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

October 1, 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 survey conducted on **August 28, 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 _____	C 08/28/2019

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
F 000	INITIAL COMMENTS An unannounced on-site investigation of a self-report was conducted on 08/28/19 by the Division of Licensing and Protection. The following regulatory violation was identified: F 689 Free of Accident Hazards/Supervision/Devices SS=E 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, interview and record review the facility failed to ensure that 1 of 3 sampled residents were adequately supervised to prevent accidents and/or intrusion on others, (Resident #1). The findings include the following: Per medical record review, Resident #1 has a diagnosis of Alzheimer's Disease and Depressive Disorder. During the past 4 months the following 6 incidents of inappropriate behavior and 3 falls are described as follows: -06/20/19 at approximately 9:30 PM, Resident #1 was found in bed with another resident. -06/24/19 Resident #1 entered another residents room and threw a jacket on the occupied bed. Staff are unsure of the time, but the victim reports incident occurred early AM during the overnight shift. -06/25/19 at approximately 11:15 AM, Resident	F 000 F 689	This plan of correction constitutes our written allegation of compliance for the deficiencies cited. However, submission of this plan of correction is not an admission that a deficiency exists or that one was cited correctly. This plan of correction is submitted to meet requirements established by state and federal law. 1.) What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? • Medical record review by the DNS for resident 1 to assess current interventions, medication and non-pharmacological interventions. • Facility will develop a care plan, based on resident assessment, which promotes resident choice, mobility and safety. Update the plan as the resident's wandering patterns change with the progression of dementia. • Physician has assessed resident to revise plan of care in accordance with need. Medications were adjusted. 2.) How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken? • All residents have the potential to be affected by this alleged deficient practice. • Facility shall review individual risk factors include depression, history of falls and residents at high-risk for fatigue, postural hypotension, incontinence or prolonged immobility. • •Residents may request or be offered visual ques and stop-sign barriers to mitigate wandering into other residents' rooms.	

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

Administrator/Executive Director | 09/24/19

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 #1 was observed in the dining room attempting to sit in another resident's wheelchair but sat on the floor. -07/24/19 at approximately 6:49 PM, while in the dining room, Resident #1 was witnessed becoming agitated with another resident who was talking. Resident #1 slammed his/her fist down on the table and shouted "shut-up", then proceeded to leave the dining room. -07/31/19 at approximately 10:50 PM, Resident #1 was found on the floor in the hallway lying on his/her right side. The unwitnessed fall resulted in an emergency transport to the hospital. Evaluation revealed a fractured clavicle (also known as the collarbone). -08/03/19 at approximately 5:51 AM, Resident #1 was found lying on the floor in his/her bedroom near the exit door. The resident was cold and clammy with increased lethargy noted, sustained a skin tear to the elbow. -08/16/19 at approximately 12 noon, Resident #1 was eating a bowl of fruit in the dining room. Staff attempted to assist the resident when s/he responded by banging a fork on the table. Simultaneously another resident sat down at the table, when Resident #1 suddenly threw a fork at the resident striking his/her left forearm. The resident was hit with the fork and responded by slapping Resident #1 on the right forearm. -08/24/19 at approximately 3 PM, Resident #1 entered the employee break-room and proceeded to pull a hose from a pipe located on the wall. This resulted in water spilling over the resident and the floor. -08/27/19 at approximately 4:26 PM, Resident #1 poured a cup of juice on another resident's head. Per review of the resident centered care plan, s/he is identified as someone that wanders, has	F 689	3.) What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? • Assign staff to work with residents in ways that support consistent relationships so that each resident develops a sense of safety and familiarity with staff. • Facility will provide activities appropriate for a resident's cognitive functioning and interests, as well as opportunities for walking, exploring and social interaction in a safe manner. • Accompany wandering residents on their journeys when required to ensure safety or encourage a meaningful alternate activity. • Facility has conducted staff training to educate on investigation to determine root cause of wandering and dementia behavior interventions for agitated residents and safely deescalating situations and/or resident-to-resident conflicts. • Monitoring environmental influences such as temperatures, lighting, noise level and sources of agitation. Resident #1 has been located to alternative dining room seating arrangement that is more conducive to individualized care and reduced stimuli. • Residents are offered visual Stop-Signs for doorway to mitigate wandering into other resident rooms. • Installation of a door keypad for employee break room to prevent unauthorized access.	

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F 689	Continued From page 2 poor interaction with others and has impaired cognition. Resident #1 is requiring more hands on cuing and staff should assist the resident to his/her room and/or walk him/her to his/her bed, help to bed and remove his/her shoes. The facility's interventions to help mitigate these tendencies were 15 minute checks, redirection, provide headphones to listen to music, provide diversional activities and relocate to a quiet environment. Per observation during the survey, the Surveyor observed Resident #1 ambulating independently throughout the facility, following staff and approaching residents in the hall. There was no observed headphone use, relocating the resident to a quiet space, and/or any attempt to manage the resident's aimless wandering. Confirmation is made by the Director of Nurses (DNS) on 08/28/19 at approximately 2 PM that the above information has been accurately obtained from the Electronic Medical Record.	F 689	4.) How the corrective action(s) will be monitored to ensure the deficient practice will not recur? Daily Nursing huddle is conducted on each change of shift to review behavioral conditions for residents. Implementation of individualized resident centered interventions including adequate supervision to reduce individual risk related to unsafe situations in the environment and monitoring for effectiveness. Facility will modify interventions when necessary. Facility interdisciplinary team will revise careplan(s) to support resident continued mobility, while protecting themselves and other residents with whom they may have contact. The QAPI Committee will review Fall Trending, Incident Reports, and resident-to-resident occurrences monthly. QAPI Committee will review all dementia management policies by October 15, 2019. Revisions to policies will be made to reflect current best-practices. Administrator shall be responsible to oversee the policy revision through the QA process. All revisions will be in conjunction with staff education. Resident incidents are reviewed at time of occurrence in a safety huddle to determine root-cause and new interventions. 5.) By what date the systemic changes will be completed? October 15, 2019 F689 POC accepted 9/30/19 MBerthaumeRN/PMC	10/15/19