



**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

Survey and Certification Fax (802) 241-0343

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

To Report Adult Abuse: (800) 564-1612

May 16, 2024

Mr. Joseph Woodin, CEO  
Copley Hospital  
528 Washington Highway  
Morrisville, VT 05661

Dear Mr. Woodin:

The Division of Licensing and Protection completed a complaint investigation at your facility on **May 15, 2024**. The purpose of the survey was to determine if your facility met the conditions of participation for Critical Access Hospitals found in 42 CFR Part 485, Subpart F including the special requirements for swing bed providers. This survey found that your facility was in substantial compliance with the participation requirements.

Please **sign the enclosed CMS-2567 and return** to this office by **May 26, 2024**.

Sincerely,

A handwritten signature in cursive script that reads "Suzanne Leavitt".

Suzanne Leavitt, RN, MS  
State Survey Agency Director  
Assistant Director, Division of Licensing & Protection

Encl

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

PRINTED: 05/16/2024  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>471305</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>05/15/2024</b>
NAME OF PROVIDER OR SUPPLIER  <b>COPLEY HOSPITAL</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>528 WASHINGTON HIGHWAY</b> <b>MORRISVILLE, VT 05661</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	
C 000	INITIAL COMMENTS  An unannounced on-site complaint investigation of complaint #22717 was conducted by the Division of Licensing and Protection on 5/15/24 at Copley Hospital to determine compliance with 42 CFR Part 482 Part 485 Subpart F Conditions of Participation for Critical Access Hospitals. No regulatory violations identified.	C 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.