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 30, 2020

Claudio Fort, Administrator
Rutland Regional Medical Center
160 Allen St
Rutland, VT 05701-4560

Provider ID #: 470005

Dear Mr. Fort:

On **December 15, 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
	470005	A. BUILDING _____ B. WING _____	C 12/15/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RUTLAND REGIONAL MEDICAL CENTER	**160 ALLEN ST RUTLAND, VT 05701**

(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 on-site investigation of complaints #19172 & #18677 was conducted on 12/14/20 through 12/15/20 by the Division of Licensing and Protection as authorized by the Centers for Medicare and Medicaid to determine compliance with the following Conditions of Participation for Acute Care Hospitals: Patient Rights, Nursing Services, and Discharge Planning. There were no regulatory violations identified for the complaints. In addition to the complaint investigations, a Focused Infection Survey was conducted on 12/14/20 through 12/15/20. The facility was found to be in substantial compliance with the infection control requirements related to COVID-19.	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.