

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

August 5, 2019

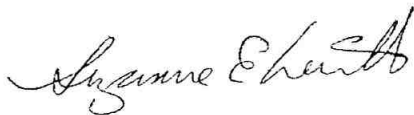
Kristin Barnum, Administrator  
Bayada Home Health Care  
600 Blair Park Road, Suite 300  
Williston, VT 05495-7589

Provider #: 477019

Dear Ms. Barnum:

The Division of Licensing and Protection conducted an onsite federal complaint investigation on **July 29, 2019**. The purpose of the investigation was to determine if your facility was in compliance with Federal participation requirements of the Medicare/Medicaid Program. The investigation was completed on **July 29, 2019** and there were no regulatory violations related to the complaint allegations.

Sincerely,



Suzanne Leavitt, RN, MS  
State Survey Agency Director  
Assistant Division Director

Enclosure

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

PRINTED: 08/05/2019  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>477019</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b>  <b>07/29/2019</b>
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NAME OF PROVIDER OR SUPPLIER  <b>BAYADA HOME HEALTH CARE</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>600 BLAIR PARK ROAD, SUITE 300 WILLISTON, VT 05495</b>
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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) COMPLETION DATE
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G 000	<p><b>INITIAL COMMENTS</b></p> <p>An unannounced investigation of four Complaints and one Entity Reported Incident was conducted on 7/29/2019 by the Division of Licensing &amp; Protection. No Federal regulatory deficiencies were identified as a result of the investigation.</p>	G 000		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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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.

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August 5, 2019

Ms. Kristin Barnum, Director  
Bayada Home Health Care  
600 Blair Park Road, Suite 300  
Williston, VT 05495-7589

Dear Ms. Barnum:

The Division of Licensing and Protection completed a complaint investigation at your facility on **July 29, 2019**. The purpose of the investigation was to determine if your agency was in compliance with Regulations for the Designation and Operation of Home Health Agencies. There were no regulatory violations as a result of this investigation.

If you have any questions regarding this report, please feel free to contact this office at (802) 241-0480.

Sincerely,



Suzanne Leavitt, RN, MS  
Assistant Division Director  
State Survey Agency Director

Division of Licensing and Protection

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>477019</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>07/29/2019</b>
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H 001	Initial Comments  An unannounced investigation of four Complaints and one Entity Reported Incident was conducted on 7/29/2019 by the Division of Licensing & Protection. No State regulatory deficiencies were identified as a result of the investigation.	H 001		
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Division of Licensing and Protection LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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