VERMONT

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
Surbey 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

November 5, 2018

Nicole Bailey, Interim Practice Manager
Morrisville Family Health Center
607 Washington Highway
Morrisville, VT 05661-8275

Provider Number: 471820

Dear Ms. Bailey:

The Division of Licensing and Protection completed a complaint investigation survey at your facility on **November 1, 2018**. The purpose of the survey was to determine if your facility was in compliance with conditions for certification in 42 CFR Part 491 Subpart A for Rural Health Clinics. This survey found that your facility was in compliance with conditions for certification in 42 CFR, Part 491, Subpart A.

Please **sign the enclosed CMS-2567 and return** to this office by **November 15, 2018**.

Sincerely,

Pamela Cota RN, MS
Licensing Chief

Enclosure

PRINTED: 11/05/2018
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	471820	A. BUILDING ______ B. WING ______	C 11/01/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORRISVILLE FAMILY HEALTH CENTER	607 WASHINGTON HIGHWAY MORRISVILLE, VT 05661

(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
J 000	INITIAL COMMENTS An unannounced on-site survey was completed on 11/1/18 by the Vermont Division of Licensing and Protection, as authorized by the Centers for Medicare and Medicaid Services. The purpose of the survey was to investigate 2 complaints (# 17100 and #16524); there were no regulatory violations found.	J 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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.