VERMONT

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

July 11, 2024

Ms. Sara King, Director
VNA & Hospice of Southwest Region, Inc.
335 Main Street 104 Office C
Bennington, VT 05201

Provider Number: 471507

Dear Ms. King:

On **July 3, 2024**, staff from the Division of Licensing and Protection conducted a complaint investigation at VNA & Hospice of Southwest Region, Inc. The purpose of the investigation 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 **July 21, 2024**. Please keep a copy for your records.

Sincerely,

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

Enclosure

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 471507	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VNA & Hospice Of Southwest Region, Inc.	**335 Main Street 104 Office C , Bennington, Vermont, 05201**

(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
L0000	INITIAL COMMENTS An unannounced on-site complaint investigation was conducted by the Division of Licensing & Protection on 7/1/24 and completed on 7/3/24. As a result of the investigation, no regulatory violations were identified.	L0000		

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	TITLE	(X6) DATE