

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  
To Report Adult Abuse: (800) 564-1612  
Survey and Certification Fax (802) 241-0343  
Survey and Certification Reporting Line: (888) 700-5330

December 20, 2022

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

**Provider #: 477019**

Dear Mr. McCardle;

The Division of Licensing and Protection completed a survey at your facility on **December 7, 2022**. The purpose of the survey was to determine if your agency was in compliance with State of Vermont Licensing and Operating Rules for Home Health Agencies. This survey found that your facility was in substantial compliance with requirements.

Please sign and date the enclosed CMS 2567 and return to our office by **January 2, 2022**. Please keep a copy for your records.

Sincerely,



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

Enclosure

Vermont State Department of Health

<b>STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS</b>		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: <b>477019</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED <b>12/07/2022</b>
NAME OF PROVIDER OR SUPPLIER <b>BAYADA HOME HEALTH CARE INC</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>600 BLAIR PARK ROAD, SUITE 300 , WILLISTON, Vermont, 05495</b>	
(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
H0001	Initial Comments  An unannounced onsite recertification survey based on the Regulations for the Designation of Home Health Agencies was conducted by the Division of Licensing & Protection on 12/5 - 12/7/2022. There were no regulatory findings.	H0001		

Office of Primary Care and Health Systems Management

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