



DEPARTMENT OF DISABILITIES, AGING AND INDEPENDENT LIVING

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

June 4, 2014

Ms. Treny Burgess  
Caledonia Home Health Care  
161 Sherman Drive  
Saint Johnsbury, VT 05819-1146

Dear Ms. Burgess:

The Division of Licensing and Protection completed a complaint investigation at your facility on **May 19, 2014**. The purpose of the investigation was to determine if your agency was in compliance with Regulations for the Designation and Operation of Home Health Agencies. There were no regulatory violations as a result of this investigation.

If you have any questions regarding this report, please feel free to contact this office at (802) 871-3317.

Sincerely,

A handwritten signature in cursive script that reads "Frances L. Keeler".

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

FK:jl

Division of Licensing and Protection

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>VT477010</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>05/19/2014</b>
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NAME OF PROVIDER OR SUPPLIER  <b>CALEDONIA HOME HEALTH CARE</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>161 SHERMAN DRIVE SAINT JOHNSBURY, VT 05819</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) COMPLETE DATE
H 001	Initial Comments  An unannounced onsite complaint investigation was conducted by the Division of Licensing and Protection on 5/19/14. There were no findings under the State Designation regulations.	H 001		

Division of Licensing and Protection  
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE \_\_\_\_\_ TITLE \_\_\_\_\_ (X6) DATE \_\_\_\_\_