



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

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

May 11, 2023

Ms. Ursula Margazano, Administrator
Menig Nursing Home
215 Tom Wicker Lane
Randolph Center, VT 05061

Provider ID #: 475058

Dear Ms. Margazano:

The Division of Licensing and Protection completed a re-certification survey at your facility on **May 10, 2023**. The purpose of the survey was to determine if your facility was in compliance with Federal participation requirements for nursing homes participating in the Medicare/Medicaid programs.

This survey found that your facility was in substantial compliance with the participation requirements.

Congratulations to you and your staff.

Sincerely,

A handwritten signature in cursive script that reads "Pamela M. Cota RN".

Pamela M. Cota, RN
Licensing Chief

Enclosure

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

PRINTED: 05/11/2023
FORM APPROVED
OMB NO. 0938-0391

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|--|---|--|---|----------------------|--|
| 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 05/10/2023 |
| NAME OF PROVIDER OR SUPPLIER MENIG NURSING HOME | | | STREET ADDRESS, CITY, STATE, ZIP CODE 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 | |
| E 000 | Initial Comments The Division of Licensing and Protection conducted an onsite, unannounced investigation of the facility's Emergency Preparedness Program on 5/10/2023 during a re-certification survey. There were no regulatory deficiencies identified during this investigation. | E 000 | | | |
| F 000 | INITIAL COMMENTS The Division of Licensing and Protection conducted an onsite, unannounced re-certification survey from 5/8/2023 through 5/10/2023. There were no regulatory deficiencies identified during this survey. | F 000 | | | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

[Handwritten Signature] Administrator / VP of Services Svcs 5/12/23

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.