



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 30, 2019

Ms. Diana Lafountain, Administrator
Pines Rehab & Health Ctr
601 Red Village Road
Lyndonville, VT 05851-9068

Provider ID #: 475044

Dear Ms. Lafountain:

On **May 29, 2019**, the Division of Fire Safety conducted a revisit to the Life Safety Code survey of **April 17, 2019** to verify that your facility had achieved substantial compliance. Based on the revisit, it was found that your facility has corrected all tags that were cited as part of the April 17, 2019, fire safety survey.

If you have any questions concerning this letter please contact me at (802) 241-0480.

Sincerely,

A handwritten signature in black ink that reads "Pamela Cota RN". The signature is fluid and cursive.

Pamela Cota, RN
Licensing Chief

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

PRINTED: 05/30/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 475044	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED R 05/29/2019
--	---	---	---

NAME OF PROVIDER OR SUPPLIER PINES REHAB & HEALTH CTR	STREET ADDRESS, CITY, STATE, ZIP CODE 601 RED VILLAGE ROAD LYNDONVILLE, VT 05851
---	--

(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
--------------------	--	---------------	---	----------------------

{K 000}	<p>INITIAL COMMENTS</p> <p>The Division of Fire Safety conducted an unannounced, onsite revisit survey at the facility on the date indicated in the upper right hand corner of this form. The violation(s) previously identified have been corrected.</p>	{K 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.