

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

January 14, 2021

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

Provider Number: 477003

Dear Ms. Rouse:

On **January 6, 2021** staff from the Division of Licensing and Protection conducted a complaint investigation survey at Central Vermont Home Health & Hospice, Inc. The purpose of the survey was to determine if your agency was in compliance with Federal participation requirements for a Home Health Agency participating in the Medicare/Medicaid programs. This survey found that your facility was in substantial compliance with the participation requirements.

Sincerely,



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

Enclosure

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

PRINTED: 01/14/2021  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>477003</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>01/06/2021</b>
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>		
(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	
G 000	INITIAL COMMENTS  An unannounced onsite investigation into three complaints was conducted by the Division of Licensing and Protection on 1/5/2021, and completed on 1/6/2021. There were no findings under the federal regulations.	G 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.