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

December 18, 2020

Anna Noonan, President, COO
Central Vermont Medical Center
Box 547
Barre, VT 05641

Provider ID #: 470001

Dear Ms. Noonan,

On **November 24, 2020**, the Division of Licensing and Protection completed a Complaint Investigation and Infection Control Survey at your facility.

The investigation determined that your facility met the conditions of participation for Acute Care Hospitals found in 42 CFR Part 482. This investigation found that your facility was in substantial compliance with the participation requirements.

In regards to the Infection Control Survey, which was completed to determine if your facility was in compliance with Federal requirements related to implementing proper infection prevention and control practices to prevent the development and transmission of COVID-19, the survey revealed that your facility was in substantial compliance with participation requirements and no deficiencies were cited.

No additional action is required on the facility's part.

Sincerely,

Suzanne Leavitt, RN, MS
State Survey Agency Director
Assistant Director, Division of Licensing & Protection

Encl

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	470001	A. BUILDING _____ B. WING _____	C 11/24/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTRAL VERMONT MEDICAL CENTER	**BOX 547 BARRE, VT 05641**

(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 onsite complaint investigation was conducted by the Division of Licensing and Protection on 11/23/20 and 11/24/20 for Complaint # 19357 as authorized by the Centers for Medicare and Medicaid Services. The Conditions of Participation authorized for review included 482.42 Infection Prevention, Control, ABX Stewardship, 482.23 Nursing Services and 482.55 Emergency Services. The investigation was conducted in conjunction with an on-site Infection Control COVID assessment. There were no regulatory violations identified.	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.