

Division of Licensing and Protection  
103 South Main Street, Ladd Hall  
Waterbury VT 05671-2306  
<http://www.dail.vermont.gov>  
Voice/TTY (802) 871-3317  
To Report Adult Abuse: (800) 564-1612  
Fax (802) 871-3318

December 26, 2012

Isabelle Sargeant  
Newport Dialysis Satellite  
1 Prospect Street  
Burlington, VT 05401

Re: 473504

Dear Ms. Sargeant:

Thank you for your cooperation with our surveyor during the recent survey of the End Stage Renal Dialysis unit (ESRD) at the North Country Dialysis Satellite on December 18, 2012. The survey determined the entity to be in substantial compliance with Conditions of Participation for 42 CFR Part 405.2150. Please sign the enclosed CMS-2567 and return them to this office no later than **January 5, 2013**.

If you have any questions regarding the enclosed, please feel free to call this office.

Sincerely,



Frances L. Keeler, RN, MSN, DBA  
Assistant Division Director  
Director State Survey Agency

Enclosure

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

PRINTED: 03/28/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>473504</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>12/18/2012</b>
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NAME OF PROVIDER OR SUPPLIER  <b>NORTH COUNTRY DIALYSIS UNIT</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>189 PROUTY DRIVE NEWPORT, VT 05855</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) COMPLETION DATE
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V 000	<p><b>INITIAL COMMENTS</b></p> <p>An unannounced recertification survey was conducted by the Division of Licensing and Protection on 12/17/12 - 12/18/12. The facility was found to be in substantial compliance with 42 Code of Federal Regulations, Part 494, Conditions of Coverage for End-stage Renal Disease Services.</p>	V 000		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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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.