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

November 3, 2025

Ms. Heather Impey, Administrator
Menig Nursing Home
215 Tom Wicker Lane
Randolph Center, VT 05061

Provider ID #: 475058

Dear Ms. Impey:

Enclosed is a copy of your acceptable plans of correction for the recertification survey conducted on **September 17, 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

Enclosure

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 475058	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 09/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Menig Nursing Home	215 Tom Wicker Lane , Randolph Center, Vermont, 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
E0000	Initial Comments The Division of Licensing and Protection conducted an onsite, unannounced survey of the facility's emergency preparedness program on 9/17/25 during an annual re-certification survey. There were no regulatory violations related to emergency preparedness as a result of this survey.	E0000	Preparation, Submission, and/ or execution of this plan of correction does not constitute an admission or agreement by the provider of the alleged violations or conclusions set forth in the statement of deficiencies. The plan of correction is prepared, submitted, and/or executed as required by State and Federal law.	
F0000	INITIAL COMMENTS The Division of Licensing and Protection conducted an unannounced, onsite recertification survey from 9/15/25 through 9/17/25 to determine compliance with 42 CFR Part 483 requirements for Long Term Care Facilities. The following regulatory deficiencies were identified:	F0000		
F0585 SS = F	Grievances CFR(s): 483.10(j)(1)-(4) §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay. §483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph. §483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident. §483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all	F0585	F 0585 Grievances: The facility will ensure a system that enables residents to file an anonymous grievance is implemented and available.	

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 reverse for further 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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Heather Torpey	CNHA	10/9/25

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F0585 SS = F	Continued from page 1 grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include: (i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system; (ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations; (iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated; (iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law; (v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written	F0585	All residents of the facility are identified as having the potential to be affected by alleged deficient practice.	

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F0585 SS = F	Continued from page 2 decision was issued; (vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. This REQUIREMENT is NOT MET as evidenced by: Based on observations, interviews, and record review, the facility failed to provide a system that enables residents to file an anonymous grievance. This has the potential to impact all residents. Findings include: Per observation on 9/16/2025 [SS1] , grievance forms were not available for residents to obtain publicly in the common area where grievance information is posted. Per interview with the Director of Nursing (DON) on 9/16/2025 at approximately 11:00 AM, she confirmed that they do not have a process for residents to submit anonymous grievances and the grievance forms are available at the nurses' station and administration office. Per observations of these areas, residents would not be able to access the forms without communicating the request to staff. Per interview with six residents at a Resident Council meeting on 9/16/2025 at 2:00 PM, the residents stated they did not know how to file an anonymous grievance. Resident #18 stated "They [the facility] have grievance forms in the office or the nurses' station, I wouldn't know how to get one without a staff member." Per record review, Resident #18 has a BIMS [Brief Interview of Mental Status] score of 15, indicating s/he has no cognitive impairment. Resident #5 stated " I don't know how to file one without a staff member." Per record review, Resident #5 has a BIMS of 14 indicating s/he has no cognitive impairment. Per record review of the facility's "Resident Grievance or Complaint" policy [last reviewed 6/12/2025] states "Complaints/grievances may be filed verbally, in writing, and may be anonymous." Per interview with a Licensed Nursing Assistant (LNA)	F0585	1. Grievance forms were placed in each resident common living room area to facilitate independent access to forms without communicating the request to a staff member. 2. Anonymous grievance reporting boxes placed in each common living room area to facilitate independent ability to submit grievance forms. 3. Reeducation provided to staff regarding grievance policy and process with a focus on new anonymous reporting avenues and locations of grievance forms. 4. Letter written and mailed to all resident representatives providing updated information on the process for filing grievance to include location of grievance forms, anonymous reporting avenues, and grievance boxes. 5. Director of Nursing attended resident council meeting on 10/7/2025 to provide information to the residents in attendance regarding resident's right to file grievance, facility grievance reporting avenues, grievance form locations, and anonymous grievance filing avenues. 6. Three individual resident and/or representative interviews/audits will be conducted weekly x 4 weeks and then monthly for 3 months to ensure anonymous reporting avenues are present and known to the residents of the facility. Results of all interview/audits will be presented to the QAPI committee to review trends, effectiveness and obtain further recommendation for remedial interventions or monitoring as needed. The Administrator and or designee holds responsibility for monitoring this plan of correction. **Tag F0585 POC accepted on 11/3/25 by C. Howard/S. Stem**	Completed 9/17/2025 Completed 9/24/2025 Completed 10/3/2025 Completed 9/26/2025 Completed 10/7/2025 10/7/2025

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F0585 SS = F	Continued from page 3 on 9/17/2025 at 9:17 AM, they stated that grievance forms are in the nurses' station file cabinet and residents request them from staff. Per interview with the Administrator and Director of Nursing (DON) on 9/17/2025 at 9:18 AM, they confirmed that grievance forms are kept in the administration office and the nurses' station and there currently is no process for residents to file an anonymous grievance without asking a staff member for a grievance form.	F0585		
F0609 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 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 report an allegation of abuse to the State Agency for 1 of 2 sampled residents (Resident #20). Findings include: Per review of the facilities policy titled "Adult Abuse and Reporting," with a review date of 5/31/2024, it	F0609	F 0609 Reporting of Alleged Violations The facility will ensure that all alleged violations involving abuse, neglect, exploitation or 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. All facility residents are identified as having the potential to be affected by the alleged deficient practice. 1. Allegation made by resident # 20 initial report filed 9/22/2025 with state survey agency and adult protective services. 2. Final investigative report regarding allegation made by resident # 20 filed with state survey agency and adult protective services 9/24/2025.	Completed 9/22/2025 Completed 9/24/2025

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F0609 SS = D	Continued from page 4 states "All alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the DON or Administrator, the State Survey Agency, Adult Protective Services and to other agencies (e.g. law enforcement, when applicable) as required." Per record review, a note dated 1/8/2025 reveals that Resident #20 stated that a Licensed Nursing Assistant (LNA) was mean, hit him/her, and swore at Resident #20. The facility did not have evidence that this was reported to the State Agency. Per interview with the Director of Nursing (DON) on 9/16/2025 at approximately 10:15 AM, she confirmed that they did not report this allegation of abuse to the state. The DON also reported that an investigation had been completed and was not submitted to the state surveying agency.	F0609	3. Adult Abuse and Reporting policy reviewed by Administrator and Director of Nursing Services 9/17/2025. Re-education provided to facility staff related to Adult Abuse and Reporting of all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property immediately to Administrator and/or Director of Nursing Services as well as process and requirement of reporting all alleged violations to state survey agency, adult protective services and other agencies when applicable or required by state or federal law. 4. Medical record review conducted to ensure no further alleged violations of abuse, neglect, exploitation, mistreatment, injuries of unknown source, or misappropriation of resident property identified without appropriate regulatory reporting completed in accordance with state law through established procedures.	Completed 9/17/25 Completed 9/30/2025 Completed 10/3/2025
F0686 SS = D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is NOT MET as evidenced by: Based on interview and record review, the facility failed to adequately assess a resident with a chronic pressure ulcer for 1 of 1 sampled residents (Resident #2). Findings include: Per record review, nursing notes and skin assessments between 10/6/24 and 9/14/25 show that Resident #2 had pressure ulcers that were not consistently assessed	F0686	5. Clinical documentation will be printed and reviewed by the Director of Nursing Services and or designee weekly to ensure no alleged violations were documented but not reported timely as required. DNS/designee will sign review and second review will be conducted by the Administrator/designee. This will take place weekly x 4 weeks to ensure substantial compliance with reporting of allegations. 6. Education understanding/competency audits to be conducted on 4 staff members weekly x 4 weeks, and then monthly x 3 months by DNS or designee to ensure effectiveness of education and continued compliance. DNS/Administrator is designated responsible for monitoring this plan of correction Results of all interview/audits will be presented to the QAPI committee to review trends, effectiveness and obtain further recommendation for remedial interventions or monitoring as needed. **Tag F0609 POC accepted on 11/3/25 by C. Howard/S Stem** F 0686 Treatment/Svcs to Prevent/Heal Pressure Ulcer: The facility will ensure that a resident with pressure ulcer/s receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing.	

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F0686 SS = D	Continued from page 5 weekly. The wound assessments that were in the record did not consistently document wound characteristics. Based on the above noted nurses notes, this residents wounds had several periods where the wound increased in size. There is limited wound measurements and none to limited wound description of characteristics provided in the above notes. Weekly wound measurements and wound description, and assessment were not consistent. Per review of the facility policy titled, "Skin Integrity/Pressure Ulcers", effective date: 2025-07-07, revealed on page 4 under heading, "ASSESSMENT" states the following: "Assessments shall include daily monitoring with protocols to minimize PI/PU [pressure injury/pressure ulcer]. The pressure ulcer assessment form is on the computer in a flow sheet labeled Wound Flow Chart (separate from standard flow chart skin assessment) and is part of the permanent record. Documentation should include: Type of injury (pressure related vs [versus] no pressure related) Location (on the unisex body) Staging per definition above and Descriptive characteristics (wound bed color) Measurements (length, width, depth) in cm [centimeters], performed weekly or per orders Progress towards healing and identification of potential complications Presence of infection Presence of pain and interventions to address Description of dressings and treatments If the PI/PU is worsening, consider changing interventions, and/or getting a consult for wound care, as neededPI/PU Characteristics include: Daily: presence of dressing, status of dressing (intact, drainage, leaking), status of area surrounding the PI/PU, signs of increasing ulceration/infection.Weekly/with dressing changes/per orders: location, size, and staging, color, evidence of healingInfections - signs of inflammation (redness, edema, pain, exudate, periwound warmth), decolorization, or abnormal order.Per interview on 9/17/25 at approximately 1:45 PM with the Director of Nursing, she confirmed that weekly wound assessments had not been done, wound measurements, and wound characteristics had not been consistently or thoroughly documented, and the wound did increase in size.	F0686	The facility identified no further residents with pressure ulcers with the potential to be affected by the alleged deficient practice. 1. Comprehensive wound assessment completed and documented in medical record for resident #2 on 9/17/2025. 2. Director of Nursing Services conducted comprehensive skin checks of all residents residing in facility to assure no other residents were affected by the alleged deficient practice. 3. Reeducation provided to nursing staff on Skin Integrity policy, prevention, and treatment of pressure injuries to include wound assessment. 4. Director of Nursing Services/designee to conduct weekly audits to ensure medical record documentation of wound assessments on all residents residing in facility with active wounds. Audits to be conducted weekly x 4 weeks and then monthly x 3 months. Director of Nursing Services is designated responsible for monitoring this plan of correction Results of all audits will be presented to the QAPI committee to review trends, effectiveness and obtain further recommendation for remedial interventions or monitoring as needed. **Tag F0686 POC accepted on 11/3/25 by C. Howard/S. Stem**	Completed 9/17/2025 Completed 9/30/2025 Completed 10/8/2025
F0699 SS = D	Trauma Informed Care CFR(s): 483.25(m) §483.25(m) Trauma-informed care The facility must ensure that residents who are trauma survivors receive culturally competent, trauma-informed care in accordance with professional standards of	F0699	F 0699 Trauma Informed Care: The facility will ensure that residents who are trauma survivors receive culturally competent, trauma-informed care in accordance with the professional standards of practice and accounting for residents' experiences and preferences in order to eliminate or mitigate triggers that may cause re-traumatization of the resident.	

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F0699 SS = D	Continued from page 6 practice and accounting for residents' experiences and preferences in order to eliminate or mitigate triggers that may cause re-traumatization of the resident. This REQUIREMENT is NOT MET as evidenced by: Based on interview and record review, the facility failed to ensure care plans contained triggers related to PTSD [Post- Traumatic Stress Disorder] for one of one sampled resident (Resident #5). Findings include: Per review of Resident #5's medical record, Resident #5 has a diagnosis of PTSD. Resident #5 has a BIMS [Brief Interview of Mental Status] score is 13 which indicates the resident is cognitively intact. Resident #5 is independent with ADLs [Activities of Daily Living], requires set-up assistance for meals, and maximal assistance with bathing. An interview was conducted with Resident #5 on 9/15/2025 at 2:12 PM. Resident #5 stated s/he has PTSD from serving in Vietnam war. S/he stated s/he does not see the social worker and did not discuss his/her triggers for his/her PTSD. Per record review, Resident #5 was screened on 3/6/25 for PTSD. His/her score was "28-29" which then states, "Some PTSD symptoms." The assessment for PTSD mentions trauma from sexual abuse and war zone work. Per record review Resident #5 does not have triggers identified in his/her care plan. An interview with the Social Worker was conducted on 9/16/25 at 10:57 AM. The Social Worker confirmed there are no triggers identified in the resident's care plan for staff to see and be informed of. She confirmed the resident has triggers and triggers are not in his/her plan and should be. An interview was conducted with the Administrator on 9/16/25 at 1:40 PM. The Administrator confirmed that the facility does not have a trauma-informed policy, stating "I couldn't find a policy specific to this [trauma-informed care], I saw some of the information in the person-centered care plan policy." Per record review of the "Comprehensive Person-Centered Care Plan" policy (effective date 8/1/25), it only states, "Care plans are culturally competent and trauma-informed and include measurable objectives, interventions and timeframes to meet a resident's clinical and mental/psychosocial needs, goals and preferences, congruent with their quality of life." There is no other information in the comprehensive person-centered care plan" policy related to trauma-informed care,	F0699	Residents of the facility requiring trauma-informed care based on initial comprehensive assessment were identified as having the potential to be affected by alleged deficient practice. 1. Resident #5 care plan updated to reflect triggers as expressed by resident # 5 on 9/23/25. 2. Social Service Coordinator conducted an audit of all current facility residents to ensure trauma-informed care plans included triggers to assist staff with mitigating any potential re-traumatization of those residents. 3. Reeducation conducted with staff regarding trauma informed care planning and assessment. 4. Audits to be conducted by Social Service Coordinator weekly x 4 weeks and then monthly x 3 months of all initial comprehensive assessments to ensure any resident identified as requiring trauma- informed care have triggers identified in the care plan as required. Results of all audits will be presented to the QAPI committee to review trends, effectiveness and obtain further recommendation for remedial interventions or monitoring as needed The Social Service Coordinator/designee is responsible for monitoring this plan of correction. **Tag F0699 POC accepted on 11/3/25 by C. Howard/S. Stem**	Completed 9/23/25 Completed 9/24/25 Completed 9/25/25

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F0699 SS = D	Continued from page 7 including identifying triggers.	F0699		
F0801 SS = F	Qualified Dietary Staff CFR(s): 483.60(a)(1)(2) §483.60(a) Staffing The facility must employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, taking into consideration resident assessments, individual plans of care and the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.71. This includes: §483.60(a)(1) A qualified dietitian or other clinically qualified nutrition professional either full-time, part-time, or on a consultant basis. A qualified dietitian or other clinically qualified nutrition professional is one who- (i) Holds a bachelor's or higher degree granted by a regionally accredited college or university in the United States (or an equivalent foreign degree) with completion of the academic requirements of a program in nutrition or dietetics accredited by an appropriate national accreditation organization recognized for this purpose. (ii) Has completed at least 900 hours of supervised dietetics practice under the supervision of a registered dietitian or nutrition professional. (iii) Is licensed or certified as a dietitian or nutrition professional by the State in which the services are performed. In a State that does not provide for licensure or certification, the individual will be deemed to have met this requirement if he or she is recognized as a "registered dietitian" by the Commission on Dietetic Registration or its successor organization, or meets the requirements of paragraphs (a)(1)(i) and (ii) of this section. (iv) For dietitians hired or contracted with prior to November 28, 2016, meets these requirements no later than 5 years after November 28, 2016 or as required by state law. §483.60(a)(2) If a qualified dietitian or other	F0801	F 0801: Qualified Dietary Staff The facility will ensure the food and nutrition services manager has necessary qualification to manage dietary services. All residents of facility were identified as having the potential to be affected by the alleged deficient practice. 1. Facility Chef Manager completed ServSafe Food Protection Manager course work on 10/3/2025. 2. Job description and requirements of Chef Manager reviewed and edited by Administrator to reflect necessary qualifications to ensure ongoing substantial compliance. 3. Facility Chef Manager is scheduled to take ServSafe Food Protection Manager certification exam and receive certification on 10/14/2025. The edited job description and requirements will be presented to the QAPI committee at which time they will evaluate and make any further recommendations. The Administrator has been identified as responsible for overseeing this plan of correction. **Tag F0801 POC accepted on 11/3/25 by C. Howard/S. Stem**	Completed 10/3/2025 Completed 10/3/2025 10/14/2025

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F0801 SS = F	Continued from page 8 clinically qualified nutrition professional is not employed full-time, the facility must designate a person to serve as the director of food and nutrition services. (i) The director of food and nutrition services must at a minimum meet one of the following qualifications- (A) A certified dietary manager; or (B) A certified food service manager; or (C) Has similar national certification for food service management and safety from a national certifying body; or D) Has an associate's or higher degree in food service management or in hospitality, if the course study includes food service or restaurant management, from an accredited institution of higher learning; or (E) Has 2 or more years of experience in the position of director of food and nutrition services in a nursing facility setting and has completed a course of study in food safety and management, by no later than October 1, 2023, that includes topics integral to managing dietary operations including, but not limited to, foodborne illness, sanitation procedures, and food purchasing/receiving; and (ii) In States that have established standards for food service managers or dietary managers, meets State requirements for food service managers or dietary managers, and (iii) Receives frequently scheduled consultations from a qualified dietitian or other clinically qualified nutrition professional. This REQUIREMENT is NOT MET as evidenced by: Based on interviews and record review, the facility failed to ensure the food and nutrition services manager has necessary qualifications to manage dietary services. This has the potential to impact all residents. Findings include: Per review of the Chef Manager's personnel record the Chef Manager, who is in charge of the kitchen on site, does not have evidence ghat they are a certified dietary manager, or a certified food service manager. S/he does not hold a similar national certification for food service management and safety from a national certifying body and does not have an associate's or	F0801		

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F0801 SS = F	Continued from page 9 higher degree in food service management hospitality. S/he does not have two or more years of experience in the position of director of food and nutrition services in a nursing facility setting and has completed a course of study in food safety and management, that includes topics integral to managing dietary operations. The above was confirmed by the Chef Manager on 9/17/2025 at approximately 11:44 AM. Per interview with Administrator on 9/17/2025 at 11:52 PM, they confirmed the facility Chef Manager is not a certified dietary or food service manager. S/he stated they have a shared certified dietician employed with Gifford Medical Center that comes to the facility one to two days a week but does not work at least 35 hours per week at the facility. Per interview with Director of Nursing (DON) on 9/17/2025 at 12:17 PM there is a full-time certified dietary manager that oversees the entire dietary department associated with Gifford Medical Center facilities. S/he comes to Menig weekly but does not work at least 35 hours a week at the facility.	F0801		
F0812 SS = F	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 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.	F0812	F0812 Food Procurement, Store/Prepare/Serve-Sanitary The facility will ensure food is stored in accordance with professional standards for food service safety. The facility identified all residents residing at facility as having the potential to have been affected by alleged deficient practice.	

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F0812 SS = F	Continued from page 10 This REQUIREMENT is NOT MET as evidenced by: Based on observation and interview, it was determined that the facility failed to store food in accordance with professional standards for food service safety. This has the potential to impact all residents. Findings include: Per observation of the walk-in freezer on 9/15/2025 at 10:06 AM, the following items were found without an expiration date: one opened plastic bag of frozen cinnamon rolls; ne opened box of fish sticks, open to air; a bag of jimmy dean sausage patties, open to air; one zip-loc bag of nine dinner rolls and one ziploc bag of 6 dinner rolls. were not dated. An interview with the Kitchen Manager on 9/15/25 at 10:22 AM confirmed these foods need to be sealed and dated after opening. S/he also confirmed there is no way to tell these items are expired without a date. Per observation the following item was identified expired in the freezer: one quart of basil pesto sauce with nuts expiration date of 4/8/22. At approximately 10:25 AM the Kitchen Manager confirmed this product had expired. Per observation of the walk-in cooler on 9/15/2025 at approximately 10:32 AM, the following items were found to be expired: three 20 oz prepared horseradish plastic containers with an expiration date of 9/6/2025, a steel bowl of sweet cream cheese spread covered with saran wrap with an expiration date of 8/20/2025, and a plastic in-house container of black beans dated 9/2/25. At approximately 10:40 AM the Kitchen Manager confirmed these items were expired. Per observation the following items were found without a date: four-pint sized containers of pizza sauce, a steel bowl covered with saran wrap of cream cheese, three 16 oz lobster base soup containers, three 16 oz vegetable base soup containers, four 16 oz chicken base soup containers, eight strips of bacon wrapped in wax paper, open to air and partially uncovered, and 35 2 oz plastic bags of Shiro Miso. Interview with the Kitchen Manager on 9/15/25 at 0:48 AM confirmed these items were not marked with an expiration date. Per observation of the kitchen's dry storage area, the following item was found to be expired: two unopened packages of dried coconut with and expiration date of	F0812	1. All items found without an expiration date and or not sealed properly in walk-in freezer were disposed of on 9/15/25. 2. Quart of basil pesto sauce with nuts with expiration date 4/8/22 was disposed of on 9/15/2025. 3. All items in walk-in cooler identified as expired were disposed of on 9/15/2025. 4. All items identified without a date were disposed of 9/15/2025. 5. All expired items in dry storage and or without secured lid were disposed of 9/15/2025. 6. Damaged lids were disposed of 9/15/2025.	Completed 9/15/2025 Completed 9/15/2025 Completed 9/15/2025 Completed 9/15/2025 Completed 9/15/2025

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F0812 SS = F	Continued from page 11 8/28/2025. The following items were found without a date, two opened bags of coconut, one opened 10 lb bag of macaroni, one gallon facility storage container of walnuts date on sticker reads " 6/24," with a lid not secure/damaged and one gallon storage container of cashews with a lid not secure/damaged. The Kitchen Manager confirmed on 9/15/25 at 11:05 AM that these items were expired, improperly sealed, and/or not dated.	F0812	7. Reeducation provided to dietary department staff specific to storing, preparing, distributing and serving food in accordance with professional standards for food service safety. 8. Audits will be conducted weekly by Kitchen Manager / designee for 8 weeks and then monthly x 3 months to ensure compliance with food storage standards. **Tag F0812 POC accepted on 11/3/25 by C. Howard/S. Stem** Kitchen Manager/Administrator are identified as responsible for overseeing this plan of correction. Results of all audits will be presented to the QAPI committee to review trends, effectiveness and obtain further recommendation for remedial interventions or monitoring as needed.	Completed 10/8/2025
F0880 SS = F	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be	F0880	F0880 Infection Prevention & Control The facility will ensure appropriate infection control practices as they relate to legionella monitoring Enhanced Barrier Precaution implementation, and annual review of infection control policies. The facility identified all residents residing at facility as having the potential to have been affected by alleged deficient practice.	

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F0880 SS = F	Continued from page 12 followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is NOT MET as evidenced by: Based on interview and record review, the facility failed to provide appropriate infection control practices related to legionella monitoring and update the infection control policies yearly. This has the potential to impact all residents. The facility also failed to implement Enhanced Barrier Precautions for 1 of 12 sampled residents (Resident #2). Findings include: 1. Per review of the facility policy titled "Water/Wastewater Distribution System" with a review date of 3/31/25, the policy does not discuss Legionella.	F0880	1. Enhanced Barrier Precautions implemented for Resident # 2 on 9/17/2025 and care plan updated to reflect utilization. 2. All Infection Prevention and Control Policies and manual reviewed and acknowledged by Administrator, Medical Director and Director of Nursing on 9/29/2025. Documentation of annual review placed in protective sleeve in front of Infection Prevention binder.	Completed 9/17/2025 Completed 9/29/2025

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F0880 SS = F	Continued from page 13 Per review of the facility water management binder, it does not identify areas specific to the nursing home for monitoring Legionella growth. Per interview with the Infection Preventionist on 9/16/25 at 3:48 PM, she reported that they don't identify areas at risk for Legionella. The Infection Preventionist also reported that two infection control policies had not been updated annually, the Antimicrobial Stewardship Program policy reviewed on 11/30/23, and the Antibiotic Stewardship Program policy reviewed on 4/21/24. She reported that that is something they update annually and then confirmed that it had not been updated. Per interview with the Maintenance Director on 9/17/25 at 8:24 AM, he reported they don't have documentation identifying areas for potential Legionella growth. He also confirmed that the water management binder needed to be updated and be made specific to the facility since it is geared towards the hospital. Additionally, the Maintenance Director confirmed the photos in the book are generic photos of plumbing and water storage equipment and are not specific to the nursing home. Per interview with the Director of Nursing (DON) and Administrator on 9/17/25 at 1:51 PM, they confirmed that they don't have a policy pertaining to Legionella and that their "Water/Wastewater Distribution System" policy with a review date of 3/31/25, does not discuss Legionella. 2. Per interview with the Infection Preventionist on 9/16/25 at 3:48 PM, she reported that two infection control policies had not been updated annually, the Antimicrobial Stewardship Program policy reviewed on 11/30/23, and the Antibiotic Stewardship Program policy reviewed on 4/21/24. She reported that that is something they update annually and then confirmed that it had not been updated. 3. Per record review of the Center for Disease Control wound care guidance, it identifies that Enhanced Barrier Precautions (EBP) should be used for chronic pressure ulcers as the standard of care (Frequently Asked Questions (FAQs) about Enhanced Barrier Precautions in Nursing Homes | LTCFs | CDC). Per review of the facilities policy titled "Isolation Precautions- Transmission based" with a review date of 10/16/24, the policy identified one of the indicators for EBP are chronic wounds like pressure ulcers. Per review of Resident #2's provider note dated 8/4/25,	F0880	3. Facility water management plan/binder reviewed and updated to include identification of areas specific to Menig Nursing Home for monitoring Legionella growth. 4. Facility water management plan/binder updated to include facility specific potable water flow diagram and photographs. 5. Facility policy specific to water management and monitoring updated and implemented. 6. All residents in facility reviewed by Director of Nursing and Administrator for any criteria that would indicate the need to implement Enhanced Barrier Precautions to ensure compliance with Infection Prevention practice as it pertains to Enhanced Barrier Precaution implementation. 7. Reeducation provided to staff regarding infection control practices as it relates to Enhanced Barrier Precaution indications for use, implementation, and examples of high contact activities. 8. Weekly audit of all residents in facility to be conducted by Director of Nursing / designee x 4 weeks and then monthly x 3 months to ensure appropriate Enhanced Barrier Precaution compliance. The Director of Nursing and Administrator have been identified as responsible for this plan of correction. Results of all audits will be presented to the QAPI committee to review trends, effectiveness and obtain further recommendation for remedial interventions or monitoring as needed. **Tag F0880 POC accepted on 11/3/25 by C. Howard/S. Stem**	Completed 10/8/2025 Completed 10/8/2025 Completed 10/8/2025 Completed 10/3/2025 Completed 10/6/2025

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F0880 SS = F	Continued from page 14 it stated that the resident has a "stage 1-2 wound on [Resident #2's] buttocks." Per interview with the DON on 9/17/25 at 11:54 AM, she reported that she wasn't sure if Resident #2, who has a chronic pressure ulcer, should be on Enhanced Barrier Precautions and stated she had asked the Infection Preventionist who didn't think Resident #2 should be on it. Per interview with the DON on 9/17/25 at 12:15 PM, when asked if she thought Resident #2 should be on Enhanced Barrier Precaution's, she stated that Resident #2 was placed on Enhanced Barrier Precautions.	F0880		