



AGENCY OF HUMAN SERVICES
DEPARTMENT OF DISABILITIES, AGING AND INDEPENDENT LIVING

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

May 9, 2024

Thomas Frank, Administrator
North Country Hospital and Health Center
189 Prouty Drive
Newport, VT 05855

Dear Mr. Frank:

The Division of Licensing and Protection completed an investigation survey at your facility on **April 18, 2024**. The purpose of the survey was to determine if your facility met the conditions of participation for Critical Access Hospitals found in 42 CFR Part 485, Subpart F including the special requirements for swing bed providers. This survey found that your facility was in substantial compliance with the participation requirements.

Please **sign the enclosed CMS-2567 and return** to this office by **May 19, 2024**.

Sincerely,

A handwritten signature in cursive script that reads "Suzanne Leavitt".

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

Encl

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

PRINTED: 05/09/2024
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 471304	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 04/18/2024
NAME OF PROVIDER OR SUPPLIER NORTH COUNTRY HOSPITAL AND HEALTH CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 189 PROUTY DRIVE NEWPORT, VT 05855		
(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	
C 000	INITIAL COMMENTS While the Division of Licensing was on-site, 4/16/24-4/17/24, investigating complaint #22857, they were authorized by the Centers for Medicare and Medicaid on 4/17/24 to review the Condition of Participation: Emergency Services found at 42 CFR Part 485 Subpart F for complaint #22949. The CAH was found to be in substantial compliance with these requirements.	C 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.