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

July 3, 2019

Ms. Judy Peterson, Director
Uvmhn Home Health And Hospice
1110 Prim Road
Colchester, VT 05446-6405

Dear Ms. Peterson:

The Division of Licensing and Protection completed a complaint investigation at your facility on **June 24, 2019**. 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. There were no federal regulatory violations as a result of this investigation.

If you have any questions regarding this report, please feel free to contact this office at (802) 241-0480.

Sincerely,

Suzanne E. Leavitt RN, MS

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

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 477000 | A. BUILDING _____ B. WING _____ | C 06/24/2019 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| UVMHN HOME HEALTH AND HOSPICE | 1110 PRIM ROAD COLCHESTER, VT 05446 |

| (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<br><br>An unannounced onsite complaint investigation was conducted by the Division of Licensing and Protection on 6/24/19. There were no Federal regulatory deficiencies identified. | 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.