

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 17, 2017

Mr. John Lippmann,  
North Country Primary Care Newport  
186 Medical Village Drive  
Newport, VT 05855-9326

Provider ID #: 473979

Dear Mr. Lippmann:

The Division of Licensing and Protection completed a survey at your facility on **August 14, 2017**. The purpose of the survey was to determine if your facility was in compliance with Federal participation requirements for nursing homes participating in the Medicare/Medicaid programs. This survey found that your facility was in substantial compliance with the participation requirements.

Congratulations to you and your staff.

Sincerely,



Pamela M. Cota, RN  
Licensing Chief

Enclosure



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

PRINTED: 08/17/2017  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  473979	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  08/14/2017
NAME OF PROVIDER OR SUPPLIER  NORTH COUNTRY PRIMARY CARE NEWPORT		STREET ADDRESS, CITY, STATE, ZIP CODE 186 MEDICAL VILLAGE DRIVE NEWPORT, VT 05855		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PRDVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
J 000	INITIAL COMMENTS  A recertification survey was completed on 8/14/17 by the Vermont Division of Licensing and Protection, as authorized by the Centers for Medicare and Medicaid Services. The Rural Health Clinic was found to be in substantial compliance with Conditions of Coverage, in 42 CFR, Part 491., Subpart A.	J 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.