
DEPARTMENT OF DISABILITIES, AGING AND INDEPENDENT LIVINGDivision 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

August 22, 2018

Ms. Eileen Whalen, Administrator
University Of Vermont Medical Center
111 Colchester Ave
Burlington, VT 05401

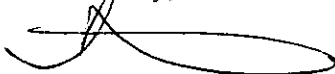
Provider ID #: 470003

Dear Ms. Whalen:

The Division of Licensing and Protection completed a complaint survey at your facility on 8/8/18. The purpose of the survey was to determine if your facility met the conditions of participation for Acute Care Hospitals found in 42 CFR Part 482.

UVMMC was found to be in compliance with the Acute Care Hospital Conditions of Participation. Please sign and return the CMS-2567 form attached.

Sincerely,



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

Enclosure

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

PRINTED: 08/22/2018
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 470003	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 08/08/2018
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NAME OF PROVIDER OR SUPPLIER UNIVERSITY OF VERMONT MEDICAL CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 111 COLCHESTER AVE BURLINGTON, VT 05401
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(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
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A 000 INITIAL COMMENTS

A 000

An unannounced complaint survey was completed 8/8/18 by the Vermont Division of Licensing and Protection, as authorized by the Centers for Medicare and Medicaid Services. The purpose of the investigation was to determine compliance with the following Conditions of Participation: Emergency Services, Radiology, Outpatient Services and Nursing Services. Based on the investigation, there were no regulatory violations related to the 3 complaints (# 16794, #16740 and #16824) and the Conditions of Participation reviewed.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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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.