



**AGENCY OF HUMAN SERVICES**

**DEPARTMENT OF DISABILITIES, ~~AGING AND INDEPENDENT LIVING~~ <sup>Division of Licensing and Protection</sup>**

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 27, 2019

Ms. Carol Ann Cunningham, Administrator  
Merten's House  
73 River Street  
Woodstock, VT 05091-1265

Provider ID #: 47S002

Dear Ms. Cunningham:

The Division of Licensing and Protection completed a survey at your facility on **September 24, 2019**. The purpose of the survey was to determine if your facility was in compliance with State Licensing Regulations for Nursing Homes. This survey found that your facility was in substantial compliance with the participation requirements. Congratulations to you and your staff.

Please **sign the enclosed CMS 2567 and return** to this office by **October 7, 2019**.

Sincerely,

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

Pamela M. Cota, RN  
Licensing Chief

Enclosure

Division of Licensing and Protection

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  47S002	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  09/24/2019
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NAME OF PROVIDER OR SUPPLIER  MERTEN'S HOUSE	STREET ADDRESS, CITY, STATE, ZIP CODE 73 RIVER STREET WOODSTOCK, VT 05091
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(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
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S 000	Initial comments  The Division of Licensing and Protection conducted an unannounced onsite annual re-licensing survey on 9/24/19. There were no regulatory deficiencies as a result.	S 000		
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Division of Licensing and Protection  
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE \_\_\_\_\_ TITLE \_\_\_\_\_ (X6) DATE \_\_\_\_\_