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

September 20, 2019

Mr. Timothy McAdoo, Administrator
Mayo Healthcare Inc.
71 Richardson Ave
Northfield, VT 05663-5644

Dear Mr. McAdoo:

Enclosed is a copy of your acceptable plans of correction for the re-certification survey completed on **June 26, 2019.** 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

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 _____	06/26/2019

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
E 000	Initial Comments An unannounced Emergency Preparedness survey was conducted in conjunction with a re-certification survey from 6/24/2019 - 6/26/2019. There were no regulatory findings identified.	E 000	This plan of correction (POC) constitutes written allegation of compliance for the deficiencies cited. However, submission of the POC is not admission the deficiencies exist or that one was cited correctly, nor is it an admission that the facts on the 2567 are accurate. This POC is submitted to meet the requirements established by federal and state law.	
F 000	INITIAL COMMENTS An unannounced re-certification survey was conducted by the Division of Licensing and Protection from 6/24/2019 - 6/26/2019. The following are the regulatory findings:	F 000	Upon identification of the alleged deficient practice by surveyors, the facility immediately took the fireplace off-line. The remote has been relocated from the the top shelf of the serenity lounge and is now located in the maintenance office which is secured from residents by a	
F 689 SS=E	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation and confirmed by interview, the facility failed to ensure that the resident environment remains as free of accident hazards as is possible. Findings include: On 6/24/19 at 11:32 AM, two nurse surveyors observed a gas fireplace operating in the Serenity Lounge on the Turkey Hill unit. The fireplace was built into a wall and stood approximately 4 feet off the floor. There is no barrier to prevent anyone from touching the surface of the fireplace. A Surveyor touched the grate on the front surface	F 689	digital code without any direct access to residents or visitors. Additionally , the facility cut the gas-line to the fireplace as part of the Lock-out Tag-Out program . A sign was placed on the fireplace notifying persons that the fireplace was out of service. The nursing staff was educated during clinical shift reporting on 06/24/2019 and 06/25/2019. There was no indication of injury to the resident s identified in the 2567 form resulting from he fireplace; Zero residents were harmed or injured using the gas fireplace in the last six years of operation. The facility has spoken with each resident identified in the roster and the respective Responsible Party to educate them on the citation and review the risk-risk benefit to the operation of the fireplace. 100% of the resident roster included in the citation was supportive of retaining the fireplace from a person-centered care approach and acknowledged the minimal risk was worth the benefit of creating a home like environment as required by CMS guidance.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [signature] LNHA, FACHCA | TITLE: Administrator | (X6) DATE: 07/12/2019

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 689	Continued From page 1 and needed to remove hand immediately, causing discomfort within 1 second and leaving a burn on a knuckle on the Surveyor's right hand. Per Raytek laser thermometer, the smooth surface surrounding the metal grate temperature registered between 154-171 degrees Fahrenheit (F). The fireplace is operated by a remote control device with operating instructions on the back. The remote was observed on top of a shelf approximately 20 feet away from the fireplace. CMS Life Safety regulation states that the controls for a direct-vent gas fireplace shall be locked or located in a restricted location. Per interview with the Director of Nursing on 6/24/19 at 11:55 AM, there are 7 residents that ambulate independently or self-propel on the unit. All residents, family and visitors have access to the Serenity Lounge. Residents were observed sitting in the room unaccompanied by staff on several occasions during the survey. Per interview with the facility Maintenance Manager on 6/24/19 at 12:22 PM, there is no system to monitor the surface temperatures of the fireplace when in operation. Additionally, there is no way to monitor when the fireplace is operating.	F 689	The facility has completed a comprehensive skin observation on all residents and found that zero additional residents were affected by the fireplace. The facility has rendered the fireplace non-operational by removing the gas regulator which restricts gas from reaching the fireplace. The remote control has also been relocated behind a secured door in a restricted area of the facility with no direct access by residents or visitors. During winter months, the remote will be secured in a wall-mounted lock-box not accessible to residents. Prior to operating the fireplace, the facility will contract with a licensed gas company to inspect the fireplace and verify that it is functioning properly. Prior to operating the fireplace, the facility shall install a thermometer to the fireplace equipped with alarm capability to alert staff if temperature exceeds 140 degrees and/or acceptable temperature range; if temp exceeds acceptable range the fireplace will be made non-operatable until serviced and able to function within acceptable parameters . The fireplace remote will be kept in a secure area that is not accessible to residents directly, and/or in a secure wall- mount lock box. Facility will conduct on-going monitoring through the weekly Clinical Care Meeting where an interdisciplinary team reviews all in-house residents plan of care and Patients at Risk (PAR). Incidents are reviewed each shift during change of shift for nursing staff. Falls and Incidents are reviewed by interdisciplinary team during the 24-hour Morning Report in addition to the change of shift. The Quality Assurance Committee shall review the- temperature logs from the maintenance director monthly for three- months. The incidents are reviewed by QAPI monthly currently and will continue this practice. If the facility falls below the threshold for compliance, or if deemed necessary, a subsequent plan of action will be developed and implemented. The Administrator is responsible for overall compliance.	7/15/2019

F689 POC accepted 9/20/19 MMathurRN

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: _____ B. WING _____	DATE SURVEY COMPLETE: 6/26/2019

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ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 623	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental

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F 623	Continued From Page 1 disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility failed to meet requirements for transfer/discharge notices for 2 of 8 applicable residents (Residents # 22 and #8). Findings include: 1. Resident # 22 was discharged to an acute care hospital on April 4, 2019. The notice provided did not contain appeal rights as required by regulation. This was confirmed by the Director of Nursing in the afternoon of 6/25/19. 2. Per medical record review, Resident #8 has a physician order for transfer to the hospital for evaluation on 03/07/19. The resident returned to the facility on 03/08/19. There is evidence identifying that the resident and family representative were provided with written notification of transfer/discharge, however the contents of the notice does not contain a statement of the resident's appeal rights as required. Nor does the notice contain the name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman. This was confirmed by the Director of Nursing in the morning of 6/26/19.
F 625	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section.

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F 625	Continued From Page 2 §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to notify the resident and/or resident's representative in writing of the bed hold policy for 1 of 2 applicable residents, (Resident #8). The findings include the following: Per record review, Resident #8 was transferred to the Emergency Room on 03/07/19 for medical evaluation and returned to the facility on 03/08/19. Confirmation was made by the Director of Nurses on 06/26/19 at approximately 9:15 AM, that s/he did not provide the resident and/or the resident's representative at the time of transfer, with a written notice of the facility's bed hold policy specifying the duration of the bed-hold as required.
F 661	Discharge Summary CFR(s): 483.21(c)(2)(i)-(iv) §483.21(c)(2) Discharge Summary When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following: (i) A recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results. (ii) A final summary of the resident's status to include items in paragraph (b)(1) of §483.20, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or resident's representative. (iii) Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over-the-counter). (iv) A post-discharge plan of care that is developed with the participation of the resident and, with the resident's consent, the resident representative(s), which will assist the resident to adjust to his or her new living environment. The post-discharge plan of care must indicate where the individual plans to reside, any arrangements that have been made for the resident's follow up care and any post-discharge medical and non-medical services. This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to ensure a discharge summary included a recapitulation (concise summary) of a resident's stay and a final summary of the resident's status including the items from the most recent comprehensive assessment for 1 applicable resident (Resident #44). Findings include:

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F 661	Continued From Page 3 Per record review Resident #44 was admitted to the facility on 2/5/19 following back surgery. While at the facility, s/he received skilled services for rehabilitation. S/he was discharged to home on 3/28/19. The facility had provided the resident with discharge instructions; however, there was no evidence that a recapitulation of the resident's stay and a final summary of the resident's status upon discharge was done. Per interview on 6/26/19 at approximately 1:00 PM with the Unit Manager, s/he confirmed that a recapitulation of the resident's stay and a final summary of the resident's status upon discharge were not done.