



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

To Report Adult Abuse: (800) 564-1612

Survey and Certification Fax (802) 241-0343

Survey and Certification Reporting Line: (888) 700-5330

March 12, 2019

Ms. Sandy Rousse, Director  
Central Vermont Home Health & Hospice  
600 Granger Road  
Barre, VT 05641-5369

Dear Ms. Rousse:

The Division of Licensing and Protection completed a complaint investigation at your facility on **February 25, 2019**. The purpose of the investigation was to determine if your agency was in compliance with Regulations for the Designation and Operation of Home Health Agencies. There were no regulatory violations as a result of this investigation.

If you have any questions regarding this report, please feel free to contact this office at (802) 241-0480.

Sincerely,

A handwritten signature in black ink that reads "Suzanne E. Leavitt RN, MS".

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

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

PRINTED: 03/12/2019  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>471505</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>02/25/2019</b>
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NAME OF PROVIDER OR SUPPLIER  <b>CENTRAL VERMONT HOME HEALTH &amp; HOSPICE</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>600 GRANGER ROAD</b> <b>BARRE, VT 05641</b>
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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) COMPLETION DATE
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L 000	<p><b>INITIAL COMMENTS</b></p> <p>An unannounced, on-site complaint investigation was conducted by the Division of Licensing and Protection on 2/25/2019. No regulatory violations were identified at this time.</p>	L 000		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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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.