

Division of Licensing and Protection

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>VT477016</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>11/01/2012</b>
NAME OF PROVIDER OR SUPPLIER  <b>FRANKLIN COUNTY HHA</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>3 HOME HEALTH CIRCLE SUITE 1 ST ALBANS, VT 05478</b>		
(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 SS=D	Initial Comments  An unannounced on-site complaint investigation was conducted on 10/29/12 and completed on 11/01/12 by the Division of Licensing and Protection. There were no regulatory findings for the Designation and Operation of Home Health Agencies.	H 001		

Division of Licensing and Protection

TITLE

(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE