

Division of Licensing and Protection

HC 2 South, 280 State Drive

Waterbury, VT 05671-2060

<http://www.dail.vermont.gov>

Survey and Certification Voice/TTY (802) 241-0480

Survey and Certification Fax (802) 241-0343

Survey and Certification Reporting Line: (888) 700-5330

To Report Adult Abuse: (800) 564-1612

April 1, 2016

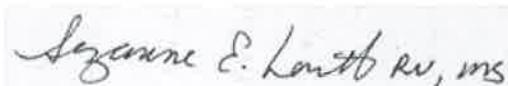
Jill Berry Bowan, Administrator  
Northwestern Medical Center Inc  
133 Fairfield Street  
Saint Albans, VT 05478-1726

Provider #: 470024

Dear Ms. Berry Bowan:

The Division of Licensing and Protection conducted an onsite complaint investigation on **March 29, 2016**. 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 **March 29, 2016** and there were no regulatory violations related to the complaint allegations.

Sincerely,



Suzanne Leavitt, RN, MS  
Assistant Division Director  
Director State Survey Agency



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

PRINTED: 04/01/2016  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>470024</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b>  <b>03/29/2016</b>
NAME OF PROVIDER OR SUPPLIER  <b>NORTHWESTERN MEDICAL CENTER INC</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>133 FAIRFIELD STREET</b> <b>SAINT ALBANS, VT 05478</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	
A 000	INITIAL COMMENTS  An unannounced on-site survey was completed by the Vermont Division of Licensing and Protection on 3/29/16, as authorized by the Federal Centers for Medicare and Medicaid Services. The purpose of the survey was to investigate a hospital complaint. There were no regulatory violations found as a result of the investigation.	A 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.