

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

February 16, 2012

Roger Deshaies
Fletcher Allen Health Care - St. Albans
7 Crest Rd Ste 78
Saint Albans, VT 05478

Dear Mr. Deshaies:

Thank you for your cooperation with our surveyor during the recent survey of the End Stage Renal Dialysis unit (ESRD) at Fletcher Allen Health Care on February 14, 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 **February 26, 2012**.

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

Sincerely,



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

Enclosure

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

PRINTED: 03/27/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 473502	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/14/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER FLETCHER ALLEN HEALTH CARE - S	STREET ADDRESS, CITY, STATE, ZIP CODE 7 CREST RD STE 78 SAINT ALBANS, VT 05478
---	--

(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>The facility was found to be in substantial compliance with 42 Code of Federal Regulations, Part 405, Subpart U, Conditions of Coverage for End-stage Renal Disease Services.</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.