VERMONT

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

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

September 6, 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 recertification survey conducted on **July 25, 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
Licensing Chief

Enclosure

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 _____	07/25/2024

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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E 000	Initial Comments An unannounced onsite re-certification survey with Emergency Preparedness review was completed by the Division of Licensing and Protection from 07/24/2024 The facility was found in substantial compliance with regulations related to Emergency Preparedness.	E 000		
F 000	INITIAL COMMENTS The Division of Licensing and Protection conducted an unannounced, onsite recertification survey from 07/22/2024 through 07/25/2024 to determine compliance with 42 CFR Part 483 requirements for Long Term Care Facilities. During the recertification survey, the survey team identified substandard quality of care as a result of a violation at t 483.70(e) F 689. An onsite extended survey was conducted on 07/25/2024 due to the determination of substandard quality of care. The following deficiencies were identified:	F 000	**Preparation and/or execution of this plan of correction does not constitute the providers admission of/or agreement with the alleged violations or conclusions set forth in this statement of deficiencies. The plan of correction is prepared and/or executed as required by State and Federal law.**	
F 550 SS=E	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident.	F 550	F550 Residents Rights to self-determination, and communication with and access to persons and services inside and outside the facility. Menig residents and families had access entry via a door bell / intercom system due to resident and staff safety and security concerns which has been in place since the facility was built in 2015.	

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

Melissa Mercier Greco, LNHN - VP of Senior Svcs 8/30/24

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 550	Continued From page 1 §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure each resident has a right to self-determination and access to persons and services outside of the facility, by locking all doors to the facility 24 hours a day, 7 days a week. By creating a locked facility, there is a failure to ensure the right of each resident to exercise their rights as a citizen (or resident) of the United States or make personal choices about going outside without interference. This has the potential to affect all residents of the facility and all visitors, including family, legal representatives and advocates.	F 550	• Residents had no negative effects as a result of the alleged deficient practice. Residents have never been denied visitation. The facility has been secured with entry access via doorbell / intercom system since being built and opened at our new location in 2015. Residents / families and friends have been allowed full access with exception of COVID/infection control triggered limitation and protocols. The facility has never received a complaint or grievance from a resident or family / representative specific to access / entry approach or visitation prior to this report. • All residents have the potential to be affected by the alleged deficient practice.	

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F 550	Continued From page 2 Per observation on 7/22/24 at approximately 10:00 AM at the entrance to the building, the main front entrance doors within the foyer were locked. A staff member approached the inside doors to the foyer, using a badge they placed over the censor, they opened the doors for the survey team to enter. Throughout the survey from 7/22-7/25/24, in order to enter the building, visitors were observed using a doorbell to alert staff they were in the foyer, and then a staff member would arrive to unlock the door. Visitors also needed to seek out staff to let them leave the facility when their visit was over. Per interview with Resident #1 on 7/22/24 at 2:36 PM visitors are only allowed 10:00 AM -7:00 PM. Per interview with Resident #24's family member on 7/22/24 at 3:48 PM visitors are asked not to come between noon and 1:00 pm because staff are busy helping others with their meals and can't stop to let visitors in and out. Sometimes it is difficult because visiting hours end at 7:00 PM. A Resident Council meeting with the survey team occurred on 7/23/2024 at approximately 2:00 PM, there were 5 attendees, Residents #4 stated "at first when I learned the doors were locked, I felt like I was in jail, now I understand it has to be that way so the people that get confused don't get out." Resident #13 stated that s/he would have visitors later if able to. Resident #13 then asked "what time do visitors have to leave, what is the curfew?" Per review of the facility policy and procedure effective 5/6/2024 titled: Secure Entry and Visitation Rights at Menig, under Safety	F 550	• Reasonable hours of immediate access have been instituted to include available badge entry and exit access for visitors. Residents / families and/or resident representative have been notified of the change in process to access the facility. Policy update to include this change completed. Completed: 9/20/24 • 5 Audits will be conducted weekly X 12 wks by the DNS &/or designee to evaluate effectiveness of this change in access. • Results of the audits will be reported to the Resident Council and QAPI committee at which time the committee will evaluate and make recommendations as needed. **Tag F 550 POC accepted on 9/6/24 by K. Humphrey/P. Cota**	

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F 550	Continued From page 3 Procedure: 1. All doors are Secured Access doors- allowing direct access to only for those with a Gifford (ownership entity) badge with security access. 2. All other people are classified as visitors (resident family friends) will ring one of the doorbells to alert staff they are at one of the doorways. a. A staff member will provide for entry for the visitor, by either walking them to the door or providing entry or using the release option from the team stations. b. When the visitor is ready to leave a staff person will provide door release by the same method as entry. The facility policy effective 3/17/2023 titled: Security Program, under section E Locking/Unlocking Of Exterior Doors #7 states "Mening Nursing Home is locked 24/7/365 with badge access only." Per interview on 7/25/24 at 2:18 PM the facility Administrator and the VP of Quality and Compliance Officer confirmed that the facility doors are kept locked 24 hours per day.	F 550		
F 563 SS=F	Right to Receive/Deny Visitors CFR(s): 483.10(f)(4)(ii)-(v) §483.10(f)(4) The resident has a right to receive visitors of his or her choosing at the time of his or her choosing, subject to the resident's right to deny visitation when applicable, and in a manner that does not impose on the rights of another resident. (ii) The facility must provide immediate access to a resident by immediate family and other relatives of the resident, subject to the resident's right to	F 563		

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F 563	Continued From page 4 deny or withdraw consent at any time; (iii) The facility must provide immediate access to a resident by others who are visiting with the consent of the resident, subject to reasonable clinical and safety restrictions and the resident's right to deny or withdraw consent at any time; (iv) The facility must provide reasonable access to a resident by any entity or individual that provides health, social, legal, or other services to the resident, subject to the resident's right to deny or withdraw consent at any time; and (v) The facility must have written policies and procedures regarding the visitation rights of residents, including those setting forth any clinically necessary or reasonable restriction or limitation or safety restriction or limitation, when such limitations may apply consistent with the requirements of this subpart, that the facility may need to place on such rights and the reasons for the clinical or safety restriction or limitation. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review the facility failed to ensure Residents' rights were maintained by not allowing unrestricted visitation based on resident choice. This has the potential to affect all residents of the facility and all visitors, including family, legal representatives and advocates. Per interview with Resident #1 on 7/22/24 at 2:36 PM visitors are only allowed 10:00 AM -7:00 PM. Per interview with a Resident's family member on 7/22/24 at 3:48 PM they are asked not to visit between noon and 1:00 pm because staff are busy helping others with their meals and can't stop to let visitors in and out. Sometimes it is difficult because visiting hours end at 7:00 PM.	F 563	F563 Right to Receive/Deny Visitors • Residents had no negative effects as a result of the alleged deficient practice. Residents have never been denied visitation. The facility has been secured with entry access via doorbell / intercom system since being built and opened at our new location in 2015. Residents / families and friends have been allowed full access with exception of COVID/infection control triggered limitation and protocols. The facility has never received a complaint or grievance from a resident or family / representative specific to access / entry approach or visitation prior to this report. • All residents have the potential to be affected by the alleged deficient practice.	

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F 563	Continued From page 5 While exiting the facility on 7/22/24 at 4:12 PM a sign with visiting hours was observed posted between the two entrances. Per visitation posting visiting hours consist of 2 hours before lunch, 4 hours between lunch and dinner, then one hour after dinner. This would be a total of 7 available hours throughout the day to visit. The posting was dated March 25, 2024 and read; Visitation at Menig Nursing Home * Visitation is welcomed Monday through Sunday: 10:00 AM - 7:00 PM with the exception of meal times: Lunch 12:00 - 1:00PM Supper 5:00 PM- 6:00 PM * If you are not feeling well, please do not visit. Per review of the facility policy and procedure effective 5/6/2024 titled: Secure Entry and Visitation Rights at Menig, under Safety Procedure: 1. All doors are Secured Access doors- allowing direct access to only for those with a Gifford (ownership entity) badge with security access. 2. All other people are classified as visitors (resident family friends) will ring one of the doorbells to alert staff they are at one of the doorways. a. A staff member will provide for entry for the visitor, by either walking them to the door or providing entry or using the release option from the team stations. b. When the visitor is ready to leave a staff person will provide door release by the same method as entry. The section Visitation: Visiting hours are as posted in the nursing home	F 563	• Reasonable hours of immediate access have been instituted to include available badge entry and exit access for visitors. Residents / families and/or resident representative have been notified of the change in process to access the facility. Policy update to include this change completed. Completed: 9/20/24 • 5 Audits will be conducted weekly X 12 wks by the DNS &/or designee to evaluate effectiveness of this change in access. • Results of the audits will be reported to the Resident Council and QAPI committee at which time the committee will evaluate and make recommendations as needed. **Tag F 563 POC accepted on 9/6/24 by K. Humphrey/P. Cota**	

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F 563	Continued From page 6 with accommodations made as needed. Per interview on 7/25/24 at 2:18 PM with the facility Administrator and Quality and Compliance Officer, there are preferred visiting hours and it has been communicated to Residents and their families that if needed, accommodations can be made. The Administrator confirmed that there are posted visiting hours to include not visiting during mealtimes.	F 563		
F 637 SS=D	Comprehensive Assessment After Signifcant Chg CFR(s): 483.20(b)(2)(ii) §483.20(b)(2)(ii) Within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a "significant change" means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of facility policy, the facility failed to complete a Significant Change in Status (SCSA) Minimum Data Assessment (MDS) for one of 17 sampled residents (Resident #15). Findings include: Per record review, Resident #15 has diagnoses that include: Alzheimer's dementia, recurring urinary tract infections, emphysema, and heart failure. Per review of Resident #15's quarterly	F 637		

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F 637	Continued From page 7 assessment dated 4/5/24, s/he does not have behaviors of inattention, does not have "physical behavioral symptoms not directed toward others," s/he does not have exhibit rejection of care, needs partial assistance for getting dressed, is independent in transferring, is always continent of bowels, and weighs 200 pounds. Review of Resident #15's weights reveal that s/he had both had both significant weight loss over the past 6 months of 11.57% when weighed at 188.8 pounds on 6/10/24 (from 202.2 pounds on 12/11/24) and significant weight loss over the past month of 8.06% when weighed at 180.2 pounds on 5/13/24 (from 196.0 pounds on 4/22/24). A 7/2/24 Dietician dietary progress note reveals that Resident #15 previously had diet restrictions related to previous weight gain but over the past quarter his/her appetite has decreased, has inconsistent meal intake, has refused meals, and has had significant weight loss. Because of the significant weight loss, the Dietician had recommended discontinuing any dietary restrictions as weight loss was a concern. Starting around 5/6/24 and increasing in frequency, nursing progress notes reveal an overall deterioration of Resident #15's condition by rejecting care including medications, meals, ADL (activities of daily living) care, and getting out of bed; s/he has an increase of aggressive behaviors, and is regularly incontinent of feces. Per review of Resident #15's MDS records, a SCSA was not completed until 7/4/24, which was approximately 6 weeks after a consistent pattern of change in weight and condition. Facility policy titled "Criteria for Determining	F 637	F637 Comprehensive Assessment After Significant Change • Resident #15 had no noted adverse effects related to the alleged deficient practice. • All residents that have a change in condition have the potentially of being affected by this alleged deficient practice. • Resident #15 had an end stage chronic condition and is closed chart. • Re-education regarding change in condition and team communication and situational awareness. Completed: 9/20/24 • Audits will be conducted weekly X 12 wks by the DNS &/or designee to monitor effectiveness of the plan. • Results of the audits will be reported to the Risk Meeting on a weekly basis and the QAPI committee at which time the committee will evaluate and make recommendations as needed.	

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F 637	Continued From page 8 Significant Change in a Resident Condition," effective 3/5/19, reads, "A significant change in Status MDS is required when: A resident experiences a consistent pattern of change, with either two or more areas of decline ..." The policy outlines areas of decline that meet a significant change include "Unplanned weight loss problem (5% change in 30 days or 10% change in 180 days)," and "Overall deterioration of a resident's condition." Per interview on 7/25/24 at 10:57 AM, the Clinical Coordinator confirmed that Resident #15 had started to consistently refuse meals, medication, care, and have an increase in behaviors in May. S/He confirmed that both her decline and significant weight loss would qualify for a SCSA MDS to be completed at that time and stated that s/he didn't think about doing it.	F 637	**Tag F 637 POC accepted on 9/6/24 by K. Humphrey/P. Cota**	
F 657 SS=E	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's	F 657		

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F 657	Continued From page 9 medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to review and revise resident care plans for 3 residents related to falls (Residents #15, #20, and #21), for 1 resident related to refusal of care (Resident #15), and 1 resident related to nutrition (Resident #15) out of a sample of 17 residents. Findings include: 1. Per record review, Resident #15 has diagnoses that include: Alzheimer's dementia, recurring urinary tract infections, emphysema, and heart failure. Starting around 5/6/24 and increasing in frequency, nursing progress notes reveal an overall deterioration of Resident #15's condition by rejecting care including medications, meals, ADL care, and getting out of bed. A 7/2/24 Dietician dietary progress note reveals that Resident #15 previously had diet restrictions related to previous weight gain but over the past quarter his/her appetite has decreased, has inconsistent meal intake, has refused meals, and has had significant weight loss. Because of the significant weight loss, the Dietician had recommended discontinuing any dietary restrictions and recommended scheduling egg salad sandwich snacks because Resident #15	F 657	F657 Care Plan Timing and Revision • Resident #15 was a closed record at the time of review. Resident #20 and #21 Care Plans reviewed with updated interventions added. • All residents that have a change in condition or incident/event have the potentially of being affected by this alleged deficient practice. • Dietician and RN/LPNs re-educated regarding the need update care plan as needed due to change in condition or incident/event. Completed: 9/20/24 • Audits will be conducted weekly X 12 wks by the DNS &/or designee to monitor effectiveness of the plan. • Results of the audits will be reported to the Risk Meeting on a weekly basis and the QAPI committee at which time the committee will evaluate and make recommendations as needed.	

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F 657	Continued From page 10	F 657	**Tag F 657 POC accepted on 9/6/24 by K. Humphrey/P. Cota**	

loves them. A 7/16/24 progress note reveals that Resident #15 fell while transferring to the bathroom.

Per record review, Resident #15's care plan, updated 7/11/24, does not address the Dietician's recommendations above and continues to contain an intervention to restrict portions sizes because of weight gain. The care plan does not include revised interventions to address Resident #15's increased behaviors of refusing care including taking medications, eating meals, accepting ADL care, and not getting out of bed. Resident #15's care plan was not revised after his/her fall on 7/16/24.

Per interview on 7/25/24 at 10:57 AM, the Clinical Coordinator confirmed that Resident #15's care plan was not revised to reflect his/her refusal of care and accurate information about weight loss and should have been. At 2:44 PM, the Clinical Coordinator confirmed that Resident #15's care plan was not revised with new interventions after their fall on 7/16/24.

2. Per record review, Resident #21's care plan reveals that s/he is at risk for falling because s/he has Alzheimer's disease and has no safety awareness. Per review of progress notes, Resident #21 experienced a fall on 1/7/24, 5/3/24, and 7/11/24.

Per interview on 7/24/24 at 10:57 AM, the Clinical Coordinator confirmed that Resident #21's care plan was not updated after his/her fall on 1/7/24 or 7/8/24 fall and should have been. S/He said that interdisciplinary team only reviews initial care plan for falls and that the floor nurse should update their care plan with interventions after the

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	475058	A. BUILDING _____ B. WING _____	07/25/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 657	Continued From page 11	F 657		

fall. S/He explained that there is a check off sheet for staff to complete after a fall and it did not include reviewing and revising the care plan. A review of this check off sheet confirms that it does not include reviewing or revising the care plan.

Per interview on 7/24/24 at approximately 2:15 PM, the Administrator stated that the facility did not have a fall prevention or management policy.

3). Per observation on 07/22/2024 at 5:00 PM this surveyor observed Resident #20 as having yellow/green discoloration below the left eye, and on the bridge of his/her nose. Per interview Resident #20 stated that s/he had recently fallen out of his/her wheelchair and hit their face. Resident #20 stated "you should have seen my nose after it happen, it hurt."

Per record review Resident #20 was admitted to the facility on 10/03/2024. S/He began having falls at the facility on 10/15/2022. Resident #20 had a facility fall risk assessment documented in their medical record on 04/06/2024, 05/27/2024, and 07/10/2024 in which s/he was identified as a fall risk.

The following Nurse's note written on 05/27/2024 regarding fall for Resident #20 stated "Unwitnessed fall. [Resident#16] found on the floor face down with [his/her] w/c [wheelchair] tipped down partially on top of her with the foot rest still on. [S/he] was screaming and anxious, observed on the floor ... Hematoma (bleeding under the skin that forms a bruise) on [his/her] forehead." Per chart review there is no documented evidence of fall care plan or revision for Resident #20 before or after actual falls. Per

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F 657	Continued From page 12 medical record Resident #20 experienced actual falls on 05/27/2024 and 06/30/2024. Per interview with the Clinical Coordinator (CC) on 07/24/2024 at 2:20 PM, s/he stated that Resident #20 is a fall risk and should have had a fall care plan in place. The CC also confirmed no current fall care plan for Resident #20. The CC stated the fall care plan had been active prior to 04/12/2024. Per further interview the CC stated the care plan was discontinued on 4/12/2024 and should not have been.	F 657		
F 689 SS=F	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure that resident environments were free of accident hazards related to safe handwashing water temperatures; the facility failed to ensure that each resident receives adequate supervision to maintain safety and prevent accidents for 4 of 17 sampled residents (Residents #20, #21, #22, #24, and #28); and the facility failed to develop policies that ensure that each resident receives adequate supervision to maintain safety and prevent accidents related to falls and elopement. Findings include:	F 689		

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F 689	Continued From page 13 1. Per observation on 7/22/24 at approximately 5:30 PM, the hot water was assessed from a faucet in an unlocked, common area bathroom, accessible to all residents. The water was too hot to hold a hand under comfortably, so a thermometer was used to take the temperature of the water. The highest reading was 124.0 degrees Fahrenheit (F). The sample was then expanded to include other common areas sinks and resident rooms. The left hallway sink read 121.8 degrees F, a right hallway sink read 121.7 degrees F, a second common area bathroom read 121.1 degrees F, and Resident #4's bathroom sink read 123.4 degrees F. Water temperatures were taken by the Facility Maintenance Technician starting on 7/22/24 at 6:17 PM along with the surveyor. Temperatures for the common area bathroom sink read 124 degrees F by the facility thermometer,124 degrees F for the left hallway sink, and 126 degrees F in Resident #4's room. Interview with the Facility Maintenance Technician on 7/22/24 at 6:59 PM revealed that water temperatures are monitored in three places daily in the basement of the facility: on a computer reading of the system, the return temperature, and the sink in the basement. The facility did not provide any evidence that temperatures were monitored on the units. The Maintenance Technician explained that the reading from downstairs can be a few degrees different from the actual water temperatures upstairs. S/He explained that the water that evening read 119 degrees F in the basement following the identified concern on the units; it did not reflect the actual temperature taken moments before on the unit.	F 689	F689 Free of Accident Hazards / Supervision/Devices • Hot water temperature exceeded the policy parameters by 1-6 degrees. • No past incidents of burns or scalds related to hot water temperatures in resident care & services areas. • Hot water temperature concern was reported and addressed immediately by facilities (maintenance team). Temperature at distribution point was set at 120 upon initial check then was adjusted down to ensure temperature in resident service areas were below 120 prior to evening care. Please note at the time of reported concern residents were being assisted with dinner and not receiving care that included washing / bathing. Facilities and leadership team confirmed that shower / tub room are equipped with antiscald mechanisms. The	

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F 689	Continued From page 14 Per the facility matrix dated 7/22/24, 19 of the 27 residents in the facility are identified as having dementia or Alzheimer's. On 7/23/24 at 10:14 AM a Registered Nurse reviewed the current census and indicated that 20 of the 27 residents in the facility could ambulate or self-propel in a wheelchair. A list provided by the Administrator on 7/25/24 indicated that 7 of the 27 residents in the facility had neuropathy (nerve damage). Cognitive impairment and the potential inability to feel pain due to nerve damage are conditions that put residents at increased risk for burns caused by scalding. Facility policy titled "Water/Wastewater Distribution System," effective 1/17/17 reads "The domestic hot water supplied to all areas of the hospital shall not exceed 120 degrees F." The procedure titled "Procedure 126," sent in an email from the Director of Plant Operations and Facilities to the Administrator on 7/22/24 at 6:54 PM describes the process to monitor water temperatures in the building of hospital daily to assure that safe operating water temperatures are maintained between 105 and 120 degrees F. This procedure does not describe a process to monitor the nursing home facility. Per interview on 7/22/24 at approximately 7:05 PM, the Administrator was unable to produce evidence that water temperatures were monitored in resident accessible areas in the nursing home facility. S/He confirmed that the above policy and procedure is not specific to the nursing home facility. 2. Per record review Resident #28 has diagnoses that include Alzheimer's disease and wanders throughout the facility. Review of Nursing	F 689	water temperature was at 116 degrees or below approximately 1-2 hours after it was reported and prior to the survey team exiting the facility. The temperature continued to be monitored in various service areas the remaining days of the survey and remained below 120 degrees. Results reported daily to the survey team. • Policy included all Gifford programs. Daily monitoring was being completed but description of location expanded to accurately reflect Menig location. Procedure updated to include expanded monitoring of temperatures in a higher number of service / care area access points with action / response documentation as needed. • Resident #20, 22, 24, and 28 new assessments completed for baseline evaluation at this point in time with care plan updated as needed.	

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F 689	Continued From page 15 Progress Notes from 3/4/2024 - 7/25/24 reveals that there were 78 entries that indicated Resident #28 was expressing behaviors such as wandering throughout the facility, wandering into other Resident's rooms, and exit seeking. On 12 of the 78 occasions documentation reflected that resident was exit seeking or focused on the exit door. A Wandering Assessment done on admission, 3/4/24, states that Resident #28 is not at risk for elopement. Another Wandering Assessment dated 6/14/24, also states the Resident is not at risk of elopement. A care plan focus dated 6/19/24 indicates that Resident #28 moves about the unit: independently with supervision or touching assistance when s/he goes into areas that s/he should not be in, such as other's rooms. Per observations made throughout the survey Resident #28 was seen wandering throughout the facility including hall bathrooms, common areas, and other Resident's rooms unsupervised. On 7/22/24 at approximately 5:00 PM Resident #28 was observed wandering up the hall, s/he walked around the common area and then entered the restroom and shut the door. There were no staff members in the area. Per observation on 7/25/24 at 9:21 AM, Resident #28, who is ambulatory, and Resident #21, was sitting in a Geri-chair (padded recliner on wheels), were in the foyer and no staff were visible in any direction. Resident #28 was moving Resident #21's arms. Resident #21 began to yell. Resident #28 continued to touch Resident #21 and moved the Geri-chair a few feet. At 9:25 AM, the first staff member to be present in the foyer area was the Care Manager, 4 minutes after this initial observation of the above residents being unsupervised. At 9:26 AM the Care Manger explained that there are no staff	F 689	• Elopement and Falls Prevention Protocols developed and implemented for use as needed. • All residents with Alzheimer's disease or memory issues have the potentially of being affected by this alleged deficient practice. • Dietician and RN/LPNs re-educated regarding updating care plans as needed due to change in condition or incident/event. Nursing staff reeducated regarding situational awareness and recognizing at risk behaviors. Completed: 9/20/24 • Audits will be conducted weekly X 12 wks by the DNS &/or designee to monitor effectiveness of the plan. • Results of the audits will be reported to the Risk Meeting on a weekly basis and the QAPI committee at which time the committee will evaluate and make recommendations as needed. **Tag F 689 POC accepted on 9/6/24 by K. Humphrey/P. Cota**	

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assigned specifically to supervise the residents in the foyer.

Per interview on 7/24/24 at approximately 2:15 PM, the Administrator stated that the facility did not have an elopement prevention policy or procedure.

Per interview with the facility Administrator and the Clinical Coordinator on 7/24/24 at 2:44 PM, Resident #28 was not assessed as an elopement risk because s/he did not exit seek. When asked how the assessment differentiated no risk, low risk, and high risk the Administrator and Clinical Coordinator were unable to explain.

3. Per record review Resident #24 was admitted to the facility with diagnoses that include Alzheimer's disease. Per care plan Resident #24 is unable to go outside on their own for their safety because of memory loss. The care plan also reflects that the Resident requires 1 helper providing supervision or touching assist at times. Progress notes from 10/11/23 - 7/18/24 there were 45 entries that indicated that Resident # 24 was expressing behaviors such as wandering throughout the facility and wandering into other Resident's rooms.

An Elopement Risk Assessment dated 10/13/2023 indicates that Resident #24 is a Total Risk Score of 7 and that s/he is not at risk for elopement. Elopement Risk Assessments were also initiated on 1/20/24 and 4/19/24 however, there is no Risk Score present.

During a phone interview on 7/25/24 at 12:56 PM the facility Medical Director stated that there is a very low risk for elopement from the facility

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F 689	Continued From page 17 because it is a locked facility. During interview on 7/24/24 at 2:50 PM the facility Administrator and the Clinical Coordinator confirmed that there were no Risk Scores identified on the 1/20/24 and 4/19/24 Elopement Risk Assessments. The Clinical Coordinator stated that the assessments had not been finished and therefor there was no score to identify if the Resident was at risk. 4. Per record review, Resident # 22 has a diagnosis of Alzheimer dementia and wanders through out the facility most of the day. An elopement risk assessment was done upon admission with a score of 9, assessing him/her with "poor safety/environment awareness, impulsive behavior, disoriented at all times." The assessment listed the resident "not at risk for elopement." However, on 7/23/2024 at approximately 5:15 PM, Resident #22 was observed in the main foyer trying to open every door. There were no staff visible. 5) Per record review Resident #20 was admitted to the facility on 10/03/2022 and began having falls on 10/15/2022. Facility fall risk assessment completed on 04/06/2024, 05/27/2024 and 07/10/2024 all identified Resident #20 as being a risk for fall. Per chart review there is no documented evidence of fall care plan or revision for Resident #20 before or after actual falls on 05/27/2024 and 06/30/2024. Per observation on 07/22/2024 at 5:00 PM this surveyor observed the Resident #20 as having yellow/green discoloration below the left eye, and on the bridge of his/her nose. Per interview Resident #20 stated that s/he had recently fallen out of his/her wheelchair and hit their face.	F 689		

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F 689	Continued From page 18 Resident #20 stated "you should have seen my nose after it happen, it hurt." The following Nurse's note written on 05/27/2024 regarding fall for Resident #20 stated "Unwitnessed fall. [Resident#16] found on the floor face down with [his/her] w/c [wheelchair] tipped down partially on top of her with the foot rest still on. [S/he] was screaming and anxious, observed on the floor ... Hematoma (bleeding under the skin that forms a bruise) on [his/her] forehead." Per chart review there is no documented evidence of fall care plan or revision for Resident #20 before or after actual falls. Per medical record Resident #20 experienced actual falls on 05/27/2024 and 06/30/2024. Per interview with the Clinical Coordinator (CC) on 07/24/2024 at 2:20 PM, S/he stated that Resident #20 had been identified as a fall risk and should have an active care plan and interventions to prevent falls. CC confirmed there was no active fall care plan for Resident #20. The CC further explained that interdisciplinary team only reviews initial care plan for falls and that the floor nurse should update their care plan with interventions after the fall. S/He explained that there is a check off sheet for staff to complete after a fall and it did not include reviewing and revising the care plan. A review of the post fall check off list, confirmed that it does not include reviewing or revising the care plan. Per interview on 7/24/24 at approximately 2:15 PM, the Administrator stated that the facility did not have a fall prevention or management policy.	F 689		
F 692 SS=D	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3)	F 692		

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F 692	Continued From page 19 §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to monitor weights as care planned for 1 of 18 residents sampled (Resident #15) and the facility failed to develop policies that ensure that each resident receives adequate supervision to maintain nutrition status related to weight monitoring and weight loss. Findings include: Per record review, Resident #15 has diagnoses that include: Alzheimer's dementia, recurring urinary tract infections, emphysema, and heart failure. Resident #15's care plan, effective 11/3/23, and last reviewed on 7/11/24 has the following nutritional interventions: weigh weekly, chart weights weekly, and reweigh the next day if	F 692	692 Nutrition/Hydration Status • Resident #15 was a closed record at the time of review. • All residents that have a weight loss have the potentially of being affected by this alleged deficient practice. • Dietician and RN/LPNs re-educated regarding the need to update care plans and re-weighs/documentation as needed due to change in condition or incident/event. Completed: 9/20/24 • Audits will be conducted weekly X 12 wks by the DNS &/or designee to monitor effectiveness of the plan. • Results of the audits will be reported to the Risk meeting on a weekly basis and the QAPI committee at which time the committee will evaluate and make recommendations as needed. **Tag F 692 POC accepted on 9/6/24 by K. Humphrey/P. Cota**	

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F 692	Continued From page 20 weight has changed by 3 pounds. The care plan does not address Resident #15's increased refusal to be weighed. Resident #15 has weights documented on the following days since 1/1/24: (1/1/24, 1/29/24, 2/12/24, 2/25/24, 3/4/24, 3/18/24, 3/25/24, 4/8/24, 4/22/24, 5/13/24, 5/31/24, 6/3/24, 6/10/24, 6/24/24, and 7/1/24). Of the 28 weeks from 1/1/24 through 7/22/24, Resident #15 was only weighed 15 times. There is no documentation that Resident #15 refused to be weighed or reattempts to weigh him/her were made for the 13 weeks they were not weighed from 1/1/24 through 7/22/24. Per interview on 7/24/24 at 10:57 AM, the Clinical Coordinator confirmed that Resident #15 frequently refused being weighed and that nursing staff did not document the refusals and should have.	F 692		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents	F 812		

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F 812	Continued From page 21 from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview the facility failed to store and prepare food in accordance with professional standards for food safety. Findings include: Per observations made during the initial kitchen tour on 7/22/2024 at approximately 10:15 AM there was an open box of pasta, 2 tubs of cream cheese icing with expiration dates of 11/16/2023, and 1 tub of chocolate fudge icing with expiration date of 9/16/2023 on a food storage shelf. On the bottom shelf of another food storage shelf there was a cardboard box with a bag of lentils open and spilling out into the box. The dietary supervisor on shift during the tour confirmed that the icing was expired, and that the pasta and lentils were open. During observation on 7/24/2024 at 11:15 AM of the kitchenette off the main dining room was a plate of uncovered deviled eggs that had been placed on the hand washing sink. There were no staff present at the time. At 11:20 a dietary aide entered the kitchenette and confirmed that the deviled eggs should have not been left on the sink and that they should have been covered. At 11:30 a Dietary Aide was observed bringing the plate of deviled eggs through the facility hall to the outside area that was set up for a resident and staff picnic. The Dietary Aide was interviewed at that time and confirmed that the deviled eggs	F 812	**F812** **Food Procurement, Store/Prepare-Sanitary –** store, prepare, distribute and serve food in accordance with professional standards for food service safety. • The opened and/or outdated food product was immediately thrown away. • All residents have the potential of being affected by this alleged deficient practice. • Re-education provided to all Menig food service staff regarding sanitary food storage and delivery. Completed: 9/20/24 • Audits will be conducted 3 Xs weekly X 12 wks by the FS Manager / Admin &/or designee to monitor effectiveness of the plan. • Results of the audits will be reported to the Leadership Huddle on a weekly basis and the QAPI committee at which time the committee will evaluate and make recommendations as needed.	

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F 812	Continued From page 22 should have been covered while on the sink and during transport through the facility. During an interview with the Food Service Manager on 7/24/24 at approximately 11:45 AM, s/he confirmed that the eggs should have been covered.	F 812	**Tag F 812 POC accepted on 9/6/24 by K. Humphrey/P. Cota**	
F 838 SS=F	Facility Assessment CFR(s): 483.70(e)(1)-(3) §483.70(e) Facility assessment. The facility must conduct and document a facility-wide assessment to determine what resources are necessary to care for its residents competently during both day-to-day operations and emergencies. The facility must review and update that assessment, as necessary, and at least annually. The facility must also review and update this assessment whenever there is, or the facility plans for, any change that would require a substantial modification to any part of this assessment. The facility assessment must address or include: §483.70(e)(1) The facility's resident population, including, but not limited to, (i) Both the number of residents and the facility's resident capacity; (ii) The care required by the resident population considering the types of diseases, conditions, physical and cognitive disabilities, overall acuity, and other pertinent facts that are present within that population; (iii) The staff competencies that are necessary to provide the level and types of care needed for the resident population; (iv) The physical environment, equipment, services, and other physical plant considerations	F 838		

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	475058	A. BUILDING _____ B. WING _____	07/25/2024

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F 838	Continued From page 23 that are necessary to care for this population; and (v) Any ethnic, cultural, or religious factors that may potentially affect the care provided by the facility, including, but not limited to, activities and food and nutrition services. §483.70(e)(2) The facility's resources, including but not limited to, (i) All buildings and/or other physical structures and vehicles; (ii) Equipment (medical and non- medical); (iii) Services provided, such as physical therapy, pharmacy, and specific rehabilitation therapies; (iv) All personnel, including managers, staff (both employees and those who provide services under contract), and volunteers, as well as their education and/or training and any competencies related to resident care; (v) Contracts, memorandums of understanding, or other agreements with third parties to provide services or equipment to the facility during both normal operations and emergencies; and (vi) Health information technology resources, such as systems for electronically managing patient records and electronically sharing information with other organizations. §483.70(e)(3) A facility-based and community-based risk assessment, utilizing an all-hazards approach. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to address in their facility assessment what staff trainings and policies are necessary to provide the level and types of care needed for the population identified in the facility assessment. This deficient practice had the potential to affect all 27 residents residing in the	F 838	F838 Facility Assessment • Facility assessment was updated to include staff education & training and evaluation of policies necessary to provide the level and type of care needed for the population identified. • All residents the potential of being affected by this alleged deficient practice. • Reeducation to all clinical staff regarding update to facility assessment. • Educate all clinical staff regarding the various means of communication, QAPI, compliance and ethics, and behavioral health • Review expectation of the medical director regarding implementation of policies to changes in condition. • Policies reviewed, updated and developed as a part of the QAPI meeting agenda. Completed: 9/20/24	

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F 838	Continued From page 24 facility. Findings include: 1. During a review of employee education records, the facility was unable to produce evidence of the following required regulatory training topics for 7 of 7 staff: communication, QAPI (quality assurance and performance improvement), compliance and ethics, and behavioral health; and was unable to produce evidence of 12 hours of required in-service for 4 of 4 nurse aides. See F 940, F 941, F 944, F 946, F 947, and F 949 for more information. A review of the facility assessment dated 2024 reveals that it does not include or address and evaluation for the facility's training program. 2. Per interview on 7/25/24 at 12:56 PM, the Medical Director explained that s/he was unaware that patient care policies did not exist for fall prevention and management, obtaining weights, weight loss prevention and management, and elopement prevention. See F841 for more information. A review of the facility assessment dated 2024 reveals that it does not address or include an evaluation of what policies and procedures required to provide care for their patient population. Per interview on 7/25/24 at 3:45 PM, the Administrator and the VP of Quality and Compliance Officer confirmed that the facility assessment did not address staff training and the patient care policies need to care for the population identified in the assessment.	F 838	• Audits will be conducted weekly X 12 wks by the DNS &/or designee to monitor effectiveness of the plan. • Results of the audits will be reported to the weekly risk meeting and the QAPI committee at which time the committee will evaluate and make recommendations as needed. **Tag F 838 POC accepted on 9/6/24 by K. Humphrey/P. Cota**	
F 841 SS=F	Responsibilities of Medical Director	F 841		

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F 841	Continued From page 25 CFR(s): 483.70(h)(1)(2) §483.70(h) Medical director. §483.70(h)(1) The facility must designate a physician to serve as medical director. §483.70(h)(2) The medical director is responsible for- (i) Implementation of resident care policies; and (ii) The coordination of medical care in the facility. This REQUIREMENT is not met as evidenced by: Based on interview and policy review, the facility failed to ensure the Medical Director assisted the facility with the development and implementation of resident care policies. This deficient practice had the potential to affect all 27 residents residing in the facility. Findings include: During an annual recertification survey on 7/22/24 through 7/25/24, multiple patient care policies and or procedures were requested including policies related to concerns identified with fall prevention and management, obtaining weights, weight loss prevention and management, and elopement prevention. See F 657, F 689, and F 692 for more information. The Clinical Care Coordinator and the Administrator were unable to produce policies related to the above concerns. Per interview on 7/24/24 at approximately 2:15 PM, the Administrator confirmed that the facility did not have policies or written procedures related to the above concerns. Facility policy titled "Medical Director," effective 11/27/17, reads "The Medical Director is responsible for: Implementation of resident care policies that reflect current professional standards of practice ..."	F 841	F841 Responsibility of Medical Director • Change in condition policy reviewed and updated. • Development of policy / procedure regarding falls and elopement prevention. • All residents the potential of being affected by this alleged deficient practice. • Nurses reeducated regarding response to changes in condition that include monitoring residents for weight loss. Nurses educated regarding the falls and elopement preventions policy / protocol. • Reviewed expectation of the medical director regarding implementation of policies related to changes in condition. • Policies reviewed, updated and developed as a part of the QAPI meeting agenda. Completed: 9/20/24	

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F 841	Continued From page 26 Per interview on 7/25/24 at 12:56 PM, the Medical Director explained that s/he is aware that the facility has had concerns with residents having falls, weight loss and elopement while in his/her role but was unaware that there were no patient care policies related to these care areas.	F 841	• Audits will be conducted weekly X 12 wks by the Administrator / DNS &/or designee to monitor effectiveness of the plan. • Results of the audits will be reported to the weekly risk meeting and the QAPI committee at which time the committee will evaluate and make recommendations as needed. **Tag F 841 POC accepted on 9/6/24 by K. Humphrey/P. Cota**	
F 940 SS=F	Training Requirements CFR(s): 483.95 §483.95 Training Requirements A facility must develop, implement, and maintain an effective training program for all new and existing staff; individuals providing services under a contractual arrangement; and volunteers, consistent with their expected roles. A facility must determine the amount and types of training necessary based on a facility assessment as specified at § 483.70(e). Training topics must include but are not limited to- This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to develop, implement, and maintain an effective training program for all new and existing staff related to QAPI (quality assurance and performance improvement), communication, compliance, and ethics training, and behavioral health training for 10 of 10 of sampled direct care staff and failed to develop a system that demonstrated the required 12 hours of annual training for the Licensed Nurse Aides (LNA's), for 4 of 4 of sampled staff. Findings include: Per the facility assessment, last reviewed 4/29/2024, on page #1, "[the facility] has created and implemented competency standards for its staff. The competency program defines	F 940		

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F 940	Continued From page 27 competency standards for each position and verifies that these competencies are continuously being met. ... The purpose of the program is to establish procedures that ensure that the competence of all staff members is assessed, maintained, demonstrated, and improved on an ongoing basis." ...1). Competency assessment is the responsibility of each department manager and human resources officer. E)."The department manager will determine that all required competencies have been satisfactorily completed during the introductory period (six months) and thereafter annually." Per review of the following employee files: LNA#1, hired 9/14/20; LNA #2, hired 4/21/21; LNA #3, hired 2/29/2016; LNA #4, hired 1/9/2019; LNA #5, hired 7/22/2024; RN #1, hired 6/3/2016; RN #2, hired 6/24/24; RN#3, hired 6/24/2024; LPN#1, hired 2/29/16; LPN #2, hired 7/25/2024, there is no evidence of required communication, QAPI, compliance and ethics, or behavioral health training. Additionally, 4 of the 4 sampled LNA employee files did not show evidence of the required 12 hours of annual training. Per interview with the Director of Nursing on 7/24/2024 at approximately 2:20 PM, s/he stated s/he was a "temporary employee" and did not know how the LNA training and competencies might be documented. S/he explained that the facility shared software systems with the hospital, and this information might be there. S/he was unable to produce evidence that the training was documented. S/he states that either s/he or the Clinical Coordinator gives an onboarding packet to new hires, including temporary staff. A review of the onboarding packet supplied to new staff, including the temporary staff, revealed	F 940	F940 Training Requirement • The facility had developed and implemented training & tracking system. The system was updated to include staff education & training for new and existing staff related to QAPI, communication, compliance and ethics, and behavioral health. The tracking method includes triggered alert notifications to ensure a minimum of 12 hours of education is completed by working LNAs. and evaluation of policies necessary to provide the level and type of care needed for the population identified. • All residents have the potential of being affected by this alleged deficient practice. • Reeducation to all staff regarding update to areas of education and tracking alerts.	

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F 940	Continued From page 28 no QAPI, communication, compliance, and ethics, or behavioral health training. Per interview with the Administrative Assistant and the Clinical Coordinator on 7/25/2024 at approximately 3:00 PM, the Administrative Assistant stated they were unaware of a system documenting the training and competencies of the LNA's. They confirmed they were unaware of a system that tracked the required 12 hours of annual LNA training.	F 940	• Educate all current and new staff, including temporary contract staff regarding the various means of communication, QAPI, compliance and ethics, and behavioral health. Completed: 9/20/24 • Audits will be conducted monthly X 3 months by the DNS &/or designee to monitor effectiveness of the plan. • Results of the audits will be reported to the weekly risk meeting and the QAPI committee at which time the committee will evaluate and make recommendations as needed.	
F 941 SS=F	Communication Training CFR(s): 483.95(a) §483.95(a) Communication. A facility must include effective communications as mandatory training for direct care staff. This REQUIREMENT is not met as evidenced by: Based on staff interviews and record review, the facility failed to include mandatory training that outlines and informs staff of the elements of effective communication, including speaking to others in a way they can understand, active listening, and observing verbal and nonverbal cues. Findings include: Per review of the training records for 7 sampled staff members, none of the 7 staff members had any evidence of training in communication: LNA#1(Licensed Nursing Assistant), hired 9/14/20; LNA #2, hired 4/21/21; LNA #3, hired 2/29/2016; LNA #4, hired 1/9/2019; RN #1(Registered Nurse), hired 6/3/2016; RN #2, hired 6/24/24; LPN#1, hired 2/29/16. Per interview on 7/25/24 with the Administrative Assistant and the Clinical Coordinator at	F 941	**Tag F 940 POC accepted on 9/6/24 by K. Humphrey/P. Cota** F941 Communication Training Requirement • The facility updated training to include education regarding communication methods for all new and current Menig staff, as well as temporary contracted staff.	

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F 941	Continued From page 29 approximately 3 PM, it was confirmed that the facility does not have mandatory training regarding effective communication, but that training is informal on a case-by-case basis and discussed at the morning meeting. They confirmed that attendance is not taken to ensure all staff receive this information.	F 941	• All residents have the potential of being affected by this alleged deficient practice. • Reeducation to all staff regarding communication methods and tracking alerts. Completed: 9/20/24	
F 944 SS=F	QAPI Training CFR(s): 483.95(d) §483.95(d) Quality assurance and performance improvement. A facility must include as part of its QAPI program mandatory training that outlines and informs staff of the elements and goals of the facility's QAPI program as set forth at § 483.75. This REQUIREMENT is not met as evidenced by: Based on staff interviews and record reviews, the facility failed to include mandatory training that outlines and informs staff of the elements and goals of the facility's QAPI (Quality Assurance Performance Improvement) program as part of the QAPI program. Findings include: Per review of the training records for 7 sampled staff members, none of the 7 staff members had any evidence of training on the facility's QAPI program. : LNA#1(Licensed Nursing Assistant), hired 9/14/20; LNA #2, hired 4/21/21; LNA #3, hired 2/29/2016; LNA #4, hired 1/9/2019; RN #1(Registered Nurse), hired 6/3/2016; RN #2, hired 6/24/24; LPN#1, hired 2/29/16 Per interview of LNA #1, LNA#2, and LNA# 3 on 7/25/2024 at approximately 3:00 PM, all three confirmed that they had not received any training on the QAPI program.	F 944	• Audits will be conducted monthly X 3 months by the DNS &/or designee to monitor effectiveness of the plan. • Results of the audits will be reported to the weekly risk meeting and the QAPI committee at which time the committee will evaluate and make recommendations as needed. **Tag F 941 POC accepted on 9/6/24 by K. Humphrey/P. Cota** F944 QAPI Training Requirement • The facility updated training to include education regarding QAPI for all new and current Menig staff, as well as temporary contracted staff.	

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F 944	Continued From page 30 Per interview on 7/25/24 at approximately 3:30 PM with the Administrative Assistant and the Clinical Coordinator, it was confirmed that the facility does not provide mandatory training for staff regarding it's QAPI program.	F 944	• All residents have the potential of being affected by this alleged deficient practice. • Reeducation to all staff regarding Quality Assurance Performance Improvement (QAPI). Completed: 9/20/24 • Audits will be conducted monthly X 3 months by the DNS &/or designee to monitor effectiveness of the plan. • Results of the audits will be reported to the weekly risk meeting and the QAPI committee at which time the committee will evaluate and make recommendations as needed.	
F 946 SS=F	Compliance and Ethics Training CFR(s): 483.95(f)(1)(2) §483.95(f) Compliance and ethics. The operating organization for each facility must include as part of its compliance and ethics program, as set forth at §483.85- §483.95(f)(1) An effective way to communicate the program's standards, policies, and procedures through a training program or in another practical manner which explains the requirements under the program. §483.95(f)(2) Annual training if the operating organization operates five or more facilities. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to include mandatory training on compliance and ethics that outlines and informs staff of the standards, policies, and procedures through a training program or in another practical manner that explains the requirements under the program. Findings include: Per review of the training records of 7 sampled direct care staff members, none of the 7 staff members had any evidence of training on the Compliance and Ethics program: LNA (Licensed Nurse Aide) #1, hired 9/14/20; LNA #2, hired 4/21/21; LNA #3, hired 2/29/2016; LNA #4, hired	F 946	**Tag F 944 POC accepted on 9/6/24 by K. Humphrey/P. Cota** F946 Compliance and Ethics Training Requirement • The facility updated training to include education regarding Compliance and Ethics training for all new and current Menig staff, as well as temporary contracted staff.	

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F 946	Continued From page 31 1/9/2019; RN (Registered Nurse) #1, hired 6/3/2016; RN #2, hired 6/24/24; LPN(Licensed Practical Nurse) #1, hired 2/29/16 Per interview on 7/25/2024 at 2:47 PM with an LPN (Licensed Practical Nurse), s/he indicated s/he does not remember attending training or an in-service on ethics. Another interview on 7/25/2024 at 3 PM with two LNAs revealed that neither could recall any training or mention of an ethics curriculum that might have been provided to them. Per an interview on 7/25/2024 at approximately 3 PM with the Administrative Assistant and the Clinical Coordinator, it was confirmed that the employee training program did not contain the mandatory compliance and ethics.	F 946	• All residents have the potential of being affected by this alleged deficient practice. • Reeducation to all staff regarding Compliance and Ethics. Completed: 9/20/24 • Audits will be conducted monthly X 3 months by the DNS &/or designee to monitor effectiveness of the plan. • Results of the audits will be reported to the weekly risk meeting and the QAPI committee at which time the committee will evaluate and make recommendations as needed. **Tag F 946 POC accepted on 9/6/24 by K. Humphrey/P. Cota**	
F 947 SS=F	Required In-Service Training for Nurse Aides CFR(s): 483.95(g)(1)-(4) §483.95(g) Required in-service training for nurse aides. In-service training must- §483.95(g)(1) Be sufficient to ensure the continuing competence of nurse aides, but must be no less than 12 hours per year. §483.95(g)(2) Include dementia management training and resident abuse prevention training. §483.95(g)(3) Address areas of weakness as determined in nurse aides' performance reviews and facility assessment at § 483.70(e) and may address the special needs of residents as determined by the facility staff.	F 947		

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F 947	Continued From page 32 §483.95(g)(4) For nurse aides providing services to individuals with cognitive impairments, also address the care of the cognitively impaired. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to develop a system to document the minimum 12 hours of nurse aide training per year required to ensure the continuing competence of the nurse aides. Findings include: Per review of the training records for 4 sampled staff members, none had evidence of the total 12 hours of training per year required to meet identified staff or resident needs. Per interview on 7/25/2024 at approximately 2:30 PM, LNA #1 (Licensed Nursing Assistant) stated s/he did not know how the education hours were documented. In a second interview with LNA # 2, s/he stated s/he often attended offered training but did not know if s/he met the minimum standard of 12 hours annually. During an interview with the Clinical Coordinator and the Administrative Assistant on 5/25/2024 at approximately 3:30 PM, they confirmed they did not have a system to document the mandatory 12 hours of nurse aide training. They were unable to identify how these hours were being accounted for or a system that could provide this information.	F 947	F947 In-Service Training for Nurse Aides • The facility updated training to include triggered notifications to track nurse aide education hours at quarterly intervals to communicate and ensure the minimal of 12 hours of education as required by nurse aide licensing is completed annually. • All residents have the potential of being affected by this alleged deficient practice. • Reeducation to all nurse aide staff regarding tracking alerts and annual licensing requirement. Completed: 9/20/24 • Audits will be conducted monthly X 3 months by the DNS &/or designee to monitor effectiveness of the plan.	
F 949 SS=F	Behavioral Health Training CFR(s): 483.95(i) §483.95(i) Behavioral health. A facility must provide behavioral health training consistent with the requirements at §483.40 and	F 949		

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F 949	Continued From page 33 as determined by the facility assessment at §483.70(e). This REQUIREMENT is not met as evidenced by: Based on staff interviews and record review, the facility failed to develop, implement, and maintain an effective training program for all staff, which includes, at a minimum, training on behavioral health care and service that is appropriate and effective, as determined by staff need and the facility assessment for 7 of 7 sampled staff. The facility's Facility Assessment [an assessment that determines what resources are necessary to care for the residents competently during both day-to-day operations and emergencies], last updated 1/24/2024, indicates that the facility can provide care and services for individuals with Psychiatric/Mood Disorders "Part 2 Services and care we offer based on our Resident's needs .....mental health and behavior: Manage the medical conditions and medication-related issues causing psychiatric symptoms and behavior, identify and implement interventions to help support individuals with issues such as dealing with anxiety, care of someone with cognitive impairment, care of individuals with depression, trauma/PTSD, other psychiatric diagnoses, intellectual or developmental disabilities." Section 2.1 of the facility assessment indicates 8 residents with behavioral health needs during this assessment period. Review of 7 direct care staff education records revealed there was no evidence of a behavior health training course that includes the competencies and skills necessary to provide care for residents with behavioral health needs: LNA#1, hired 9/14/20; LNA #2, hired 4/21/21; LNA	F 949	• Results of the audits will be reported to the weekly risk meeting and the QAPI committee at which time the committee will evaluate and make recommendations as needed. **Tag F 947 POC accepted on 9/6/24 by K. Humphrey/P. Cota** **F949** Behavior Health Training Requirement • The facility updated training to include education regarding Behavioral Health training for all new and current Menig staff, as well as temporary contracted staff. • All residents have the potential of being affected by this alleged deficient practice. • Reeducation to all staff regarding behavioral health and situational awareness. Completed: 9/20/24	

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 _____	07/25/2024

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 949	Continued From page 34 #3, hired 2/29/2016; LNA #4, hired 1/9/2019; RN #1, hired 6/3/2016; RN #2, hired 6/24/24; LPN#1, hired 2/29/16 Per interview on 7/25/2024 at approximately 3:30 PM with the Administrative Assistant and the Clinical Coordinator on 7/25/2024, they indicated they do not have a training program that includes training on behavioral health as part of the direct care staff training program.	F 949	• Audits will be conducted weekly X 12 wks by the DNS &/or designee to monitor effectiveness of the plan. • Results of the audits will be reported to the weekly risk meeting and the QAPI committee at which time the committee will evaluate and make recommendations as needed. **Tag F 949 POC accepted on 9/6/24 by K. Humphrey/P. Cota**	