

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

March 9, 2017

Attn: Administrator/Office Manager
St Johnsbury Family Health Ctr
185 Sherman Drive, Suite 1
Saint Johnsbury, VT 05819-9811

Provider #: 471808

Dear Administrator/Office Manager :

The Division of Licensing and Protection conducted an onsite complaint investigation on **March 1, 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 **March 1, 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: 03/09/2017
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 471808	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 03/01/2017
NAME OF PROVIDER OR SUPPLIER ST JOHNSBURY FAMILY HEALTH CTR			STREET ADDRESS, CITY, STATE, ZIP CODE 185 SHERMAN DRIVE, SUITE 1 SAINT JOHNSBURY, VT 05819		
(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	<p>INITIAL COMMENTS</p> <p>An unannounced on-site survey was conducted by the Vermont Division of Licensing and Protection, as authorized by the Centers for Medicare and Medicaid Services, on 3/1/17. The purpose of the survey was to investigate a complaint related to maintenance of confidentiality of patient protected health information. There were no regulatory violations found and the complaint was unsubstantiated.</p>	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.