

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

December 11, 2013

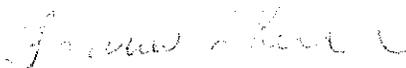
John Brumsted, Administrator
Fletcher Allen Hospital Of Vermont
111 Colchester Ave
Burlington, VT 05401

Dear Dr. Brumsted:

The Division of Licensing and Protection completed a complaint investigation at your facility on **November 26, 2013**. The purpose of the complaint investigation was to determine if your facility met the conditions of participation for Acute Care Hospitals found in 42 CFR Part 482. This complaint investigation found that your facility was in substantial compliance with the participation requirements.

Please sign the enclosed CMS-2567 and return to this office by December 24, 2013 .

Sincerely,



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

FK:jl

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

PRINTED: 12/11/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 470003	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/26/2013
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NAME OF PROVIDER OR SUPPLIER FLETCHER ALLEN HOSPITAL OF VERMONT	STREET ADDRESS, CITY, STATE, ZIP CODE 111 COLCHESTER AVE BURLINGTON, VT 05401
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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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A 000	<p>INITIAL COMMENTS</p> <p>An unannounced on-site investigation was conducted on 11/25/13 and 11/26/13 by the Division of Licensing and Protection, as authorized by the Centers for Medicare and Medicaid Services, to determine compliance with the Conditions of Participation for Emergency Services and Patient Rights. There were no regulatory violations identified related to complaint #10606.</p>	A 000		
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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.