
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

June 14, 2018

Mr. David Bourgeois, Director
North Country Primary Care Barton Orleans
488 Elm Street
Barton, VT 05822

Provider Number: 473987

Dear Mr. Bourgeois:

The Division of Licensing and Protection completed a survey at your facility on **June 4, 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 **June 24, 2018**.

Sincerely,



Pamela Cota RN, MS
Licensing Chief

Enclosure

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

PRINTED: 06/13/2018
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 473987	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/04/2018
--	---	--	---

NAME OF PROVIDER OR SUPPLIER NORTH COUNTRY PRIMARY CARE BARTON ORLEANS	STREET ADDRESS, CITY, STATE, ZIP CODE 488 ELM STREET BARTON, VT 05822
--	---

(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	<p>INITIAL COMMENTS</p> <p>A re-certification survey was completed on 6/4/18 by the Vermont Division of Licensing and Protection, as authorized by the Centers for Medicare and Medicaid Services. The Rural Health Clinic was found to be in substantial compliance with Conditions of Coverage, in 42 CFR, Part 491., Subpart A. and Emergency Preparedness Requirements for CAH at 485.625., for hospital based RHC.</p>	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.