



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

June 5, 2023

Ms. Christine Werneke, Administrator
UVMHN Home Health and Hospice
1110 Prim Road, Suite 1
Colchester, VT 05446

Provider Number: 477000

Dear Ms. Werneke:

On **May 31, 2023**, staff from the Division of Licensing and Protection conducted an investigation survey at UVMHN Home Health and Hospice. 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.

Please sign and date the enclosed CMS 2567 and return to our office by **June 15, 2023**. Please note that this is a corrected Statement of Deficiencies. Please keep a copy for your records.

Sincerely,

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

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

Enclosure

UVMHN Home Health and Hospice

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 477000	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 05/31/2023
NAME OF PROVIDER OR SUPPLIER UVMHN Home Health And Hospice			STREET ADDRESS, CITY, STATE, ZIP CODE 1110 Prim Road, Suite 1 , Colchester, Vermont, 05446	
(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
G0000	<p>INITIAL COMMENTS</p> <p>An unannounced onsite investigation of a Complaint was conducted by the Division of Licensing & Protection on 5/31/2023. There were no regulatory deficiencies identified related to the investigation and the agency was found to be in substantial compliance with the applicable Home Health regulations.</p>	G0000		

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 reverse for further 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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Christie W...</i>	TITLE <i>President & COO</i>	(X6) DATE <i>6/7/2023</i>
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