



AGENCY OF HUMAN SERVICES
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

October 14, 2013

Coleen Kohaut, Administrator
Holiday House Residential Care Home
642 Sheldon Road
Saint Albans, VT 05478

Provider #:

Dear . Kohaut:

The Division of Licensing and Protection conducted an onsite complaint investigation on **April 10, 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 **April 10, 2013** and there were no regulatory violations related to the complaint allegations.

Sincerely,

A handwritten signature in black ink that reads "Pamela M. Cota RN". The signature is written in a cursive style.

Pamela M. Cota, RN
Licensing Chief

Enclosure

Division of Licensing and Protection

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0541	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 04/10/2013
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NAME OF PROVIDER OR SUPPLIER HOLIDAY HOUSE RESIDENTIAL CARE HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 642 SHELDON ROAD SAINT ALBANS, VT 05478
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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) COMPLETE DATE
R100	<p>Initial Comments:</p> <p>An unannounced onsite complaint investigation was conducted by the Division of Licensing and Protection on 4/10/13. No regulatory violations related to the allegations were cited.</p>	R100		

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