

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

February 20, 2014

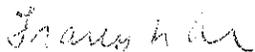
Janet McCarthy, Administrator
Franklin County HHA
3 Home Health Circle Suite 1
St Albans, VT 05478-9737

Provider #: 477016

Dear Ms. McCarthy:

The Division of Licensing and Protection conducted an onsite complaint investigation on **February 10, 2014**. The purpose of the investigation was to determine if your facility was in compliance with Federal participation requirements of the Medicare/Medicaid Program and State Regulations for the Designation and Operation of Home Health Agencies. The investigation was completed on **February 11, 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

Enclosure

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

PRINTED: 02/20/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 477016	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/11/2014
NAME OF PROVIDER OR SUPPLIER FRANKLIN COUNTY HHA			STREET ADDRESS, CITY, STATE, ZIP CODE 3 HOME HEALTH CIRCLE SUITE 1 ST 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	PRDVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
G 000	INITIAL COMMENTS An unannounced onsite investigation into multiple self-reported incidents and complaints was conducted by the Division of Licensing and Protection from 2/10- 2/11/14. There were no federal regulatory findings.	G 000			

LABDRATORY 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.

Division of Licensing and Protection

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: VT477016	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 02/11/2014
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NAME OF PROVIDER OR SUPPLIER FRANKLIN COUNTY HHA	STREET ADDRESS, CITY, STATE, ZIP CODE 3 HOME HEALTH CIRCLE SUITE 1 ST ALBANS, VT 05478
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H 001	Initial Comments An unannounced onsite investigation into multiple self-reported incidents and complaints was conducted by the Division of Licensing and Protection from 2/10- 2/11/14. There were no state regulatory findings.	H 001		
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Division of Licensing and Protection
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