



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 Reporting Line (888) 700-5330
To Report Adult Abuse: (800) 564-1612

November 2, 2023

Ms. Shellie Stevens, Administrator
Mayo Healthcare Inc.
71 Richardson Ave
Northfield, VT 05663-5644

RE: Complaint Survey Findings - Past Non-Compliance

Dear Ms. Stevens:

On **October 25, 2023**, the Division of Licensing and Protection completed a complaint investigation at Mayo Healthcare Inc. As a result of that investigation, the Division determined that at a point in time prior to the date of our visit you were not in substantial compliance with the federal regulations applicable to long-term care facilities.

Statement of Deficiencies Form CMS 2567

Enclosed is a statement of deficiencies generated as a result of the survey. All references to regulatory requirements in the enclosure and in this letter are found in Title 42, Code of Federal Regulations. As the cited deficiency was corrected at the time of our visit, no plan of correction is required. Please **sign page 1 and return a signed copy of the 2567 to this office.**

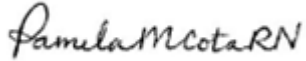
Informal Dispute Resolution

In accordance with §488.331, you have an opportunity to question cited deficiencies through an informal dispute process. To be given such an opportunity, you are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies to Suzanne Leavitt RN, MS, Assistant Division Director, Division of Licensing and Protection. **This written request must be received by this office by November 14, 2023.**

Per the CMS State Operations Manual, facilities may not use the informal dispute resolution process to delay the formal imposition of remedies or to challenge any other aspect of the survey process, including the:

- Scope and severity assessments of deficiencies, with the exception of scope and severity assessments that constitute substandard quality of care or immediate jeopardy;
- Remedy(ies) imposed by the enforcing agency;
- Alleged failure of the survey team to comply with a requirement of the survey process;
- Alleged inconsistency of the survey team in citing deficiencies among facilities;
- Alleged inadequacy or inaccuracy of the informal dispute resolution process.

Sincerely,

Handwritten signature of Pamela M. Cota RN in cursive script.

Pamela M. Cota, RN
Licensing Chief

Enclosure

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 475053	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 10/25/2023
--	---	--	---

NAME OF PROVIDER OR SUPPLIER MAYO HEALTHCARE INC.	STREET ADDRESS, CITY, STATE, ZIP CODE 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 The Division of Licensing and Protection conducted an unannounced, on-site investigation of complaint #22376 on 10/25/2023, to determine if the facility was in compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. The following regulatory violation was identified as a result; however, the facility completed corrective actions prior to the onsite survey, thus making this past non-compliance.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her	F 550		

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

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

PRINTED: 11/02/2023
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 475053	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 10/25/2023
NAME OF PROVIDER OR SUPPLIER MAYO HEALTHCARE INC.			STREET ADDRESS, CITY, STATE, ZIP CODE 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 550	<p>Continued From page 1</p> <p>rights as a resident of the facility and as a citizen or resident of the United States.</p> <p>§483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility.</p> <p>§483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on staff interviews and record review, the facility failed to ensure 2 of 2 applicable residents (Residents #1 & #2) were treated with respect and dignity. Findings include:</p> <p>Per record review and confirmed via interview, a Licensed Nursing Aide (LNA) verbally abused Residents #1 & #2 on 10/17/23. Per review of the facility's own investigation and confirmed by witness statements, a LNA told Resident #1 to "shut up" and called Resident #2 a "fool". These incidents were done while other staff members were present, and the remarks were heard by these staff members. Staff did intervene by speaking with the offending LNA and telling them this was inappropriate behavior. It is not known if the residents heard these remarks, but because of their cognitive status, they could not recall the incident. Both residents remain at their baseline, with no negative outcomes.</p> <p>When the LNA was interviewed by the Administrator, the LNA denied saying "shut up"</p>	F 550			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 475053	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 10/25/2023
NAME OF PROVIDER OR SUPPLIER MAYO HEALTHCARE INC.			STREET ADDRESS, CITY, STATE, ZIP CODE 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 550	<p>Continued From page 2</p> <p>but did confirm that s/he called the resident a "fool" after the resident called them a "fool". However, they said it was done so in a joking manner and not in a mean way.</p> <p>Based on corrective actions completed prior to the onsite, this citation is designated as past non-compliance. The following actions were completed by the facility:</p> <ol style="list-style-type: none"> 1. A report was made to The Agency as required on 10/18/23 and notification was made to Adult Protective Services (APS) on 10/18/23. 2. The LNA was terminated before their shift started on 10/18/23. 3. On 10/18/23, residents involved were assessed by a Registered Nurse (RN) and residents were determined to be at their baseline. 4. On 10/19/23 the Advance Practice Registered Nurse (APRN) assessed the residents in question and no negative outcomes were found. 5. Notifications were made to The Board of Nursing (BON) and the LNA's school, as s/he is still in high school and became an LNA through a technical center program at their high school. 6. Education regarding abuse prohibition, abuse reporting and dementia training was provided to staff on 10/18/23. 7. On 10/18/23 a discussion was held with the leadership team, and it will be brought forth at the next QAPI meeting on 10/31/23. 8. The facility interviewed 6 additional residents 	F 550			

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

PRINTED: 11/02/2023
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 475053	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 10/25/2023
NAME OF PROVIDER OR SUPPLIER MAYO HEALTHCARE INC.		STREET ADDRESS, CITY, STATE, ZIP CODE 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 550	Continued From page 3 to determine if they had ever had a negative interaction with any staff member and whether or not they felt safe in the facility. All indicated they were always treated with dignity and respect and felt safe.	F 550		