



AGENCY OF HUMAN SERVICES  
Division of Licensing and Protection

DEPARTMENT OF DISABILITIES, AGING AND INDEPENDENT LIVING  
102 South 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

December 2, 2019

Richard Wrase, Manager  
Hilltop Recovery Residence  
94 Westminster Terrace  
Bellows Falls, VT 05101

Dear Mr. Wrase:

Thank you for the cooperation you gave our surveyor during the **November 25, 2019** annual survey of your facility.

Enclosed is the Residential Care Home Survey Statement indicating that your facility is in substantial compliance with the current regulatory requirements. Congratulations to you and your staff.

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

Sincerely,

A handwritten signature in cursive script that reads "Pamela Cota RN".

Pamela Cota, RN  
Licensing Chief

Division of Licensing and Protection

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>0604</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>11/25/2019</b>
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NAME OF PROVIDER OR SUPPLIER  <b>HILLTOP RECOVERY RESIDENCE</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>94 WESTMINSTER TERRACE BELLOWS FALLS, VT 05101</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) COMPLETE DATE
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R100	<p>Initial Comments:</p> <p>An unannounced on-site recertification survey was completed by the Division of Licensing and Protection on 11/25/2019. The facility was found to be in substantial compliance with regulatory requirements.</p>	R100		
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Division of Licensing and Protection  
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE \_\_\_\_\_ TITLE \_\_\_\_\_ (X6) DATE \_\_\_\_\_