

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

August 28, 2015

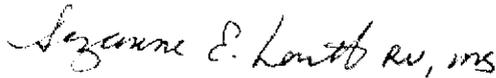
Tom Huebner, Administrator  
Rutland Regional Medical Center  
160 Allen St  
Rutland, VT 05701-4560

Provider #: 470005

Dear Mr. Huebner:

The Division of Licensing and Protection conducted an onsite complaint investigation on **August 20, 2015**. 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 **August 20, 2015** and there were no regulatory violations related to the complaint allegations.

Sincerely,



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

Enclosure

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

PRINTED: 08/28/2015  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>470005</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>08/20/2015</b>
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NAME OF PROVIDER OR SUPPLIER  <b>RUTLAND REGIONAL MEDICAL CENTER</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>160 ALLEN ST</b> <b>RUTLAND, VT 05701</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) COMPLETION DATE
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A 000	<p><b>INITIAL COMMENTS</b></p> <p>An unannounced onsite complaint investigation was conducted on 8/10/15 &amp; 8/11/15 and completed on 8/19/15 by the Division of Licensing and Protection to determine compliance with the Condition of Participation Emergency Services for complaint # 00013671 as authorized by the Center for Medicare and Medicaid. No regulatory violations were identified.</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.