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

January 21, 2022

Ms. Danielle Nickerson, Administrator
Mayo Healthcare Inc.
71 Richardson Ave
Northfield, VT 05663-5644

Dear Ms. Nickerson:

Enclosed is a copy of your acceptable plans of correction for the recertification survey and investigation conducted on **January 5, 2022.** 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 01/05/2022 |

| 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 |
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| E 000 | Initial Comments<br><br>The Division of Licensing and Protection conducted an onsite, unannounced emergency preparedness program investigation on 1/5/2022. The following regulatory deficiency was 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 laws. | |
| E 018 SS=C | Procedures for Tracking of Staff and Patients<br>CFR(s): 483.73(b)(2)<br><br>§403.748(b)(2), §416.54(b)(1), §418.113(b)(6)(ii) and (v), §441.184(b)(2), §460.84(b)(2), §482.15(b)(2), §483.73(b)(2), §483.475(b)(2), §485.625(b)(2), §485.920(b)(1), §486.360(b)(1), §494.62(b)(1).<br><br>[(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years [annually for LTC facilities]. At a minimum, the policies and procedures must address the following:]<br><br>[(2) or (1)] A system to track the location of on-duty staff and sheltered patients in the [facility's] care during an emergency. If on-duty staff and sheltered patients are relocated during the emergency, the [facility] must document the specific name and location of the receiving facility or other location.<br><br>*[For PRTFs at §441.184(b), LTC at §483.73(b), ICF/IIDs at §483.475(b), PACE at §460.84(b):] Policies and procedures. (2) A system to track the location of on-duty staff and sheltered residents in | E 018 | Upon identification of the alleged deficient practice by surveyors, the administrator took immediate action to ensure there is a clear tracking method for on-duty staff, below is a list of steps taken to be in complete compliance. Residents that could be potentially harmed by alleged deficient practice would be residents that are receiving care by on-duty staff members that are not being tracked during an emergency. The below steps have been taken to ensure that any potential residents that could be harmed by this alleged deficient practice is corrected. The administrator updated Mayo's Evacuation Policy and the Employee Communication-Form to track on-duty staff during an emergency. Education on new policy and procedure for tracking on-duty staff will be provided to all staff by 01/28/2022. Compliance will be monitored by yearly skills fair that includes the Evacuation Policy and Employee Communication-Form to track on-duty staff during the emergency. Updated policy will be discussed and reviewed in next QAPI meeting. | |

| LABORATOI | :R/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
|---|---|---|---|
| | , LNHA | Administrator | January 18, 2022 |

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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| E 018 | Continued From page 1<br>the [PRTF's, LTC, ICF/IID or PACE] care during and after an emergency. If on-duty staff and sheltered residents are relocated during the emergency, the [PRTF's, LTC, ICF/IID or PACE] must document the specific name and location of the receiving facility or other location.<br><br>*[For Inpatient Hospice at §418.113(b)(6):] Policies and procedures.<br>(ii) Safe evacuation from the hospice, which includes consideration of care and treatment needs of evacuees; staff responsibilities; transportation; identification of evacuation location(s) and primary and alternate means of communication with external sources of assistance.<br>(v) A system to track the location of hospice employees' on-duty and sheltered patients in the hospice's care during an emergency. If the on-duty employees or sheltered patients are relocated during the emergency, the hospice must document the specific name and location of the receiving facility or other location.<br><br>*[For CMHCs at §485.920(b):] Policies and procedures. (2) Safe evacuation from the CMHC, which includes consideration of care and treatment needs of evacuees; staff responsibilities; transportation; identification of evacuation location(s); and primary and alternate means of communication with external sources of assistance.<br><br>*[For OPOs at § 486.360(b):] Policies and procedures. (2) A system of medical documentation that preserves potential and actual donor information, protects confidentiality of potential and actual donor information, and | E 018 | **TAG E 018 POC Accepted on 01/20/22 by K. Ruffe/P. Cota** | |

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| E 018 | Continued From page 2<br>secures and maintains the availability of records.<br><br>*[For ESRD at § 494.62(b):] Policies and procedures. (2) Safe evacuation from the dialysis facility, which includes staff responsibilities, and needs of the patients.<br>This REQUIREMENT is not met as evidenced by:<br>Based on staff interview and record review, the facility failed to ensure there is a system to track the location of on-duty staff in the facility's care during an emergency. Findings include:<br><br>1. Per record review, the facility's emergency preparedness program did not contain policies or procedures for tracking on-duty staff in the facility's care during an emergency.<br><br>Per interview on 1/5/22 at approximately 9:30 AM, the Administrator confirmed that their emergency preparedness program policies and procedures did not include a system to track the location of on-duty staff during an emergency. | E 018 | Upon identification of the alleged deficient practice by surveyors, the facility took immediate action to ensure temperatures are being taken at each meal, below is a list of steps taken to be in complete compliance. Residents that could be potentially harmed by alleged deficient practice would be residents that receive meal that has not had temperatures taken. The below steps have been implemented to ensure that any potential residents that could be harmed by this alleged deficient practice is corrected. The corrective action will be monitored as follows; Food temperature logs have been updated; daily food temperatures at each meal are now recorded daily, instead of on a weekly sheet. Each evening the cook is responsible for making a copy and leaving the daily food temperature log in the administrators mail box, as well as put the sheet in a binder in the dietary office. All dietary staff will be fully educated on new daily form for taking temperatures and where to place the daily log in both the Administrators mail box and dietary office. This education for dietary staff will be completed by 01/21/2022. | |
| F 000 | INITIAL COMMENTS<br><br>The Division of Licensing and Protection conducted an onsite, unannounced recertification survey from 1/3/2022 through 1/5/2022. The following regulatory violation was identified: | F 000 | | |
| F 812 SS=E | Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2)<br><br>§483.60(i) Food safety requirements.<br>The facility must -<br><br>§483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. | F 812 | | |

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| F 812 | Continued From page 3<br>(i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations.<br>(ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices.<br>(iii) This provision does not preclude residents from consuming foods not procured by the facility.<br><br>§483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety.<br>This REQUIREMENT is not met as evidenced by:<br>Based on staff interview and record review, the facility failed to prepare, distribute and serve food in accordance with professional standards for food service safety. Findings include:<br><br>1. Per review of the facility food temperature logs between 7/5/21 - 12/26/21, there were no food temperatures recorded for 68 meals. Facility policy is to record food temperatures prior to service at each meal. U.S. Food and Drug Administration's (FDA) Food Code and the Centers for Disease Control and Prevention's (CDC) food safety guidance states that food temperatures above 41 degrees Fahrenheit (F) and below 135 degrees F that allow the rapid growth of pathogenic microorganisms that can cause foodborne illness. There is no evidence that the facility ensured that these standards were met on the 68 occasions. This was confirmed by the Administrator on 1/4/21 at 1:37 PM. | F 812 | Our staff development nurse will provide education to all staff on how to safely prepare, distribute and serve food in accordance with professional standards for food service safety. The education includes the food safety hazards that may result if food is not brought to the correct temperature and how this critical step helps to prevent or eliminate food borne illness that could potentially effect all residents. Education will be completed by 01/26/2022. Updated form and process will be discussed and reviewed in next QAPI meeting.<br><br>**TAG F 812 POC Accepted on 01/20/22 by K. Ruffe/P. Cota** | |