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

June 25, 2018

Ms. Christine Scott, Administrator
Mayo Healthcare Inc.
71 Richardson Ave
Northfield, VT 05663-5644

Dear Ms. Scott:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **May 23, 2018**. 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

| 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 05/23/2018 |

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

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| E 000 | Initial Comments<br><br>During an unannounced onsite re-certification survey, conducted by the Division of Licensing and Protection on 5/21 though 5/23/18, the facility was found in substantial regulatory compliance regarding emergency preparedness planning activities. | E 000 | 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. | |
| F 000 | INITIAL COMMENTS<br><br>An unannounced onsite re-certification survey and complaint investigation was conducted by the Division of Licensing and Protection on 5/21 though 5/23/18. The findings include the following: | F 000 | **F-602** Mayo Healthcare took immediate steps and terminated the employee who admitted to the transfer of Trust Accounts funds to the General Fund Account. Additionally Mayo Healthcare has hired American Healthcare Software Enterprises, Inc. to determine the exact amount of money owed, if any, and to include interest to the accounts affected. Once determined, the cost report and the accounts will be reconciled.<br>Since all Residents have the potential to be affected by the same deficient practice, Mayo Healthcare has taken steps to assure the protection of Resident Trust (Escrow) accounts from misappropriation of funds by instructing Northfield Savings Bank that this account must have two signatures from authorized Mayo Healthcare personnel including the Administrator's signature in order to transfer or remove any funds from the Trust Accounts. | |
| F 602 SS=E | Free from Misappropriation/Exploitation<br>CFR(s): 483.12<br><br>§483.12<br>The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms.<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review and confirmed by staff interview, the facility failed to ensure the protection of Resident Trust (Escrow) accounts from misappropriation. The findings include the following:<br><br>Per interview with the Licensed Nursing Home Administrator (LNHA) on 5/22/18 at approximately 8:30 AM, confirmation was made that during the annual audit conducted by a contracted accounting firm, discovery was made | F 602 | | |

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

Christine Scott, Administrator 6/18/18

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.

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| F 602 | Continued From page 1<br>that the Resident Escrow Accounts (titled Trust Accounts) were unable to be reconciled. Through interviews with the office staff, conducted by the LNHA, it was discovered that money was deliberately transferred from the Trust (Escrow) Account to the General Fund Account. The General Fund Account is used to meet the facility's financial obligations.<br><br>The Trust (Escrow) Account retains the deposits of private paying residents, who are required to provide the facility with a 60 day advanced payment at the time of admission. Each resident earns interest on the money held, a quarterly report is submitted to resident/families of the balance of the account, and this balance is returned to the resident at the time of discharge.<br><br>The LNHA confirms that facility staff admitted to the transfer of Trust Account funds to the General Fund Account to meet the facility's financial obligations with out authority and/or permission from residents, families, Administration or the Board of Trustees. The LNHA confirms that different private accounting firm has been hired to determine the exact amount of money owed (to include interest), to each of the numerous residents who had a balance in their Escrow Account. At that time, full discovery will be known, and the accounts whose money was misappropriated will be reconciled. | F 602 | To ensure that the deficient practice does not recur American Healthcare Software Enterprises, Inc.'s agreement includes providing comprehensive accounting systems and assistance with supervision and maintenance of proper records to ensure full and true entries in accordance with good accounting practices.<br>The Administrator will review the balance of all Trust Accounts each month and submit a written report to the Quality Assurance committee for review in June, July & September.<br>The frequency & duration of further audits will be determined by the committee.<br>The corrective action will be completed by June 22, 2018<br><br>F602 POC accepted 6/19/18<br>M. Bertrand RN / S. Remy RN | |
| F 655<br>SS=D | Baseline Care Plan<br>CFR(s): 483.21(a)(1)-(3)<br><br>§483.21 Comprehensive Person-Centered Care Planning<br>§483.21(a) Baseline Care Plans<br>§483.21(a)(1) The facility must develop and | F 655 | **F- 655** Resident # 49 met his rehab goals and discharged so the baseline care plan could not be updated. All baseline care plans will include the date created and all sections relating to the individual resident will be completed including goals and a discharge plan. | |

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| F 655 | Continued From page 2<br>implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must-<br>(i) Be developed within 48 hours of a resident's admission.<br>(ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to-<br>(A) Initial goals based on admission orders.<br>(B) Physician orders.<br>(C) Dietary orders.<br>(D) Therapy services.<br>(E) Social services.<br>(F) PASARR recommendation, if applicable.<br><br>§483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan-<br>(i) Is developed within 48 hours of the resident's admission.<br>(ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section).<br><br>§483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to:<br>(i) The initial goals of the resident.<br>(ii) A summary of the resident's medications and dietary instructions.<br>(iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility.<br>(iv) Any updated information based on the details of the comprehensive care plan, as necessary. | F 655 | Since all Residents have the potential to be affected by the same deficient practice, all RN/LPNs will be educated on how to date and complete baseline care plans by the DNS or Staff Development Nurse. To ensure that the deficient practice does not recur, specific training on Care Plan development will be provided to all staff who contributes to Care plan development by the DNS or Staff Development Nurse. Baseline care plans will be reviewed and audited by the DNS or designee and findings will be submitted to the Quality Assurance Committee. The frequency & duration of further audits will be determined by the committee. The corrective action will be completed by June 22, 2018<br><br>F-655 POC accepted 6/19/18<br>M. Bertrand RN / S. Lemy, RN | |

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| F 655 | Continued From page 3<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review and confirmed by staff interview the facility failed to ensure that a complete base line care plan was reviewed, developed and implemented for 1 of 19 residents sampled, (Resident # 49). The findings include the following:<br><br>Per record review for Resident #49 who was admitted on 2/23/18, with diagnosis to include, but not limited to, repeat falls, abnormality of gait and mobility, muscle weakness and Adult Failure to Thrive. A base line care plan was developed, but does not identify the date created nor is the plan complete. The following sections of the base line care plan were deficient:<br>-Eating identifies a regular diet, but no notation related to the failure to thrive;<br>-Pain Management was left blank, and the resident was receiving facial dressings;<br>-Safety was left blank and the resident has history of falls. On 3/6/18 the resident was found on the floor. The base line care plan did not identify initiatives for safety to the direct staff;<br>-Social Services did not identify any plan for a discharge back to the community. The resident was discharged home on 3/30/18.<br><br>Interview with the Director of Nurses on 5/23/18 at approximately 3 PM, confirms that the base line care plan was incomplete. | F 655 | | |
| F 656 SS=D | Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)<br><br>§483.21(b) Comprehensive Care Plans<br>§483.21(b)(1) The facility must develop and implement a comprehensive person-centered | F 656 | **F-656** The comprehensive care plan for Resident # 32 has been reviewed and all RN/LPN staff has been re-educated on following Mayo's Policies and Procedures on wound care, skin issues and pressure ulcers including taking measurements once per week. | |

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| F 656 | Continued From page 4<br>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 -<br>(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<br>(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).<br>(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.<br>(iv)In consultation with the resident and the resident's representative(s)-<br>(A) The resident's goals for admission and desired outcomes.<br>(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.<br>(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.<br>This REQUIREMENT is not met as evidenced by: | F 656 | Since all Residents have the potential to be affected by the same deficient practice, all RN/LPNs will be re-educated on Mayo's Policies and Procedures on wound care, skin issues and pressure ulcers.<br>To ensure that the deficient practice does not recur, audits of the Treatment records and the electronic Wound Weekly Observation Tool (WOOT) will be conducted by the DNS or designee.<br>Periodic and random audits will be submitted to the Quality Assurance Committee. The frequency & duration of further audits will be determined by the committee. The corrective action will be completed by June 22, 2018<br><br>F656 POC accepted 6/19/18<br>M. Bertrand RN/S. Curry RN | |

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| F 656 | Continued From page 5<br>Based on interview and record review the facility failed to follow the comprehensive care plan for wound care for 1 of 19 residents in the applicable sample (Resident # 32). Findings include:<br><br>Per record review Resident #32's care plan read, "Treatment to left lower extremity per MD orders (see Treatment Administration Record (TAR), 3/2/18. Refer to TAR for dressing to right lower extremity skin tear. Measure both areas weekly." Per review of the wound assessments for Resident #32's left and right lower extremity wounds, measurements were only done on 4/24/18 and 5/15/18. Per interview on 5/23/18 at approximately 10:00 AM with the Director of Nursing (DNS), s/he stated that his/her expectation was that if a resident had a wound, the nursing staff was to measure it once a week.<br><br>Per review of Skin Issue Protocol, reviewed 1/18, "6) Skin tears and Pressure Ulcers will be measured and monitored using the Wound Weekly Observation Tool (WWOT) in PCC (the electronic medical record). 9) Document condition of skin and evidence of healing in wound in WWOT in PCC." | F 656 | | |
| F 657 SS=E | Care Plan Timing and Revision<br>CFR(s): 483.21(b)(2)(i)-(iii)<br><br>§483.21(b) Comprehensive Care Plans<br>§483.21(b)(2) A comprehensive care plan must be-<br>(i) Developed within 7 days after completion of the comprehensive assessment.<br>(ii) Prepared by an interdisciplinary team, that includes but is not limited to--<br>(A) The attending physician.<br>(B) A registered nurse with responsibility for the | F 657 | **F-657** The twelve comprehensive care plans identified will be reviewed by the resident's attending physicians.<br>Since all Residents have the potential to be affected by the same deficient practice, Mayo Healthcare's attending Physicians have been informed that they are required to show written proof that they are involved in the care plan meetings or must review the meeting specifics. | |

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| F 657 | Continued From page 6<br>resident.<br>(C) A nurse aide with responsibility for the resident.<br>(D) A member of food and nutrition services staff.<br>(E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan.<br>(F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident.<br>(iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review and staff interviews the facility failed to assure that the comprehensive care plan is reviewed and revised by an interdisciplinary team (IDT). The IDT must, at a minimum, consist of the resident's attending physician, a registered nurse and nurse aide with responsibility for the resident, a member of the food and nutrition services staff, and to the extent possible, the resident and resident representative, if applicable. The findings include the following:<br><br>Per record review, it is found that there are signed care plan meeting attendance sheets in the resident records. However, in a review of those records, it was found that 12 of 19 sampled residents (Residents #2, 9, 10, 16, 20, 21, 26, 29, 30, 32, 38 and 44) have no evidence of the involvement of the resident's attending physician | F 657 | To ensure that the deficient practice does not recur, all Physicians will be provided with an updated written care plan or updated minutes of the care plan and will be instructed to review and sign each care plan to show proof of involvement.<br>Periodic and random audits of care plans will be conducted by the DNS or designee to assure that each Physician has signed showing evidence of involvement in the development of the care plan and these audits will be submitted to the Quality Assurance Committee. The frequency & duration of further audits will be determined by the committee. The corrective action will be completed by June 22, 2018<br><br>F657 POC accepted 6/19/18<br>M. Bertrand RN / S. Perry RN | |

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| F 657 | Continued From page 7<br>in the care plan meetings or review of the meeting specifics.<br><br>The Director of Nurses confirms during the three day review (5/21-5/23/18), that the physician does not attend the care plan meetings nor is there actual evidence of involvement by the physician in the development of the resident centered comprehensive care plan. | F 657 | | |
| F 758 SS=D | Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5)<br><br>§483.45(e) Psychotropic Drugs.<br>§483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories:<br>(i) Anti-psychotic;<br>(ii) Anti-depressant;<br>(iii) Anti-anxiety; and<br>(iv) Hypnotic<br><br>Based on a comprehensive assessment of a resident, the facility must ensure that---<br><br>§483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record;<br><br>§483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; | F 758 | **F- 758** Resident #2's Diagnosis list now includes depression and anxiety as confirmed by the Attending Physician who was treating this resident for mood and anxiety associated with depression.<br>Since all Residents have the potential to be affected by the same deficient practice, all RN/LPNs have been re-educated on the importance of obtaining an associated diagnosis for all medications.<br>To ensure that the deficient practice does not recur, audits will be conducted by Mayo Healthcare's Pharmacy Consultant and DNS or designee to assure that all medications including Psychotropic Drugs have an associated diagnosis.<br>Periodic and random audits will be submitted to the Quality Assurance Committee. The frequency & duration of further audits will be determined by the committee. The corrective action will be completed by June 22, 2018 | |

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| F 758 | Continued From page 8 | F 758 | F 758 POC accepted 6/19/18 M. Bertrand RN/Surv RN | |

§483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and

§483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order.

§483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication.
This REQUIREMENT is not met as evidenced by:
Based on interview and record review the facility failed to ensure that residents drug regimens were free from unnecessary psychotropic medication use for 1 of 5 residents in the applicable sample (Resident #2). Findings include:

Per record review, a physician's order for Resident #2 read, "Sertraline HCL (medication used for depression) Tablet 50 mg, give 50 mg by mouth once a day." Resident #32 has the following diagnoses: Parkinson's disease, dementia with behavioral disturbance, diabetes, osteoporosis, hypertension, and repeated falls. There was no evidence in the medical record that the resident had a diagnosis of depression. Per interview on 5/23/18 at 12:07 PM with the DNS,

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| F 758 | Continued From page 9<br>s/he confirmed that the the resident was taking the medication and that there was no diagnosis for the medication in the medical record. | F 758 | **F- 761** All expired medications have been discarded according to procedures for medication disposal.<br>Since all medications have the potential to be affected by the same deficient practice, Mayo Healthcare has contacted our Pharmacy vendor to request that they include an inspection of all medications for expiration dates during their monthly consultation services visits.<br>To ensure that the deficient practice does not recur, audits will be conducted by Mayo Healthcare's Pharmacy Consultant and DNS or designee to assure that all medications storage areas have been checked for out dated medications.<br>Periodic and random audits will be submitted to the Quality Assurance Committee. The frequency & duration of further audits will be determined by the committee. The corrective action will be completed by June 22, 2018 | |
| F 761 SS=E | Label/Store Drugs and Biologicals<br>CFR(s): 483.45(g)(h)(1)(2)<br><br>§483.45(g) Labeling of Drugs and Biologicals<br>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.<br><br>§483.45(h) Storage of Drugs and Biologicals<br><br>§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.<br><br>§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.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview and record review, the facility failed to label drugs and biologicals in accordance with accepted professional principles for 2 of 2 medication carts and 1 of 1 medication storage room. Findings | F 761 | F761 POC accepted 6/19/18<br>M. Bertrand RN/S. Lang, RN | |

| 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 05/23/2018 |

| 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 |
|---|---|---|---|---|
| F 761 | Continued From page 10 | F 761 | | |

include:

Per observation on 5/22/18 at 10:10 AM of the medication storage room, there were 3 bottles of liquid Lactulose (medication used for constipation) on the shelf that had expiration dates of 10/17, 1/18, and 4/18. Per interview with the DNS at that time, s/he confirmed that the medication had expired and removed the medication from the shelf.

Per observation on 5/22/18 at approximately 10:30 AM of medication cart #2, in the second drawer, there was a medication card containing 19 pills of Lasix 20 mg (medication used for fluid removal) for Resident #39 with an expiration date of 12/7/17. Per interview with the staff nurse at that time s/he confirmed that the card of medications had expired and should have been removed from the medication cart.

Per observation on 5/22/18 at 3:29 PM of medication cart #1, there was a bottle of magnesium citrate (medication used for constipation) for Resident #16 with a date opened of 1/28/18. Upon review of the directions on the bottle, the medication was to be discarded 24 hours after it was opened. Per interview with a staff nurse at that time, s/he confirmed that the bottle should have been discarded and not used for the resident 24 hours after the bottle was opened.

Per review of the policy, Storage of Medication, updated 11/17, it read "14. Outdated, contaminated, discontinued or deteriorated medications and those containers that are cracked, soiled, or without secure closures are immediately removed from stock, disposed of

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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|---|---|---|---|---|
| F 761 | Continued From page 11<br>according to procedures for medication disposal, and reordered from the pharmacy, if a current order exits." | F 761 | F761 POC accepted 6/19/18 M. Bertrand RN/SPecialist RD | |

JUN 21 2018

Mayo Rehabilitation & Continuing Care *Caring for Life*

June 18, 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 State survey completed on May 23, 2018 for which we received the FORM CMS 2567 on June 6, 2018. I have signed the Form CMS 2567 & dated it 06/18/18. The completion date for compliance with both tags is June 22, 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: Amy Melna, RN, DNS