

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

April 9, 2014

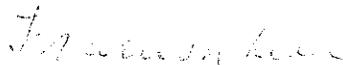
Roger Deshanes, Administrator
Fletcher Allen Health Care - S
160 Allen St
Rutland, VT 05701

Provider #: 473501

Dear Mr. Deshanes:

The Division of Licensing and Protection conducted an onsite complaint investigation on **April 7, 2014**. The purpose of the investigation was to determine if your facility was in compliance with Conditions of Participation for 42 CFR Part 405.2150. The investigation was completed on **April 7, 2014** and there were no regulatory violations related to the complaint allegations.

Sincerely,



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

FK:jl

CC: Carol Muzzy, Regulatory Director, FAHC

Enclosure

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

PRINTED: 04/09/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 473501	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 04/07/2014
NAME OF PROVIDER OR SUPPLIER FLETCHER ALLEN HEALTH CARE - S		STREET ADDRESS, CITY, STATE, ZIP CODE 160 ALLEN ST RUTLAND, VT 05701		
(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
V 000	<p>INITIAL COMMENTS</p> <p>An unannounced on-site complaint survey was conducted by the Division of Licensing and Protection on 4/7/14. Complaint # 011325 was investigated to determine compliance with 42 Code of Federal Regulations part 405, subpart U, Conditions for Coverage for End Stage Renal Disease Services. No regulatory violations were identified.</p>	V 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.