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

March 9, 2018

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 **February 26, 2018**. 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 **February 27, 2018** and there were no regulatory violations related to the complaint allegations.

Sincerely,

Pamela M. Cota, RN
Licensing Chief

Enclosure

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 470024 | A. BUILDING _____ B. WING _____ | C 02/27/2018 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **NORTHWESTERN MEDICAL CENTER INC** | **133 FAIRFIELD STREET SAINT ALBANS, VT 05478** |

| (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<br><br>An unannounced on-site complaint investigation was conducted by the Division of Licensing and Protection from 2/26/18 - 2/27/18, as authorized by the Federal Centers for Medicare and Medicaid Services, to determine compliance with the following Conditions of Participation: Patient's Rights, and Quality Assessment and Performance Improvement Program. There were no regulatory violations found related to complaint # 16359. | 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.