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

September 27, 2018

Ed Smith, A.S.R.T.
Director of Operations - Northeast Region
Mobilexusa
20 Technology Drive
North Green Village, Suite M-3
Brattleboro, VT 05301

Proivder ID #: 47X0009801

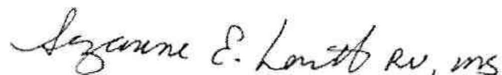
Dear Mr Smith:

The Division of Licensing and Protection completed a survey of the supplier MobileUSA on **September 20, 2018**. The purpose of the survey was to determine if the supplier was in compliance with the Portable X-Ray Conditions for Coverage 486.100 through 486.110. This survey found that the supplier was in substantial compliance with the participation requirements.

Congratulations!

Please sign the enclosed CMS-2567 and return to this office by **October 7, 2018**.

Sincerely,



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

Enc.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	47X0009801	A. BUILDING ______ B. WING ______	**09/20/2018**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOBILEXUSA	**20 TECHNOLOGY DRIVE** **BRATTLEBORO, VT 05301**

(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
H 000	INITIAL COMMENTS A recertification survey was conducted by the Division of Licensing and Protection on 9/20/18. The supplier was in substantial compliance with the Conditions for Coverage for Portable X-rays 486.100 through 486.110.	H 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.