STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	475053	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	05/22/2018

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) COMPLETION DATE
K 000	INITIAL COMMENTS An unannounced onsite Life Safety Code inspection was completed by the Division of Fire Safety on 5/22/18. While the facility was found to be in substantial compliance, the following issue was identified that requires correction.	K 000		

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

Christine Scott | Administrator | 6/28/18

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.

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

AII
"A" FORM

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER # 475053	MULTIPLE CONSTRUCTION A. BUILDING: 01 - MAIN BUILDING 01 B. WING	DATE SURVEY COMPLETE 5/22/2018

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

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
K 291	Emergency Lighting CFR(s): NFPA 101 Emergency Lighting Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9.18.2.9.1, 19.2.9.1 This REQUIREMENT is not met as evidenced by: Based on observation, the facility failed to ensure all emergency lighting is functional in one area of the facility. Per observation on 5/22/18, accompanied by the Director of Facilities, one emergency light in the facility was not functioning. The submission of this plan of correction does not imply agreement with the existence of a deficiency. It is submitted in the spirit of cooperation, to demonstrate our commitment to continued improvement in the quality of our Residents lives. **K-291** Emergency Lighting Emergency lighting of at least 1-1/2 hour duration is provided automatically in accordance with 7.9.18.2.9.1, 19.2.9.1 All but one light in the facility was functional on test. Emergency Lighting is requires, in the event the generator fails. Mayo Healthcare took immediate steps and all batteries were replaced in the Emergency lighting fixtures. Since all residents have the potential to be affected by the same deficient practice, the maintenance department personnel will provide routine checks of the system to assure that the batteries have not expired or blown out due to local power surges or storms. To ensure that the deficient practice does not recur maintenance personnel have been educated on the importance of providing routine checks. Routine checks will be documented and a report will be submitted to the Quality Assurance Committee for review. The frequency & duration of these reports and audits will be determined by the committee. The corrective action has been completed.

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

The above isolated deficiencies pose no actual harm to the residents

Mayo Rehabilitation & Continuing Care *Caring for Life*

JUN 29 2018

June 28, 2018

Pam M, Cota, RN
Licensing Chief
Department of Disabilities, Aging and Independent Living
Division of Licensing & Protection
HC 2 South, 280 State Drive
Waterbury, VT 05671

Dear Pam,
Enclosed please find Mayo Rehabilitation & Continuing Care's Plan of Correction for the Life Safety State survey completed on May 22, 2018 for which we received the Fire Inspection results and CMS Form 2567 on June 28, 2018.
I have signed the Form CMS 2567 & dated it 06/28/18. The completion date for compliance is July 8, 2018.
Should you have any questions or concerns regarding our POC, please do not hesitate to contact me at 802-495-3161 or cscott@mayohc.org.

Sincerely,

Christine Scott, Administrator

Cc: Patrick McLaughlin, Assistant State Fire Marshal
Jim Roux, Maintenance Manager