

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

1/11/2023

Ms. Andrea Patrick-Baudet  
Franklin County Home Health Agency  
3 Home Health Circle, Suite 1  
St. Albans, VT 05478

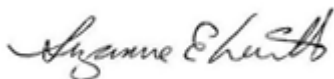
Provider Number: 477016

Dear Ms. Patrick-Baudet:

On **November 16, 2022** staff from the Division of Licensing and Protection conducted an investigation survey at Franklin County Home Health. 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 **January 21, 2023**. Please keep a copy for your records.

Sincerely,



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

Enclosure

<b>STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS</b>		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: <b>477016</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED <b>11/16/2022</b>
NAME OF PROVIDER OR SUPPLIER <b>FRANKLIN COUNTY HHA</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>3 HOME HEALTH CIRCLE SUITE 1 , ST ALBANS, Vermont, 05478</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
G0000	<p>INITIAL COMMENTS</p> <p>An unannounced onsite survey was conducted on 11/16/2022 by the Division of Licensing and Protection. There were no regulatory deficiencies identified as a result of this survey.</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	(X6) DATE
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