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

April 10, 2024

Ms. Shellie Stevens, Administrator
Mayo Healthcare Inc.
71 Richardson Ave
Northfield, VT 05663-5644

Dear Ms. Stevens:

Enclosed is a copy of your acceptable plans of correction for the recertification survey conducted on **March 13, 2024.** Please post this document in a prominent place in your facility.

We may follow up to verify that substantial compliance has been achieved and maintained. If we find that your facility has failed to achieve or maintain substantial compliance, remedies may be imposed.

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
	475053	A. BUILDING _____ B. WING _____	C 03/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAYO HEALTHCARE INC.	71 RICHARDSON AVE NORTHFIELD, VT 05663

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E 000	Initial Comments An unannounced on-site re-certification survey was conducted by the Division of Licensing and Protection on 3/11/24 through 3/13/24 including Emergency Preparedness Requirements for 42 CFR Part 483 requirements for Long Term Care Facilities. The result of the Emergency Preparedness Survey identified no regulatory violations.	E 000	DOC 4/19/24 for POC	
F 000	INITIAL COMMENTS The Division of Licensing and Protection conducted an unannounced, onsite recertification survey and complaint investigation, including report(s) # 22723 and 22452, from 3/11/24 through 3/13/24 to determine compliance with 42 CFR Part 483 requirements for Long Term Care Facilities. Deficiencies were cited as a result of this survey.	F 000		
F 578 SS=D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult	F 578	Resident #15 has had the care plan updated to match the orders and COLST. All residents are at risk for this alleged deficient practice. A housewide audit was conducted to ensure all care plans match the current orders and COLSTs. Social Services was reeducated on timely updating of care plans when Code Status's are changed per the Advanced Directives Policy. The Administrator or designee will conduct random weekly audits X 4 and monthly X 2 of residents who are transferred out/back from hospital to ensure advance directives are current with resident wishes. These audits will be added to the ongoing QAPI audits Mayo conducts. The results will be reviewed at QAPI to determine if further action is needed.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Shellie Stevens Shellie Stevens, MSN-RN	Licensed Nursing Home Administrator	4/5/2024

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.

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F 578	Continued From page 1 residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on record reviews and interviews, the facility failed to clarify code status and review care plan instructions and determine if the resident wishes to change or continue these instructions related to Advanced Directives, for 1 of 25 Residents in the sample. (Resident #15). Findings include: Per a record review, Resident #15 has resided at the facility since 12/13/2016 with the following diagnoses: Hemiplegia and Hemiparesis (A severe or complete loss of strength or paralysis on one side of the body) following a cerebral infarction (a stroke) and Dysphagia (Difficulty	F 578	**Tag F 578 POC accepted on 4/10/24 by K. Ruffe/P. Cota**	

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F 578	Continued From page 2 swallowing) related to the cerebral infarction. Another record review indicates a COLST (clinician orders for life-sustaining treatment) form that is dated 2/13/24 and signed by the Nurse Practitioner (NP) and Resident# 15's Power of Attorney (POA). The form indicates that the resident should be resuscitated, including chest compression, intubation, mechanical ventilation, defibrillation, and transfer to the hospital. Another record review reveals the Medication Administration Record (MAR) indicates Resident #15 is a "Full Code" (If the heart stops beating and/or breathing stops, all resuscitation procedures will be implemented to sustain life) A record review of Resident 15's care plan revealed the following entry: "[name] has an advance directive of DNR/DNI (Do not resuscitate/Do not intubate)", with an entry date of 1/24/24. Per an interview with the Unit Manager on 3/13/24 at 8:51 AM, s/he confirmed there is a discrepancy in the medical record; the care plan does not match the COLST or the MAR, s/he indicated Resident # 15 had a procedure that required her to have a code status that allowed resuscitation, and the correct status was not updated to reflect the resident's wishes of DNR/DNI.	F 578		
F 656 SS=E	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and	F 656		

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F 656	Continued From page 3 implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.	F 656	Resident 28 and 31 continue to reside at the facility and have had their care plans updated to reflect behaviors and pressure ulcer. Resident 31 no longer resides at the facility and had their care plan updated to reflect additional comfort measures. All residents with behaviors, pressure ulcers and comfort measures are at risk for this alleged deficient practice. The DNS and UM were reeducated on the timely updating of resident's care plans per policy. A house wide audit was conducted to ensure care plans were up dated for all residents with behaviors, pressure ulcers and on comfort measures. The Administrator or designee will conduct random weekly audits X 4 and monthly X 2 of residents who develop behaviors, pressure ulcers or comfort measures to ensure care plans have been updated. The results will be reviewed at QAPI to determine if further action is needed. **Tag F 656 POC accepted on 4/10/24 by K. Ruffe/P. Cota**	

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F 656	Continued From page 4 §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review the facility failed to ensure that there was a care plan in place related to behaviors for 1 of the 3 sampled residents (#28), related to pressure ulcers for 1 of 4 sampled residents (Resident #31), and related to end-of-life care for 1 of 2 sampled residents (Resident #17). findings included: 1. Per observation of an interaction on 3/11/24 at approximately 12:00 PM, Resident #28 was overheard saying "I'm going to deck you!" to a nurse while staff attempted to draw blood from them. Per observation of an interaction on 3/12/24 at approximately 11:00 AM, Resident #28 was observed making a gesture toward a nurse giving them medications as if they would dump water on the nurse. Per record review, Resident #28 has exhibited a pattern of aggressive and labile behaviors since their initial admission to the facility on 9/13/2023. The following progress notes were found in Resident #28's chart: - "11/3/2023 15:14 Activity Note When writer was assisting [Resident #28] to make a phone call [Resident #28] hollered several times to 'get that Goddamn mask of my face' she also hollered that the operator knew where to find the 'goddamn number' [Resident #28] flailed [their] arms around in a way that made me leave to	F 656		

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F 656	Continued From page 5	F 656		

diffuse the situation."
- "11/17/2023 13:42 Activity Note Activity Assistant was playing cards with [Resident #28] and another resident. [Resident #28] started to get disruptive with activity assistant, grabbing at her hands and cards. [Resident #28] used profanity and called the activity assistant names, activity assistant stopped the game and had to walk away to give [Resident #28] space. Social worker was made aware of the situation."
- "11/21/2023 05:01 Behavior Note Resident was heard slamming the door over and over and screaming for help, when this scribe went to resident's door, bottom half was closed and resident stated "open this damn door before I break it down" door opened and resident sitting in wheelchair without [their] oxygen at this time. Resident was asked to put oxygen back on where [they] became agitated and stated 'when will you people understand, i don't need to wear that all the time'."
- "12/3/2023 02:43 Nursing/Health Status Note ... Resident hitting [their] bed and flailing [their] arms and body around and grabbing at this writer ..."
- "1/25/2024 15:54 Activity Note [Resident #28] was in the hallway stating that she was very mad, using profanity, that [their] new roommate has 'a lot of junk in the room' ... [Resident #28] was raising [their] voice in anger about having a roommate."
- "2/11/2024 16:05 Behavior Note [Resident #28] was playing cards with other resident, where [they] began to yell at [other] resident saying [they weren't] smart enough to be playing so [they] shouldn't play anymore."

Per interview on 3/12/2024 at approximately 12:00 PM, an LPN who works with Resident #28

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F 656	Continued From page 6	F 656		

regularly stated that Resident #28 generally has a gruff and dry sense of humor, but at times can smack and grab staff when upset. When they first started working with Resident #28, they needed a lot of help from other staff who knew Resident #28 well in order to learn how to effectively manage Resident #28's behaviors.

Per review of Resident #28's care plan, Resident #28 has no care plan focus or care plan interventions that address Resident #28's behaviors or what interventions can be used by staff when Resident #28 exhibits maladaptive behaviors.

Per interview on 3/13/24 at approximately 1:00 PM, The Director of Nursing confirmed that Resident #28 does not have a care plan for behaviors despite exhibiting a pattern of behaviors.

2. Per Record review, Resident #31 has a provider order started on 3/5/24 for Stage 2 (an open wound) sacral region (the area at the top of the buttocks); Cleanse with soap and water, pat dry apply collagen powder (a treatment used to encourage healing) to 2 open areas, and cover with Mepliex foam border dressing every day shift every 3 days for stage 2 wound care and as need for soiled or dislodged dressing.
A progress note written by the Nurse Practitioner (NP) on 3/4/24 reveals there are 2 small round open areas. The note indicates these are stage 2 pressure ulcers with 100% epithelial tissue which is a thin, continuous, protective layer of compactly packed cells. The note includes measurements of 1.62 centimeters (cm) in length and 0.61 cm in width and scant depth.

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Further record review reveals a skin and wound evaluation dated 3/4/24 related to the stage 2 pressure ulcers, including the above wound measurements.

Per an interview with the Unit Manager Licensed Practical Nurse on 3/13/24 at 12:22 p.m. s/he confirms that there was not a care plan for Resident# 31 pressure ulcers, the care plan was added after the facility was made aware that there was not one in place earlier this morning 3/13/24.

3. Per an interview on 3/12/23 at approximately 9:00 AM, Resident #17's family indicated Resident# 17 had been refusing food and medications for several days. The decision was made to start end-of-life care. The family did not want complete Hospice care; rather, they felt the facility could provide adequate pain control and allow the family to be present. The resident was moved to a designated space that the facility provided for end-of-life care.

Per record review, Resident #17 has a diagnosis of Alzheimer's Dementia and chronic pain related to spinal stenosis (when the space inside the backbone is too small, putting pressure on the spinal cord and nerves that travel through the spine). A progress note written by the Nurse Practitioner (NP) on 3/4/24 reveals a discussion with Resident 17's family regarding the recent decline and the family's decision to move Resident #17 to end-of-life care.
A record review of Resident#17's care plan reveals no evidence of a comprehensive care plan developed specifically for end-of-life care.

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F 656	Continued From page 8 Per an interview on 3/12/24 at approximately 1:30 PM with the Unit Manager, a Licensed Practical Nurse (LPN), when asked about the care plan, s/he indicated the nursing staff knew how to care for the resident "because [s/he] was in that room." Per an interview with the Director of Nursing on 3/13/24 at approximately 1:10 PM, s/he confirmed that the care plan was not developed to reflect Resident#17's care change. S/he agreed the care plan should have been updated to reflect the resident's person-centered goals at the end of life.	F 656		
F 660 SS=D	Discharge Planning Process CFR(s): 483.21(c)(1)(i)-(ix) §483.21(c)(1) Discharge Planning Process The facility must develop and implement an effective discharge planning process that focuses on the resident's discharge goals, the preparation of residents to be active partners and effectively transition them to post-discharge care, and the reduction of factors leading to preventable readmissions. The facility's discharge planning process must be consistent with the discharge rights set forth at 483.15(b) as applicable and- (i) Ensure that the discharge needs of each resident are identified and result in the development of a discharge plan for each resident. (ii) Include regular re-evaluation of residents to identify changes that require modification of the discharge plan. The discharge plan must be updated, as needed, to reflect these changes. (iii) Involve the interdisciplinary team, as defined by §483.21(b)(2)(ii), in the ongoing process of developing the discharge plan. (iv) Consider caregiver/support person availability	F 660	F660 Resident # 40 is no longer at the facility and had no ill effects. All residents are at risk for this alleged deficient practice. A house wide audit was conducted on all residents to ensure they have appropriate discharge planning in place. The Social Services director was reeducated to the discharge planning process per policy. The administrator will conduct random weekly audits X 4 and monthly X 2 of all new residents to ensure proper discharge planning has begun and on all discharging residents to ensure properly completed discharge summaries. The results of these audits will be reviewed at QAPI to determine the need for additional interventions.	

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F 660	Continued From page 9 and the resident's or caregiver's/support person(s) capacity and capability to perform required care, as part of the identification of discharge needs. (v) Involve the resident and resident representative in the development of the discharge plan and inform the resident and resident representative of the final plan. (vi) Address the resident's goals of care and treatment preferences. (vii) Document that a resident has been asked about their interest in receiving information regarding returning to the community. (A) If the resident indicates an interest in returning to the community, the facility must document any referrals to local contact agencies or other appropriate entities made for this purpose. (B) Facilities must update a resident's comprehensive care plan and discharge plan, as appropriate, in response to information received from referrals to local contact agencies or other appropriate entities. (C) If discharge to the community is determined to not be feasible, the facility must document who made the determination and why. (viii) For residents who are transferred to another SNF or who are discharged to a HHA, IRF, or LTCH, assist residents and their resident representatives in selecting a post-acute care provider by using data that includes, but is not limited to SNF, HHA, IRF, or LTCH standardized patient assessment data, data on quality measures, and data on resource use to the extent the data is available. The facility must ensure that the post-acute care standardized patient assessment data, data on quality measures, and data on resource use is relevant and applicable to the resident's goals of care and treatment	F 660	**Tag F 660 POC accepted on 4/10/24 by K. Ruffe/P. Cota**	

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preferences.
(ix) Document, complete on a timely basis based on the resident's needs, and include in the clinical record, the evaluation of the resident's discharge needs and discharge plan. The results of the evaluation must be discussed with the resident or resident's representative, All relevant resident information must be incorporated into the discharge plan to facilitate its implementation and to avoid unnecessary delays in the resident's discharge or transfer.
This REQUIREMENT is not met as evidenced by:
Based upon interview and record review, the facility failed to develop a discharge care plan to identify goals and needs prior to discharge for 1 resident [Res.#40] of 4 residents reviewed.
Findings include:
Per review of Physician notes dated 12/5/23, Res. #40 "was admitted to Mayo initially after a fall and femur fracture in September. [S/he] was discharged home in early November. A few days later [s/he] had a fall and went back to the Emergency Department." Res. #40 was admitted back to Mayo on 11/17/23, where the physician noted Res.#40 "is making some progress with physical therapy and plan is to return home."
Review of Res.#40's medical record after their admission on 11/17/23 reveals no documentation involving the resident and/or a resident representative in the development of the discharge plan. Review of Res.#40's Care Plan reveals no mention of discharge or that the discharge needs of the resident were identified and the resident or representative informed of a final plan.
Per review of Res. #40's medical record, there are no Social Services notes after h/her admission to the facility on 11/17/23. Res.#40

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F 660	Continued From page 11 was discharged from the facility on 12/20/23. Physician notes prior to the resident's discharge recommend on-going Physical Therapy after discharge, along with blood pressure monitoring related to h/her recent hospitalization due to blood pressure issues, and additional support at home for safety concerns related to the resident's diagnosis of Alzheimer's dementia with mood disturbance. Review of Res.#40's discharge summary contains only a referral to a local Home Health Agency made on the day of discharge, with no listing of the recommended services in place. Further review of the Discharge Summary reveals Occupational Therapy recommendations for meals on wheels and a 'Life Alert' telecommunication system. The Discharge Summary lists meals on wheels, Lifeline, as well as the physician's recommendation for Outpatient Therapy as support services available, with none marked as arranged prior to discharge. An interview was conducted with the Director of Nursing [DON] on 3/13/24 at 9:59 AM. The DON reported they would investigate Res.#40's Care Plan regarding discharge planning. The DON was unable to produce any documentation that the discharge needs of the resident were identified and a discharge plan developed to address the resident's discharge goals and needs.	F 660		
F 712 SS=E	Physician Visits-Frequency/Timeliness/Alt NPP CFR(s): 483.30(c)(1)-(4) §483.30(c) Frequency of physician visits §483.30(c)(1) The residents must be seen by a physician at least once every 30 days for the first 90 days after admission, and at least once every 60 thereafter.	F 712		

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F 712	Continued From page 12 §483.30(c)(2) A physician visit is considered timely if it occurs not later than 10 days after the date the visit was required. §483.30(c)(3) Except as provided in paragraphs (c)(4) and (f) of this section, all required physician visits must be made by the physician personally. §483.30(c)(4) At the option of the physician, required visits in SNFs, after the initial visit, may alternate between personal visits by the physician and visits by a physician assistant, nurse practitioner or clinical nurse specialist in accordance with paragraph (e) of this section. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility failed to ensure that every resident is seen by a provider, who assesses the residents' total program of care, once every 30 days for the first 90 days after admission and then every 60 days thereafter for 6 of 25 sampled residents (Residents #28, #38, #30, #31, #29, and #22). Findings include: 1. Per record review, Resident #28 was admitted on 9/13/23. Records of physician visits, during which they assessed the Resident's total program of care, were found for the dates of 9/29/23 and 3/10/24. A Nurse Practitioner note is also present with a date of 1/2/24. There were no other physician visit notes of this type in Resident #28's record. Per interview on 3/12/24 at approximately 1:45 PM, The Unit Manager confirmed that there were not enough provider visit notes in Resident #28's chart to meet the regulation.	F 712	F712 Resident's 38, 28, 22, 29, and 31 continue to reside at the facility and have their needs met. Resident # 30 has returned to the residential care side of the facility. All residents who reside in the facility and have a Gifford provider are at risk for this alleged deficient practice. A house wide audit was conducted on all Residents with a Gifford provider from January to present to ensure the progress notes have been sent over to be a part of the facility medical record. The Administrator reeducated the providers on 483.30(c) Frequency of physician visits and the provider visits progress notes sent over to the facility timely. The facility has a new tracking system for provider visits that will be reviewed weekly. The administrator or designee will conduct random weekly X 4 and monthly X 2 audits of all Gifford providers to ensure visit notes are received timely and uploaded into the medical record. **Tag F 712 POC accepted on 4/10/24 by K. Ruffe/P. Cota**	

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F 712	Continued From page 13 2. Per record review, Resident #38 was admitted on 1/22/24. No physician notes that contained a review of the total program of care could be located in Resident #38's record. 3. Per record review, Resident #30 was admitted on 10/3/23. Only one physician/provider note that contained a review of the total program of care could be located in the chart on 1/3/24. 4. Per record review, Resident #31 was admitted on 12/5/23. No physician notes that contained a review of the total program of care could be located in Resident #31's record. 5. Per record review, Resident #29 was admitted on 1/17/24. No physician notes that contained a review of the total program of care could be located in Resident #29's record. 6. Per record review, Resident #22 was admitted on 11/8/22. No physician notes that contained a review of the total program of care could be located in Resident #22's record. Per interview on 3/13/24 at approximately 1:00 PM, the Administrator confirmed that resident records did not reflect the appropriate amount of physician/provider visit notes that include a review of the total program of care for each Resident.	F 712		
F 761 SS=E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the	F 761		

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F 761	Continued From page 14 appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure that all drugs and biologicals are stored and labeled according to accepted professional principles for expiration dates. Findings include: 1. Per observation of medications stored in the Turkey Hill Medication cart on 3/11/24 at approximately 2:00 PM, the following products were found with expiration date concerns: - A Lantus Solostar long-acting insulin pen for a resident was opened with no date of opening specified on the pen or pen bag. The insulin pen was not full and had been used for an undetermined number of days. The manufacturer	F 761	F761 All expired meds and undated meds were disposed of. All residents could potentially be affected by this alleged deficient practice. A house wide audit of both med carts, med room, stock room was conducted for any expired medications. All licensed nurses and the central supply clerk have been reeducated on the proper storage and labeling of medications per policy. The administrator or designee will conduct random weekly X 4 and monthly X 2 audits of the med carts, med room and central supply room to ensure all medication is stored and labeled per policy. The results of this audit will be brought to QAPI for review and to determine if further interventions need to occur. **Tag F 761 POC accepted on 4/10/24 by K. Ruffe/P. Cota**	

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F 761	Continued From page 15 specifies that the remaining insulin be discarded 28 days after opening. - A bottle of Latanoprost eye drops for a resident was opened with no date of opening specified on the bottle or the packaging. The packaging from the manufacturer specified that the remaining solution was to be discarded within 60 days of opening. - A bottle of Deep Sea Nasal Spray for a resident was labeled with an expiration date of 1/11/2024 per the manufacturer. - A bottle of Aspirin for multi-resident use had a manufacturer's expiration date of January 2024. - A package of Benadryl for multi-resident use had a manufacturer's expiration date of December 2023. - A box of safety lancets used for resident Point of Care Testing was labeled with an expiration date in the year 2022. Per interview on 3/11/24 at approximately 2:15 PM, the Unit Manager confirmed that the above products were not stored according to expiration dates and/or appropriately labeled with expiration dates. Per record review, the facility policy titled "Storage of Medication" states, "Insulin products should be stored in the refrigerator until opened, Note the date on the label for insulin vials and pens when first used." The policy also states, "Outdated, contaminated, discontinued, or deteriorated medications and those in containers that are cracked, soiled, or without secure closures are immediately removed from stock..."	F 761		
F 880 SS=F	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f)	F 880		

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F 880	Continued From page 16 §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation,	F 880	F880 1. The IPCP Manual has been updated and reviewed. 2. Room #3 did have a sign indicating to wear "Gloves, Gown and Mask before entering room" and was shown to surveyor KR with the DNS, however, the sign did not match another sign on another C-diff room with visuals on it of donning and doffing. Current CDC guidelines is for the wearing of gowns and gloves for C-diff precautions in the healthcare setting. The sign hanging outside the room indicated this, in addition to a mask for the care of this specific resident d/t splattering. Our policy does not specify a sign requirement to include pictures of donning/doffing nor does the CDC. The sign was replaced with a CDC sign preferred by surveying nurse. The " Stop - See Nurse" sign and the "Wash Hands With Soap and Water before leaving the room" sign was present. 3. The facility does have a current water management program for legionella and testing had been performed as the policy indicated. In August of 2023 when the scheduled testing occurred two areas outside of the lines were identified as having legionella (not the lines) the water fountain (unused since early Covid days- was disconnected and has since been removed) and the small ice machine on the unit, not the lines had it in the reservoir, not the lines. When the two areas were removed the testing company Analytical Solutions indicated no further testing required.	

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F 880	Continued From page 17 depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Per observation, interview, and record review, the facility failed to maintain an Infection, Prevention, and Control Program (IPCP) that reduces the risk of Residents contracting communicable diseases to the greatest extent possible as evidenced by an IPCP that is not updated annually, a lack of transmission-based precaution signage, and a lack of a water management program for Legionella. Findings include: 1. Per review of the provided IPCP polices and	F 880	The policy "Legionella - Eradication of" noted in this 2567, is in the event a resident is diagnosed with Legionella. The facility has not had any residents diagnosed with Legionella and therefor the eradication procedures were not required. 1. The IPCP has been reviewed and signed off by the IDT team, including the Medical Director. This will be reviewed at QAPI for further interventions. 2. The facility changed the sign to the surveyors preferred sign and is doing random weekly X4 and monthly X 2 audits to ensure those signs are in place on any C-diff precaution rooms. The audits will be brought to QAPI for review. 3. The Water management program had already been updated 2/2023 and signed off as reviewed on 11/23/2023 and in the facility "All Hazards Plan Manual provided to the surveyor via fax on 3/14/2024. A copy of the Northfield Water Department Consumer Confidence Report was obtained online and added to the All Hazards Plan Manual and will be updated annually. This is added to the Tels system.	

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F 880	Continued From page 18 procedures, all policies and procedures had a "last revised" date in the year 2022. Per interview on 3/13/24 at approximately 12:00 PM, the Administrator confirmed that the facility's IPCP has not been reviewed or updated within the last year as required. 2. Per observation on 3/12/24 at approximately 11:00 AM, there was a Personal Protective Equipment (PPE) cart outside of Resident #3's room. A sign on the door said "check with nurse prior to entering" and another sign said "wash hands with soap and water". A housekeeper inside the resident room is wearing PPE (gown, gloves). There is no signage on the door to indicate which type of transmission-based precautions staff/visitors should use or what PPE to use in the room. Per observation on 3/13/24 at approximately 9:00 AM, Resident #3's room had no change in signage. Per record review, Resident #3 is currently diagnosed with Clostridioides Difficile (a gastrointestinal infection that is very contagious and that resists common treatments) and contact precautions are to be used when in the room or providing Resident #3 with care. Per interview on 3/13/24 at approximately 1:30 PM, the Director of Nursing confirmed that the proper signage to indicate which PPE items to use in Resident #3's room was missing. 3. Per interview on 3/13/24 at approximately 1:20 PM, the facility Maintenance Manager stated that they have been in the role since the summer of	F 880	**Tag F 880 POC accepted on 4/10/24 by K. Ruffe/P. Cota**	

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F 880	Continued From page 19 2023. When they came on board, they decided to test the water for legionella at 16 previously identified risk sites within their water system. In August 2023, two of these tests came back positive for Legionella. The access points at the positive sites were shut off and disconnected. All other areas that had not tested positive for legionella remained accessible to staff and residents. The Maintenance Director confirmed that there were no additional measures implemented to treat the water system. The Maintenance Director stated that the facility uses water from the town's Department of Public Works. The Maintenance Director stated that he believes that the town water is chlorinated by the Department of Public Works, but confirms that the facility does not monitor the town's chlorination levels or testing and cannot validate that the town's mitigation measures are within acceptable parameters to prevent growth of Legionella. They were not aware of the facility having any formal Water Management Program or policy. Per review of the facility policy titled "Water Management Program", the policy states the following: II) [The Facility's] building water system description includes: a) Water originates from the Town of Northfield's Department of Public Works b) Testing and treatment (chlorination) is performed at the DPW facility ... The policy also describes the following procedure in the event of legionella in the water system: "PROCEDURE:	F 880		

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F 880	Continued From page 20 1. Upon notification that a resident has been diagnosed with Legionnaires' disease, notify the Vermont Department of Health for direction. 2. If [The facility]'s water system is suspected as having Legionella, the Vermont Department of Health will work with Mayo to collect samples of water for them to test. (Typically, test results take 10 days). 3. Notify DLP (Division of Licensing and Protection) 4. Until test results are available the following steps will be taken: a. Restrict bathing in all century tubs and showers b. Restrict use of all ice machines; empty all ice machines and discard all ice stock from the machine. c. Ask the Dept of Health if we should move to using bottled water versus tap water 5. Call [contracted services] to schedule an eradication of the building's water system. If possible, schedule this in advance of the results on a contingency basis. Here is a sample process that is followed when eradication) occurs. When scheduled, this should be reviewed and agreed on with the firm doing the eradication. In addition, all managers and staff need to be alerted in advance. The evening of the eradication: 1. 5:00pm: [Facility] Maintenance Staff, including director, are scheduled to work overnight. The maintenance director increases water temperature on water heaters to 170 degrees and bypasses the mixing valve. All water use in building is secured except for toileting. To secure the water supply, we post signs over all faucets and on any equipment to note use the water. 2. At the same time, the technician from the eradication group arrives and begin: preparations, installing a chemical feed pump to the main	F 880		

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F 880	Continued From page 21 infeed of town water. 3. 5:30pm -The eradication group begins pumping a 12.5% sodium hypochlorite solution (or equivalent) into the water infeed. [Facility] Maintenance staff proceed to run water at the end of each water branch through the building until chlorine is detected in both hot and cold water lines. Water is run at preceding fixtures to ensure chlorine is present at all points of the branches. Chlorine levels were monitored by serial dilution method as instructed by the eradication group. 4. 6:00pm-5:00am - Every hour on the hour, Maintenance Staff run water at all fixtures for 2 minutes introducing a fresh chlorine solution into the system at all points. The eradication group continues to monitor solution injection and running water in fixtures and plumbing in basement. 5. Next Morning, 5:30 am - The eradication group stops chlorine injection. [Facility] Maintenance Staff begin flushing the water system, ensuring there is less than .1 mg/l of chlorine at all fixtures using serial dilution method. 6. 6:30 am - Maintenance Staff adjust water heaters down to normal temperature of 160 degrees and mixing valve adjusted to provide normal temperature of 110 degrees. Water use is returned to normal. 7. 3:00 pm - Maintenance Director collects water samples and swabs from all fixtures/areas that tested positive at earlier testing done by Vermont Department of Health. Samples are then driven to lab for testing. Lab testing must be arranged in advance."	F 880		

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S320 SS=F	7.13 (d)(1) QUALITY OF CARE - STAFFING LEVELS 7.13 (d)(1) The facility shall maintain staffing levels adequate to meet resident needs. 1. At a minimum, nursing homes must provide: i. no fewer than three (3) hours of direct care per resident per day, on a weekly average, including nursing care, personal care and restorative nursing care, but not including administration or supervision of staff; and ii. of the three hours of direct care, no fewer than two (2) hours per resident per day must be assigned to provide standard LNA care (such as personal care, assistance with ambulation, feeding, etc.) performed by LNAs or equivalent staff and not including meal preparation, physical therapy or the activities program. This REQUIREMENT is not met as evidenced by: Based on staff interviews and record review, the facility failed to maintain the required minimum staffing levels to allow for 2.0 hours of direct care per resident per day (PPD) on a weekly average by Licensed Nursing Assistants (LNAs) for 8 of the 12 sampled weeks. Findings include: A review of the daily nursing PPD hours shows that the average direct care PPD by LNA staff was below the minimum of 2 hours per day during the following weeks in October, January, and February: 10/1/23-107/23 =1.85 10/8/23-10/14/23 =1.89	S320	S320 The facility has an existing ongoing QAPI due to a self identified staffing concern: 1. Daily review of the PPD by the Administrator. 2. Geriatric Support Aides hired and on the floor 6 days a week pending LNA class starting when facility receives approval. 3. Feeding assistants on 7 days a week. 4. Department heads provided hands on care including Administrator, DNS, UM, Activities Director, Admission Director, Staff Development Nurse, Scheduler, Medical Records. 5. Bonuses given for shifts picked up totaling $13,800. 6. Raises given to full time staff for retention 7. Every other week orientation for nursing staff 9. LNA class began with 4 students (have successfully completed course, pending final exam 4/16/24. 10. Social media campaign for hiring 11. New radio adds purchased for hiring 12. New TV ads for hiring 13. Admissions have been extremely limited to facility readmissions only. The facility has maintained the required average direct care PPD for the entire month of March and to date. The deficient practice has been eliminated by assuring the average direct care PPD does not fall below 2.0. The facility is committed to providing quality care and maintaining or exceeding the required PPD.	

Division of Licensing and Protection
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Sheelee Stevens | TITLE | (X6) DATE: 4/5/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	475053	A. BUILDING: _____ B. WING _____	C 03/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAYO HEALTHCARE INC.	71 RICHARDSON AVE NORTHFIELD, VT 05663

(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) COMPLETE DATE
S320	Continued From page 1 10/15/233-10/21/23 =1.79 10/22/23-10/28/23 = 1.77 1/15/24-1/21/24 =1.94 1/23/24-1/28/24 =1.96 2/8/24-2/14/24 =1.94 2/22/24-2/29/24 =1.94 Per interview on 3/13/24 at approximately 2:00 PM, the Administrator confirmed that the facility had experienced some short staffing due to callouts and that the direct care PPD, as referenced above, did not meet the 2.0 hours required.	S320	**Tag S 320 POC accepted on 4/10/24 by K. Ruffe/P. Cota**	