

---

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

September 18, 2013

Janet McCarthy, Administrator  
Franklin County Home Health & Hospice  
3 Home Health Circle Suite 1  
Saint Albans, VT 05478

Provider #: 471501

Dear Ms. McCarthy:

The Division of Licensing and Protection conducted an onsite complaint investigation on **September 11, 2013**. The purpose of the investigation was to determine if your facility was in compliance with Federal participation requirements of the Medicare/Medicaid Program. The investigation was completed on **September 11, 2013** and there were no regulatory violations related to the complaint allegations.

Sincerely,



Pamela M. Cota, RN  
Licensing Chief

PC:jl

Enclosure

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

PRINTED: 09/18/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>471501</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>09/11/2013</b>
NAME OF PROVIDER OR SUPPLIER  <b>FRANKLIN COUNTY HOME HEALTH &amp; HOSPICE</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>3 HOME HEALTH CIRCLE SUITE 1 SAINT 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) COMPLETION DATE
L 000	<p><b>INITIAL COMMENTS</b></p> <p>An unannounced, on-site complaint investigation was conducted by the Division of Licensing and Protection on 09/11/2013. There were no findings that rose to the level of federal deficiencies.</p>	L 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.