

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

December 24, 2013

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 **December 16, 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 **December 17, 2013** 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: 12/24/2013
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 12/17/2013
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) COMPLETION DATE
G 000	INITIAL COMMENTS An unannounced, on-site complaint investigation was conducted by the Division of Licensing and Protection from 12/16-12/17/2013. There were no federal regulatory deficiencies identified.	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.

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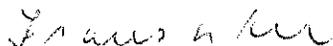
Judy Peterson, Administrator
Visiting Nurse Association
1110 Prim Road
Colchester, VT 05446-6405

Provider #: 477000

Dear Ms. Peterson:

The Division of Licensing and Protection conducted an onsite complaint investigation on **December 16, 2013**. The purpose of the investigation was to determine if your facility was in compliance with State Regulations for the Designation and Operation of Home Health Agencies. The investigation was completed on **December 17, 2013** 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

Division of Licensing and Protection

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: VT477000	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 12/17/2013
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NAME OF PROVIDER OR SUPPLIER VISITING NURSE ASSOCIATION	STREET ADDRESS, CITY, STATE, ZIP CODE 1110 PRIM ROAD COLCHESTER, VT 05446
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H 001	<p>Initial Comments</p> <p>An unannounced, on-site complaint investigation was conducted by the Division of Licensing and Protection on 12/16-12/17/2013. There were no state regulatory deficiencies identified.</p>	H 001		

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