents." es "Resident dragging her/his] arm into their room, the other resident removed sident started cursing and wing objects in the common a, resident then went to mmed door shut." es that Resident #2 was other resident by [his/her] es that Resident #2 dent's wrist and started e opposite way pulling	F	689			

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

Facility ID: VT475058

	S FOR MEDICARE &						D. 0938-03
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
						C 04/19/2024	
		475058	B. WING				
NAME OF P	ROVIDER OR SUPPLIER				REET 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 SC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETIO DATE
F 689	Continued From page 13		F6	389			
	down the hallway to the point the other resident said, 'ow stop that'."						
	A Social Service note dated 1/03/2024 states "resident can get irritated by certain residents so [he/she] needs to be watched and redirected if needed and provided alternative." Resident #2's						
		lated to reflect the need for					
	Per interview on 4/16/2024 at approximately 1130 AM, an RN stated that s/he is concerned that there may not be enough staff to do one on one						
		ugn staff to do one on one en they are agitated. The					
		worse of the behaviors		1			
	occur between 3:00 a not enough staff to wa	nd 5:00 PM when there is atch the residents.					
		2024 at approximately 4:30					
		al Nurse stated "[Resident hth, has had an increase in					
		ed that Resident #2 can be					
		ne perceives that another			x		
		tening toward these staff.					
		edirection is an intervention;			-		
		Iways work. S/He explained notified of Resident #2's					
		n 4/02/2024 but has not					
	seen updated orders r	elated to communication to					
	-	munication note, dated					
		owing "resident was in the					
		e] went over to another mpting to stand from their					
		d [him/her] back down into					
	[his/her] chair. Concer						
		LPN requested medication					
	adjustment."						

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