

## 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 3, 2014

Sandy Rouse, Administrator  
Central Vermont Home Health & Hospice  
600 Granger Road  
Barre, VT 05641-5369

Provider #: 477003

Dear Ms. Rouse:

The Division of Licensing and Protection conducted an onsite complaint investigation on **January 21, 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 **January 21, 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: 02/03/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>477003</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b>  <b>01/21/2014</b>
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NAME OF PROVIDER OR SUPPLIER  <b>CENTRAL VERMONT HOME HEALTH &amp; HOSPICE</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>600 GRANGER ROAD</b> <b>BARRE, VT 05641</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 onsite investigation into a self-reported incident was conducted by the Division of Licensing and Protection on 1/21/14. There were no regulatory findings identified.</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.

Division of Licensing and Protection

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NAME OF PROVIDER OR SUPPLIER  <b>CENTRAL VERMONT HOME HEALTH &amp; HOSPI</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>600 GRANGER ROAD BARRE, VT 05641</b>
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H 001	Initial Comments  An unannounced onsite investigation into a self-reported incident was conducted by the Division of Licensing and Protection on 1/21/14. There were no regulatory violations identified.	H 001		
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Division of Licensing and Protection LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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