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 27, 2022

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

Provider #: 475053

Dear Ms. Nickerson:

Enclosed is a copy of your acceptable plans of correction for the **Life Safety Code survey** conducted on **January 5, 2022**. Please post this document in a prominent place in your facility.

We will 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

Enclosure

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	475053	A. BUILDING **01** B. WING _____	**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
K 000	INITIAL COMMENTS The Division of Fire Safety completed an unannounced onsite Life Safety Code inspection on January 5, 2022. Entry and exit interviews were conducted with the Administrator. While the facility was in substantial compliance with applicable Life Safety Code requirements, the following issues were identified that require correction by the facility.	K 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.	
K 232 SS=B	Aisle, Corridor, or Ramp Width CFR(s): NFPA 101 Aisle, Corridor or Ramp Width 2012 EXISTING The width of aisles or corridors (clear or unobstructed) serving as exit access shall be at least 4 feet and maintained to provide the convenient removal of nonambulatory patients on stretchers, except as modified by 19.2.3.4, exceptions 1-5. 19.2.3.4, 19.2.3.5 This REQUIREMENT is not met as evidenced by: Per observation on January 5, 2022, the facility failed to ensure that aisles, corridors, and ramps meet the minimum width. Findings include the following: Per observation on January 5, 2002, and accompanied by the Director of Facility Maintenance, inspection revealed empty PPE boxes were found in the Turkey Hill corridor.	K 232	Upon identification of the alleged deficient practice by surveyor, the Maintenance Director took immediate action and removed boxes from hallway. Residents that could be potentially harmed by alleged deficient practice would be residents that reside on the hallway that has obstructions. The below steps have been taken to ensure that any potential residents that could be harmed by this alleged deficient practice is corrected. Education was provided to all staff regarding the importance of corridors not being obstructed and that boxes can not be left on the floor in any hallways. Education to all staff will be provided by 01/28/2022. The alleged deficient practice and steps taken to correct it, will be discussed and reviewed in next QAPI meeting. K232 POC Accepted 1/26/22 *P.McLaughlin* *T Wehmeyer*	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
, LNHA	Administrator	01/18/2022

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.