



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

August 28, 2019

Deborah Wesley, Director
Addison County Home Health & Hospice Inc
Po Box 754
Middlebury, VT 05753-0754

Dear Ms. Wesley:

The Division of Licensing and Protection completed an investigation at your facility on **August 7, 2019**. The purpose of the survey was to determine if your agency was in compliance with State of Vermont Licensing and Operating Rules for Home Health Agencies. This survey found that your facility was in substantial compliance with requirements.

Please sign and date the enclosed CMS 2567 and return to our office by **September 7, 2019**. Please keep a copy for your records.

Sincerely,

A handwritten signature in cursive script that reads "Suzanne E. Leavitt RN, MS".

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

Enclosure

Division of Licensing and Protection

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: VT477014	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 08/07/2019
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NAME OF PROVIDER OR SUPPLIER ADDISON COUNTY HOME HEALTH & HOSPICE	STREET ADDRESS, CITY, STATE, ZIP CODE PO BOX 754 MIDDLEBURY, VT 05753
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(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) COMPLETE DATE
H 001	<p>Initial Comments</p> <p>An unannounced onsite investigation of a complaint was conducted by the Division of Licensing & Protection on 8/7/19. There no State regulatory deficiencies identified as a result of the investigation.</p>	H 001		

Division of Licensing and Protection
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____