

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(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 Menig Nursing Home		STREET ADDRESS, CITY, STATE, ZIP CODE 215 Tom Wicker Lane Randolph Center, VT 05061	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
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<p>F 0585</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances.</p> <p>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) 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.</p>		

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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>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 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.</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</p> <p>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 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 needed PI/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 healing Infections - 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.</p>		

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<p>F 0699</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide care or services that was trauma informed and/or culturally competent.</p> <p>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, including identifying triggers.</p>		

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<p>F 0801</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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 that 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 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 [NAME] 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 [NAME] Medical Center facilities. S/he comes to [NAME] weekly but does not work at least 35 hours a week at the facility.</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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 [NAME] 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 [NAME] 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 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.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Provide and implement an infection prevention and control program.</p> <p>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.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, 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.</p>		