

Division 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

December 29, 2015

Mr. Robert Simpson, Administrator
Brattleboro Retreat
Anna Marsh Lane PO Box 803
Brattleboro, VT 05301-0803

Provider ID #: 474001

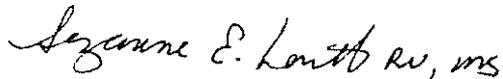
Dear Mr. Simpson:

The Department of Public Safety completed a Life Safety Code Survey at your facility on November 18, 2015. This survey found your facility to be in Substantial Compliance with all Fire Safety and ANSI standards.

Enclosed is the Deficiency Summary Sheet, Form CMS-2567, which requires your signature in accordance with instructions noted on the form. Please return the form to this office no later than **January 8, 2016**.

If you have any questions regarding this report, please do not hesitate to contact me.

Sincerely,



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

Enclosure



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

PRINTED: 12/28/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 474001	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - MAIN BUILDING B. WING _____	(X3) DATE SURVEY COMPLETED 11/18/2015
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NAME OF PROVIDER OR SUPPLIER BRATTLEBORO RETREAT	STREET ADDRESS, CITY, STATE, ZIP CODE ANNA MARSH LANE PO BOX 803 BRATTLEBORO, VT 05301
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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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K 000	INITIAL COMMENTS An unannounced onsite Life Safety Code inspection was completed by the Division of Fire Safety on 11/17/15. The facility was found to be in substantial compliance with applicable Life Safety Code requirements.	K 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.