



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

May 2, 2023

Ms. Kathleen Demars, Director
Lamoille Home Health & Hospice
54 Farr Avenue
Morrisville, VT 05661

Dear Ms. Demars:

The Division of Licensing and Protection completed a survey at your facility on **April 26, 2023**. The purpose of the survey was to determine if your agency was in compliance with the 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 **May 12, 2023**. Please keep a copy for your records.

Sincerely,

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

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

Enclosure

Vermont State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 477015	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/26/2023
NAME OF PROVIDER OR SUPPLIER Lamoille Home Health & Hospice			STREET ADDRESS, CITY, STATE, ZIP CODE 54 Farr Avenue , Morrisville, Vermont, 05661	
(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 on-site State Re-Licensure Survey was conducted, in conjunction with a Federal Recertification Survey, on 4/24-26/2023. The agency was found to be in substantial compliance with State Regulations as a result of the survey.	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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