

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

June 13, 2017

Lynn Desautels, MT, CPHQ  
Quality Assurance Manager  
Richford Health Center  
44 Main Street, Suite 200  
Richford, VT 05476

Provider #: 471807

Dear Ms. Desautels:

The Division of Licensing and Protection conducted an onsite complaint investigation on **June 8, 2017**. The purpose of the investigation was to determine if your facility was in compliance with Federal participation requirements of the Medicare/Medicaid Program. The investigation was completed on **June 8, 2017** and there were no regulatory violations related to the complaint allegations.

Sincerely,



Pamela M. Cota, RN  
Licensing Chief

Enclosure



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

PRINTED: 06/13/2017  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>471807</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>06/08/2017</b>
NAME OF PROVIDER OR SUPPLIER  <b>RICHFORD HEALTH CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>44 MAIN STREET, SUITE 200</b> <b>RICHFORD, VT 05476</b>		
(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
J 000	INITIAL COMMENTS		J 000		
	<p>An announced on-site survey was completed on 6/8/17 by staff from the Vermont Division of Licensing and Protection. The purpose of the survey was to investigate a complaint regarding patient quality of care and services to assure compliance with regulatory requirements (Centers for Medicare and Medicaid Services) for Federally Qualified Healthcare Centers (FQHC).</p>				

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.