

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

July 12, 2013

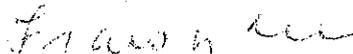
Mr. Melvyn Patashnick, Administrator  
Copley Hospital  
528 Washington Highway  
Morrisville, VT 05661

Dear Mr. Patashnick:

The Division of Licensing and Protection completed a survey at your facility on **July 10, 2013**. The purpose of the survey was to determine if your facility met the conditions of participation for Critical Access Hospitals found in 42 CFR Part 485, Subpart F including the special requirements for swing bed providers. This survey found that your facility was in substantial compliance with the participation requirements.

Please **sign the enclosed CMS-2567 and return** to this office by **July 22, 2013**.

Sincerely,



Frances L. Keeler, RN, MSN, DBA  
Assistant Division Director  
Director State Survey Agency

FK:jl

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

PRINTED: 09/04/2015  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>471305</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>07/10/2013</b>
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NAME OF PROVIDER OR SUPPLIER  <b>COPLEY HOSPITAL</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>528 WASHINGTON HIGHWAY</b> <b>MORRISVILLE, VT 05661</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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C 000	<p><b>INITIAL COMMENTS</b></p> <p>An unannounced on-site complaint investigation was conducted by the Division of Licensing and Protection on 7/9 -7/10/13. There were no regulatory findings.</p>	C 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.