



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

April 24, 2023

Mr. Nicholas McCardle
Bayada Home Health Care, Inc.
600 Blair Park Road, Suite 300
Williston, VT 05495

Provider Number: 477019

Dear Mr. McCardle:

On **April 18, 2023**, staff from the Division of Licensing and Protection conducted a complaint investigation survey at Bayada Home Health Care, Inc. The purpose of the survey was to determine if your agency was in compliance with Federal participation requirements for a Home Health Agency participating in the Medicare/Medicaid programs. This survey found that your facility was in substantial compliance with the participation requirements.

Please sign and date the enclosed CMS 2567 and return to our office by **May 4, 2023**. Please keep a copy for your records.

Sincerely,

A handwritten signature in cursive script that reads "Suzanne Leavitt".

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

Enclosure

Bayada Home Health Care, Inc.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 477019	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/18/2023
--	---	--	---

NAME OF PROVIDER OR SUPPLIER Bayada Home Health Care, Inc.	STREET ADDRESS, CITY, STATE, ZIP CODE 600 Blair Park Road, Suite 300 , Williston, Vermont, 05495
--	--

(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
--------------------	--	---------------	---	----------------------

G0000	<p>INITIAL COMMENTS</p> <p>An unannounced onsite investigation of five Complaints and one Facility Reported Incident was conducted by the Division of Licensing and Protection on 4/18/2023. The agency was found to be in substantial compliance as a result of the investigation.</p>	G0000		
-------	--	-------	--	--

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 reverse for further 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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE <i>Division Director</i>	(X6) DATE <i>5-2-23</i>
---	-----------------------------------	----------------------------