VERMONT

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

August 24, 2018

Mr. Ron Cioffi, Director
Rutland Area Visiting Nurse Association & Hospice
7 Albert Cree
Rutland, VT 05701-4648

Provider Number: 477007

Dear Mr. Cioffi:

On **August 14, 2018** staff from the Division of Licensing and Protection conducted an investigation at Rutland Area Visiting Nurse Association and Hospice. 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 **September 3, 2018**. Please keep a copy for your records.

Sincerely,

Suzanne E. Leavitt RN, MS

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

Enclosure

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	477007	A. BUILDING _____ B. WING _____	C 08/14/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RUTLAND AREA VISITING NURSE ASSOCIATION & HOSPICE	7 ALBERT CREE RUTLAND, VT 05701

(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
G 000	INITIAL COMMENTS An unannounced, on-site complaint investigation was conducted by the Division of Licensing and Protection on 8/14/2018. There were no federal regulatory issues identified at this time.	G 000		

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

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.