VERMONT

Department of Disabilities, Aging and Independent Living
Division of Licensing and Protection
280 State Drive/HC 2 South
Waterbury, VT 05671-2060
www.dlp.vermont.gov

[phone] 802-241-0344
[fax] 802-241-0343

AGENCY OF HUMAN SERVICES

October 29, 2025

Ms. Heather Presch, Administrator
Merten's House
73 River Street
Woodstock, VT 05091-1265

Dear Ms. Presch:

Enclosed is a copy of your acceptable plans of correction for the re-licensure survey conducted on **October 13, 2025.** 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, BS
Assistant Division Director
State Survey Agency Director

Division of Licensing and Protection

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	47S002	A. BUILDING: _____ B. WING _____	10/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MERTEN'S HOUSE	73 RIVER STREET WOODSTOCK, VT 05091

(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) COMPLETE DATE
S 000	Initial comments The Division of Licensing and Protection conducted an unannounced, onsite re-licensure survey on 10/13/25. The following deficiencies were identified:	S 000		
S220 SS=C	3.7 (a.1-a.2) WRITTEN INFORMATION 3.7 (a) The facility must furnish a written description of the residents' legal rights which includes: 1. a description of the manner of protection of personal funds under subsections (3.10 a), (3.10.b.1.), and (3.10. b. 2) of these rules. 2. a posting of the names, addresses, and telephone numbers of all pertinent State client advocacy groups, such as the licensing agency, the ombudsman, protection and advocacy organizations and the Medicaid Provider Fraud Unit of the Office of the Attorney General. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure that advocacy and protection agencies information was visible to residents and resident representatives. Findings include: Per observation on 10/13/25 at 10:10 AM of the second floor where residents reside, there are no names, addresses, or telephone numbers for DLP [Division of Licensing and Protection], Medicaid Fraud Unit of the Attorney General's office, or protection and advocacy organizations. The resident rights poster only displays the ombudsman's information. An interview was conducted with the Executive Director on 10/13/25 at 11:24 AM. She confirmed	S220	S220 Written Information Poster signage that includes names, addresses, and telephone numbers for DLP, the Medicaid Fraud Unit of the Attorney General's office, and protection and advocacy organizations, along with the Ombudsman's information on the resident rights poster was requested from VHCA on 10/13/25. A poster was ordered locally and picked up and hung on 10/15/25. An audit will be conducted of facility postings to ensure compliance. As a result of the audit, facility postings that are not compliant will be replaced. Facility postings will be reviewed by the ED quarterly. This information will be presented quarterly at QAPI X4 to ensure compliance. **Tag S220 POC accepted on 10/29/25 by C. Howard/S. Stem**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	47S002	A. BUILDING: _____ B. WING _____	10/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MERTEN'S HOUSE	73 RIVER STREET WOODSTOCK, VT 05091

(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) COMPLETE DATE
S220	Continued From page 1 that information pertaining to DLP, Medicaid Fraud Unit of the Attorney General's office, and protection and advocacy organizations are not posted on the second floor where residents reside. She stated, "I have that information in my office."	S220		
S291 SS=E	5.2 (c) ASSESSMENTS REQUIREMENTS - FREQUENCY AND USE 5.2 (c) Assessments must be conducted: 1. no later than 14 (fourteen) days after the date of admission; 2. promptly after a significant change in the resident's physical or mental condition; and 3. in no case less often than once every 12 (twelve) months. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to conduct an initial comprehensive, accurate, standardized, reproducible assessment of each resident's functional capacity for 2 of 2 sampled residents (Resident #5 and Resident #7) related to resident assessments. Findings include: Per record review of the facility policy titled, "Comprehensive Assessments and the Care Delivery Process" includes the requirement to "complete the Minimum Data Set within 14 days after admission." Per record review, Resident #5 was admitted to the facility on 8/13/25 and a comprehensive assessment was not completed within 14 days of	S291	S291 Assessments Requirements- Frequency and Use Assessments for Residents #5 and #7 were completed by 10/14/25 and printed for the resident paper chart to bring the 2 resident assessments into compliance. PCC was contacted and the issue with closing assessments, was corrected by 10/17/25 and electronic assessments were closed for residents #5 and #7 by 10/20/25. An audit of resident assessments will be conducted. As a result of the audit, assessments that are out of compliance will be completed on or before 11/2/25. Assessments will be reviewed monthly by the DNS or designee. This information will be presented quarterly at QAPI X4 to ensure ongoing compliance. **Tag S291 POC accepted on 10/29/25 by C. Howard/S. Stem**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	47S002	A. BUILDING: _____ B. WING _____	10/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MERTEN'S HOUSE	73 RIVER STREET WOODSTOCK, VT 05091

(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) COMPLETE DATE
S291	Continued From page 2 that date, on or before 8/27/25. Review of Resident #5's record shows that as of 10/13/25, no MDS (Minimum Data Set) assessment has been completed for this resident. Resident #7 was admitted to the facility on 8/26/25 and a comprehensive assessment was not completed within 14 days of that date, on or before 9/9/25. Review of Resident #7's record shows shows that as of 10/13/25, no MDS (Minimum Data Set) assessment has been completed for this resident. Per record review of the facility's "Comprehensive Assessments and the Care Deliviery Process" policy [no revision date] states, "2.Complete the Minimum Data Set [MDS] within 14 days after admssion, within 14 days after it is determined that the resident has had a significant change in physical or mental condition, and annually." An interview was conducted with Administrator and DNS (Director of Nursing Services) on 10/13/25 at 11:30 AM. They stated they can start an MDS in Point Click Care (electronic health record) but cannot close them and complete them. They discussed that they have been having this problem since mid-August. They confirmed the the MDS assessments have not been completed since that time.	S291		
S330 SS=F	7.14 (g)(1-3) DIETARY SERVICES - SANITARY CONDITIONS 7.14 (g) The facility must: 1. procure food from sources approved or considered satisfactory by Federal, State, or local authorities; 2. store, prepare, distribute and serve food under	S330		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	47S002	A. BUILDING: _____ B. WING _____	10/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MERTEN'S HOUSE	73 RIVER STREET WOODSTOCK, VT 05091

(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) COMPLETE DATE
S330	Continued From page 3 sanitary conditions; and 3. dispose of garbage and refuse properly. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to store food in accordance with professional standards for food service safety. Findings include: Per observation of the kitchen on 10/13/25 at 9:46 AM, there was a 16-ounce container of marshmallow Fluff with an expiration date of 10/7/25. There was a 10-ounce jar of Real Mint Jelly with an expiration date of 4/4/25. There were (5) two-pack Oreo packages with an expiration dates of 8/19/25. There was a 5-ounce packet of taco seasoning that expired on 8/2025. There was a 1.25-ounce packet of fajita seasoning with an expiration date of 11/14/24. There was a 0.9-ounce bottle of caraway seeds with an expiration date of 1/19/25. Per record review of the facility's "Labeling and Dating Food Items" policy [last revised 5/15/23] states, "'Use By' Dating Guidelines: 1. The manufacturer's expiration date, when available is the 'use by' date for unopened items ... 5. Guidelines assume that food is properly stored, covered, and handled. 6. Guidelines apply regardless of store location (e.g., kitchen, pantry, etc.)." An interview was conducted with the Kitchen Manager on 10/13/25 at 9:52 AM. The Kitchen Manager confirmed that these items had expired. She stated, "I'll throw those items away."	S330	S330 Dietary Services – Sanitary Conditions Identified unlabeled or expired food items were discarded on 10/13/25. Food storage areas were inspected on 10/13/25 and any unlabeled or expired items were discarded. Policies and education pertaining to labeling and dating food items, expiration dates of food items and discarding of expired foods will be reviewed with dietary staff members on or before 10/31/25. Audits of food storage areas will be conducted weekly by the ED or designee, to ensure compliance with the policies. This information will be presented quarterly at QAPI X4 to ensure ongoing compliance. **Tag S330 POC accepted on 10/29/25 by C. Howard/S. Stem**	