

Division of Licensing and Protection  
103 South Main Street  
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 22, 2014

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 **October 20, 2014**. 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 **October 21, 2014** and there were no regulatory violations related to the complaint allegations.

Sincerely,



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

Enclosure

FK:kc

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

PRINTED: 10/22/2014  
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>10/21/2014</b>
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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>
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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 CORRECTIDN (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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A 000	<p><b>INITIAL COMMENTS</b></p> <p>An unannounced on-site complaint investigation was conducted by the Division of Licensing and Protection, on 10/20/14 and 10/21/14, as authorized by the Centers for Medicare and Medicaid Services to determine compliance with the Conditions of Participation (CoPs) for Patient Rights and Quality Assessment and Performance Improvement. There were no regulatory violations identified related to complaint #12350.</p>	A 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.