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DEPARTMENT OF DISABILITIES, AGING AND INDEPENDENT LIVINGDivision of Licensing and Protection

103 South Main Street

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

May 21, 2015

Robin Frasier, Director  
VNA & Hospice Of SVHC  
1128 Monument Avenue  
Bennington, VT 05201

Provider Number: 477017

Dear Ms. Frasier:

On **May 20, 2015** staff from the Division of Licensing and Protection conducted a validation survey at Southwestern Vermont Medical Center, Inc.. The purpose of the survey was to determine if your agency was in compliance with Federal participation requirements for a Home Health Agency participating in the Medicare/Medicaid programs. This survey found that your facility was in substantial compliance with the participation requirements.

Please sign and date the enclosed CMS 2567 and return to our office by **May 31, 2015**. Please keep a copy for your records.

Sincerely,



Suzanne Leavitt, RN, MS  
Assistant Division Director  
Director State Survey Agency

Enclosure

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

PRINTED: 05/21/2015  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>477017</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>05/20/2015</b>
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NAME OF PROVIDER OR SUPPLIER  <b>VNA &amp; HOSPICE OF SVHC</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>1128 MONUMENT AVENUE BENNINGTON, VT 05201</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) COMPLETION DATE
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G 000	<p><b>INITIAL COMMENTS</b></p> <p>An unannounced on-site self report investigation was conducted on 05/20/15 by the Division of Licensing and Protection. There were no Federal regulatory findings.</p>	G 000		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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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.