VERMONT

AGENCY OF HUMAN SERVICES
DEPARTMENT OF DISABILITIES, AGING AND INDEPENDENT LIVING

Division of Licensing and Protection
HC 2 South, 280 State Drive
Waterbury, VT 05671-2060
http://www.dail.vermont.gov
Survey and Certification Voice/TTY (802) 241-0480
Survey and Certification Fax (802) 241-0343
Survey and Certification Reporting Line: (888) 700-5330
To Report Adult Abuse: (800) 564-1612

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,

Pamela M Cota RN
Pamela M. Cota, RN
Licensing Chief

Enclosure

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	475058	A. BUILDING _____ B. WING _____	C 04/19/2024

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

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F 000	INITIAL COMMENTS The Division of Licensing and Protection conducted an onsite, unannounced investigation of 1 facility reported incident (ACTS #22914) on 4/16//2024, with additional offsite record review and interviews that ensued through 4/19/2024, to determine compliance with 42 CFR Part 483 requirements for Long Term Care Facilities. The following regulatory deficiencies were identified:	F 000		
F 607 SS=C	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(5)(ii)(iii) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, §483.12(b)(4) Establish coordination with the QAPI program required under §483.75. §483.12(b)(5) Ensure reporting of crimes occurring in federally-funded long-term care facilities in accordance with section 1150B of the Act. The policies and procedures must include but are not limited to the following elements. §483.12(b)(5)(ii) Posting a conspicuous notice of employee rights, as defined at section 1150B(d)(3) of the Act.	F 607		

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

[signature] LNHA - VP Senior SVCS 5/10/24

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 607	Continued From page 1 §483.12(b)(5)(iii) Prohibiting and preventing retaliation, as defined at section 1150B(d)(1) and (2) of the Act. This REQUIREMENT is not met as evidenced by: Based on facility policy review and staff interview, the facility failed to develop written policies and procedures that include all the required topics to prohibit and prevent abuse, neglect, exploitation of residents, and misappropriation of resident property, potentially impacting all residents in the facility. Findings include: Facility policy titled "Adult Abuse and Reporting," effective 11/28/2017, does not address the required topics related to the following components: Screening. The facility policy does not include the following screening topics: o Written procedures for screening prospective residents to determine whether the facility has the capability and capacity to provide the necessary care and services for each resident admitted to the facility. Training. The facility policy does not include the required training topics: o Written policies and procedures that include training new and existing nursing home staff and in-service training for nurse aides in the following topics: -Prohibiting and preventing all forms of abuse, neglect, misappropriation of resident property, and exploitation; -Identifying what constitutes abuse, neglect, exploitation, and misappropriation of resident property; -Recognizing signs of abuse, neglect, exploitation	F 607	**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.** F607 Develop/Implement Abuse/Neglect 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 by the alleged deficient practice. 3. Adult Abuse and Reporting Policy MEC-106 was updated to include more defined verbiage per regulatory update. Re-education specific to updated policy completed with all direct care staff. Completed: 4/26/24	

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F 607	Continued From page 2 and misappropriation of resident property, such as physical or psychosocial indicators; -Reporting abuse, neglect, exploitation, and misappropriation of resident property, including injuries of unknown sources, and to whom and when staff and others must report their knowledge related to any alleged violation without fear of reprisal; and -Understanding behavioral symptoms of residents that may increase the risk of abuse and neglect and how to respond. Prevention. The facility policy does not include the required prevention topics: o Written policies and protocols for preventing sexual abuse, such as the identify when, how, and by whom determinations of capacity to consent to a sexual contact will be made and where this documentation will be recorded; and the resident's right to establish a relationship with another individual, which may include the development of or the presence of an ongoing sexually intimate relationship. Identification. The facility policy does not include the required identification topics: o Written procedures to assist staff in identifying abuse, neglect, and exploitation of residents, and misappropriation of resident property. This would include identifying the different types of abuse-mental/verbal abuse, sexual abuse, physical abuse, and the deprivation by an individual of goods and services. Investigation. The facility policy does not include the required investigation topics: o Written procedures for investigating abuse, neglect, misappropriation, and exploitation that include:	F 607	4. 5 Audits will be conducted weekly X 12 wks by the DNS &/or designee to evaluate competency and effective utilization. 5. Results of the audits will be reported to the QAPI committee at which time the committee will evaluate and make recommendations as needed. **Tag F 607 POC accepted on 5/13/24 by S. Stem/P. Cota**	

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F 607	Continued From page 3 -Identifying staff responsible for the investigation; -Exercising caution in handling evidence that could be used in a criminal investigation (e.g., not tampering or destroying evidence); -Investigating different types of alleged violations; -Identifying and interviewing all involved persons, including the alleged victim, alleged perpetrator, witnesses, and others who might have knowledge of the allegations; -Focusing the investigation on determining if abuse, neglect, exploitation, and/or mistreatment has occurred, the extent, and cause; and -Providing complete and thorough documentation of the investigation. Protection. The facility policy does not include the required protection topics: o Written procedures that ensure that all residents are protected from physical and psychosocial harm during and after the investigation. This must include: -Responding immediately to protect the alleged victim and integrity of the investigation; -Examining the alleged victim for any sign of injury, including a physical examination or psychosocial assessment if needed; -Increased supervision of the alleged victim and residents; -Room or staffing changes, if necessary, to protect the resident(s) from the alleged perpetrator; -Protection from retaliation; and -Providing emotional support and counseling to the resident during and after the investigation, as needed. Reporting/Response. The facility policy does not include the required reporting topics: o Written procedures that include:	F 607		

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F 607	Continued From page 4 -Immediately reporting all alleged violations to the Administrator, state agency, adult protective services and to all other required agencies (e.g., law enforcement when applicable) within required specified timeframes; -Assuring that reporters are free from retaliation or reprisal; -Post a conspicuous notice of employee rights, including the right to file a complaint with the State Survey Agency if they believe the facility has retaliated against an employee or individual who reported a suspected crime and how to file such a complaint; and -Taking all necessary actions as a result of the investigation. Coordination with QAPI. The facility policy does not include the required QAPI topics: o Written policies and procedures that define how staff will communicate and coordinate situations of abuse, neglect, misappropriation of resident property, and exploitation with the QAPI program. Per phone interview on 4/19/24 at 12:38 PM, the Administrator confirmed that while the facility abuse policy and other facility policies acknowledge the topics generally, the policies do not include the specific regulatory requirements that are listed above.	F 607		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or	F 609	F609 Reporting of Alleged Violations was completed but was outside of the regulatory timeframe. 1. Resident #1 had no negative effects as a result of the alleged deficient practice.	

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F 609	Continued From page 5 mistreatment, including injuries of unknown 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 administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure that allegations involving abuse are reported to the Administrator of the facility and other officials in accordance with State law for 1 applicable resident (Resident #1) and the facility failed to develop policies and procedures for ensuring the reporting of a reasonable suspicion of a crime in accordance with section 1150B of the Act, potentially impacting all residents in the facility. Findings include: 1. Per review of a facility investigation report of an allegation of abuse submitted to the State Survey Agency on 4/9/2024, Licensed Practical Nurse #1 (LPN #1) witnessed a staff to resident altercation	F 609	2. All residents have the potential to be affected by the alleged deficient practice. 3. Re-education regarding updated MEC-106 Adult Abuse & Reporting provided to all direct care staff by DNS &/or designee. Completed: 5/10/24 Competency review with direct care staff to ensure understanding specific to reporting timelines and policy update by DNS &/or designee. Completed: 5/17/24 Weekly communication emails to direct care staff included reminders that we are all mandated reporters, please review updated policy MEC-106, and timely reporting expectations. Completed: 5/2/24 4. Competency audits will be conducted weekly X 12 wks by the DNS &/or designee to ensure understanding of policy & expectations of a mandated reporter.	

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F 609	Continued From page 6 between Resident #1 and Licensed Nursing Assistant #1 (LNA #1) that occurred on 4/7/2024. This investigation report reveals that the altercation was not reported to the Administrator, State Survey Agency, Adult Protective Services, or local law enforcement agency until 4/9/2024, two days after the event occurred. Per interview on 4/16/2024 at 2:56 PM, LPN #1 explained that s/he had heard LNA #1 yelling at Resident #1 in the bathroom and saw LNA #1 and Resident #1 push and grab each other. S/He explained that s/he knew s/he was supposed to report the altercation but was afraid to report the event to the Administrator because s/he was worried it would come back on him/her negatively. Per interview on 4/16/2023 at 3:47 PM, the Administrator and Director of Nursing stated that they had educated LPN #1 about reporting allegations of abuse to his/her supervisor or other leadership within the required timeframes and confirmed that LPN #1 did not report it during the required timeframe. 2. Facility policy titled "Adult Abuse and Reporting," effective 11/28/2017, does not address the required topics to ensure the reporting of a reasonable suspicion of a crime: o Written policies and procedures that include: -Each covered individual shall report to the State Agency and one or more law enforcement entities for the political subdivision in which the facility is located any reasonable suspicion of a crime against any individual who is a resident of, or is receiving care from, the facility. -Each covered individual shall report immediately, but not later than 2 hours after forming the	F 609	5. Results of the audits will be reported to the QAPI committee at which time the committee will evaluate and make recommendations as needed. **Tag F 609 POC accepted on 5/13/24 by S. Stem/P. Cota**	

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F 609	Continued From page 7 suspicion, if the events that cause the suspicion result in serious bodily injury, or not later than 24 hours if the events that cause the suspicion do not result in serious bodily injury. -Orienting new and temporary/agency/contractor staff to the reporting requirements; -Assuring that covered individuals are annually notified of their responsibilities in a language that they understand; -Identifying barriers to reporting such as fear of retaliation or causing trouble for someone, and implementing interventions to remove barriers and promote a culture of transparency and reporting; -Identifying which cases of abuse, neglect, and exploitation may rise to the level of a reasonable suspicion of crime and recognizing the physical and psychosocial indicators of abuse/neglect/exploitation; -Working with law enforcement annually to determine which crimes are reported; -Assuring that covered individuals can identify what is reportable as a reasonable suspicion of a crime, with competency testing or knowledge checks; -Providing in-service training when covered individuals indicate that they do not understand their reporting responsibilities; and -Providing periodic drills across all levels of staff across all shifts to assure that covered individuals understand the reporting requirements Per phone interview on 4/17/24 at 11:49 PM, the Administrator confirmed that the abuse policy did not include the required information about reporting a reasonable suspicion of a crime.	F 609		
F 689 SS=E	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2)	F 689		

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F 689	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. 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 "I may be sad, try to help 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 residents back or arms." Care plan goals for Resident #1 include "interact appropriately with those around me." Review of Resident #1's care plan reveals interventions that include monitoring, documenting, and reporting changes in behaviors, evaluating medication effectiveness, asking Resident #1 questions and saying positive and reassuring statements. The intervention "check on me" for the aides is the only intervention related to supervising Resident #1.	F 689	Free of Accident Hazards / Supervision/ Devices 1. Resident #1 & #2 had no noted adverse effects related to the alleged deficient practice. 2. All residents have the potentially of being affected by this alleged deficient practice. 3. Resident #1 & #2 additional interventions for engagement and prevention were added to their care plans and reviewed with direct care staff during huddle. Completed: 5/10/24 Dining seating changes to encourage and support a calm & pleasant dining experience Completed: 5/6/24 Re-education regarding work flow changes, team communication and situational awareness. Completed: 5/17/24	

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F 689	Continued From page 9 While the care plan was revised with new interventions on 4/8/2024 and 4/9/2024 to include a list of activities that the resident likes (folding clothes, reading picture books, and working on puzzles), and an increase in their sertaline dose, there are no interventions added to the care plan related to supervising Resident #1. Per observation on 4/16/2024 at 11:30 AM, Resident #1 is observed in the common area, walking around to multiple residents, touching them on their shoulders and arms and holding onto their wheelchairs. An Activity staff member is in the room facing away from Resident #1. There 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	F 689	4. Audits will be conducted weekly X 12 wks by the DNS &/or designee to monitor effectiveness of the plan. 5. Results of the audits will be reported to the QAPI committee at which time the committee will evaluate and make recommendations as needed. **Tag F 689 POC accepted on 5/13/24 by S. Stem/P. Cota**	

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F 689	Continued From page 10 reorient. On 3/28/2024 Resident #1 is noted to grab a walker of another resident while they were walking by, wander, push resident wheelchairs, and have other disruptive behaviors. On 4/1/12024 Resident #1 is noted to be screaming, pushing, grabbing others and have other disruptive behaviors. On 4/3/2024 Resident #1 is noted to be intrusive, wander, and take other resident's walkers, On 4/5/2024 Resident #1 is noted to be screaming, exit seeking, and attempting to push other residents in their wheelchairs. On 4/6/2024 Resident #1 is noted to be rubbing and kissing other residents even when the residents and staff ask him/her to stop, feeding other residents, and becoming physically aggressive. On 4/10/2024 Resident #1 is noted to be rubbing another resident who is continuing to ask them to stop, wandering, screaming, grabbing, and other aggressive behaviors. On 4/13/2024 Resident #1 is noted to touch multiple residents including attempting to touch another resident's groin, and other intrusive behaviors. On 4/14/2024 Resident #1 is noted to be grabbing and pulling another resident and staff, yelling, wandering, touching multiple people, taking food from a resident, and attempted to pull them out of their chair, and other aggressive and	F 689		

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F 689	Continued From page 11 intrusive behaviors. These nursing notes reveal that staff had attempted interventions for the above behaviors and the results were an unchanged or a deterioration in Resident #1's behavior. Per interview on 4/16/2024 at 11:40 AM, a Registered Nurse (RN) reported that s/he frequently finds Resident #1 in other residents' rooms. S/He indicated that she is concerned Resident #1 can hurt other residents because s/he tries to help them transfer. S/He explained that there are not enough staff to supervise him/her, or any of the other residents with these behaviors, especially during the hours of 3-5 PM. Per interview on 4/16/2024 at 1:34 PM, a Licensed Nursing Assistant (LNA) explained that staff cannot keep Resident #1, or other residents with these behaviors, occupied enough to stop them from having these behaviors. S/He stated that s/he is aware that other residents feel very uncomfortable by Resident #1's behaviors. Per interview on 4/16/2024 at 2:56 PM, a Licensed Practical Nurse (LPN) explained that Resident #1 can get very physical with staff sometimes and stated that Resident #1 would need one on one supervision to keep other residents safe and there is not enough staff to do that. S/He explained that interventions for these behaviors, like redirection, do not work and make the situation worse. Per interview on 4/16/2024 at 5:05 PM, the Nurse Care Coordinator confirmed that Resident #1's care plan had not been revised since 4/9/2024. 2. Per record review Resident #2 was admitted to	F 689		

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 04/19/2024

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

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F 689	Continued From page 12	F 689		

the facility with a diagnosis of dementia. Resident # 2 has a care plan for forgetfulness, wandering, and confusion. Interventions include monitor for behavior changes and report changes to provider, monitor whereabouts, redirect out of other rooms, offer one on one conversations. Care plan revision on 04/08/2024 reveal additional interventions such as offer outside for a walk and staff one on one when needed.

Per record review, Resident # 2 has been involved in several altercations at the facility involving other residents. The following sample of nursing notes reveal these altercations:

A 3/23/2023 note states "resident has been trying to tell other resident what to do, and where to go, pushing another resident hard in [his/her] wheelchair away from [himself/herself], cussing and threatening staff as well as other residents."

A 4/05/2024 note states "Resident dragging another resident by [her/his] arm into their room, staff intervened, and the other resident removed from the situation. Resident started cursing and threatening staff, throwing objects in the common area, punching tables, resident then went to [his/her] room and slammed door shut."

A 4/10/2024 note states that Resident #2 was "attempting to pull another resident by [his/her] arm into their room."

A 4/14/2024 note states that Resident #2 "grabbed another resident's wrist and started turning [her/him] in the opposite way pulling [her/him] down the hallway. 5 minutes later resident grabbed the same resident again looking irritated and started dragging them by the wrist

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F 689	Continued From page 13 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 care plan was not updated to reflect the need for supervision until 4/08/2024. 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 with the residents when they are agitated. The RN explained that the worse of the behaviors occur between 3:00 and 5:00 PM when there is not enough staff to watch the residents. Per interview on 4/16/2024 at approximately 4:30 PM, a License Practical Nurse stated "[Resident #2], over the past month, has had an increase in behaviors." S/He stated that Resident #2 can be protective of staff if s/he perceives that another resident may be threatening toward these staff. The LPN stated that redirection is an intervention; however, it does not always work. S/He explained that the provider was notified of Resident #2's increased behaviors on 4/02/2024 but has not seen updated orders related to communication to the provider. The communication note, dated 4/2/24, reveals the following "resident was in the dining room when [s/he] went over to another resident who was attempting to stand from their wheelchair and pushed [him/her] back down into [his/her] chair. Concern recent increase in aggressive behaviors. LPN requested medication adjustment."	F 689		