



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

March 28, 2013

Ms. Linda Phypers, Administrator  
Wake Robin-Linden Nursing Home  
200 Wake Robin Drive  
Shelburne, VT 05482

Dear Ms. Phypers:

Thank you for the cooperation you gave our surveyor during the **March 27, 2013** annual survey of your facility.

Enclosed is the non-Medicare Certified Nursing Home Survey Statement indicating that your facility is in substantial compliance with the Vermont Licensing and Operating Rules for Nursing Homes. Congratulations to you and your staff.

If you have any questions regarding this report, please feel free to contact this office at (802) 871-3317.

Sincerely,

Pamela Cota, RN  
Licensing Chief

PC:jl



Division of Licensing and Protection

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>475056</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>03/27/2013</b>
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NAME OF PROVIDER OR SUPPLIER  <b>WAKE ROBIN-LINDEN NURSING HOME</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>200 WAKE ROBIN DRIVE SHELburnE, VT 05482</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) COMPLETE DATE
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N 001	<p>Initial Comments</p> <p>An unannounced on-site Re-Licensure survey was completed from 3/25/13 to 3/27/13 to determine if the non-Medicare Certified Nursing Home is in compliance with the Vermont Licensing and Operating Rules for Nursing Homes. The survey found that the State-licensed Nursing Home is in substantial compliance with regulations.</p>	N 001		
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Division of Licensing and Protection

TITLE

(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE



VERMONT

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March 28, 2013

Ms. Linda Phypers, Administrator  
Wake Robin-Linden Nursing Home  
200 Wake Robin Drive  
Shelburne, VT 05482

Provider ID #: 475056

Dear Ms. Phypers:

The Division of Licensing and Protection completed a survey at your facility on March 27, 2013. The purpose of the survey was to determine if your facility was in compliance with Federal participation requirements for nursing homes participating in the Medicare/Medicaid programs. This survey found that your facility was in substantial compliance with the participation requirements. Congratulations to you and your staff.

Please sign the enclosed CMS 2567 and return to this office by **April 7, 2013**.

Sincerely,

A handwritten signature in cursive script that reads "Pamela M. Cota RN".

Pamela M. Cota, RN  
Licensing Chief

PC:jl

Enclosure



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

PRINTED: 03/27/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>475056</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>03/27/2013</b>
NAME OF PROVIDER OR SUPPLIER  <b>WAKE ROBIN-LINDEN NURSING HOME</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>200 WAKE ROBIN DRIVE SHELBURNE, VT 05482</b>		
(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	
F 000	INITIAL COMMENTS  An unannounced on-site CMS (Centers for Medicare and Medicaid Services) Recertification survey was conducted in the Medicare Certified Nursing Home from 03/25/13 to 3/27/13. The facility was found to be in substantial compliance with regulatory requirements.	F 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.