

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

April 8, 2014

Judy Peterson, Administrator
Visiting Nurse Association
1110 Prim Road
Colchester, VT 05446-6405

Provider #: 477000

Dear Ms. Peterson:

The Division of Licensing and Protection conducted an onsite complaint investigation on **March 17, 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 **March 17, 2014** 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: 04/08/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 477000	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 03/17/2014
--	--	--	---

NAME OF PRDVIDER OR SUPPLIER VISITING NURSE ASSOCIATION	STREET ADDRESS, CITY, STATE, ZIP CODE 1110 PRIM ROAD COLCHESTER, VT 05446
--	---

(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
--------------------	--	---------------	---	----------------------

G 000	<p>INITIAL COMMENTS</p> <p>An unannounced onsite investigation into a self-reported incident and a complaint was conducted by the Division of Licensing and Protection on 3/17/14. There were no federal regulatory violations identified.</p>	G 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.

Division of Licensing and Protection

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIDN	(X1) PRDVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: VT477000	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 03/17/2014
--	--	---	---

NAME OF PROVIDER OR SUPPLIER VISITING NURSE ASSOCIATION	STREET ADDRESS, CITY, STATE, ZIP CODE 1110 PRIM ROAD COLCHESTER, VT 05446
--	---

(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 investigation into a self-reported incident and a complaint was conducted by the Division of Licensing and Protection on 3/17/14. There were no state regulatory violations identified as a result.	H 001		

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