VERMONT

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

October 15, 2018

Thomas Dee, Administrator
Southwestern Vermont Medical Center
100 Hospital Drive
Bennington, VT 05201

Dear Mr. Dee:

The Division of Licensing and Protection completed a complaint investigation at your facility on **October 10, 2018** The purpose of the investigation was to determine if 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.

Please sign the enclosed CMS-2567 and return to this office by October 29, 2018 .

Sincerely,

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

Enc.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	470012	A. BUILDING _____ B. WING _____	C 10/10/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHWESTERN VERMONT MEDICAL CENTER	100 HOSPITAL DRIVE BENNINGTON, VT 05201

(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 for complaint #16980 was conducted on 10/9/18 through 10/10/18 by the Division of Licensing and Protection as authorized by the Centers for Medicare and Medicaid to determine compliance with the Conditions of Participation: Emergency Services. There were no regulatory violations identified for complaint #16980.	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.