

Division of Licensing and Protection
103 South Main Street
Waterbury, VT 05671-2306
<http://www.dail.vermont.gov>
Voice/TTY (802) 871-3317
To Report Adult Abuse: (800) 564-1612
Fax (802) 871-3318

October 5, 2015

Ms. Christine Scott, Administrator
Mayo Healthcare Inc.
71 Richardson Ave
Northfield, VT 05663-5644

Dear Ms. Scott:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **August 18, 2015**. 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



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

PRINTED: 09/24/2015
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 08/18/2015
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NAME OF PROVIDER OR SUPPLIER MAYO HEALTHCARE INC.	STREET ADDRESS, CITY, STATE, ZIP CODE 71 RICHARDSON AVE NORTHFIELD, VT 05663
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(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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F 282 Continued From page 1
Resident #1 did receive physical therapy when first admitted but was discontinued after several weeks. Per a care plan revision and a physician order dated 06/19/15, states "PT [physical therapy] to eval and treatment". There is no documentation to note the full evaluation nor the treatment provided. Per a telephone interview on 08/18/15 at 4:34 PM the physical therapist (PT) confirmed the evaluation and treatment were not done, only a screen. Additionally, the resident had four falls within a period of approximately one month from 06/22/15, with an injury consisting of a fracture to the right hip resulting from the last fall on 07/31/15.
Per a nursing note dated 08/07/15 at 0430 AM states resident was very restless, anxious and complaining of pain at 0030 (12:30 AM). Trying to climb out of lounge chair, given Ativan 0.25mg (anti-anxiety) with effect. Per review of the MAR [medication admission record] the resident's treatment procedure is to check the pain levels every shift. At that time (on 08/07/15) the As Needed Administrations Report documentation shows the pain level of a five out of ten which is noted as severe. No pain medication was given. A physician order is noted for Tramadol HCL 50mg 1 tab every six hours as needed for severe pain. Tramadol 50mg was given the night before on 08/06/15 at 5:29 PM for severe pain and on 08/07/15 at 6:24 AM for severe pain but not was not given on 08/07/15 at 0030 when the resident was complaining of pain. The Unit Manager on 08/18/15 at 4:45 PM stated "I am not sure why the Nurse gave Ativan, I can't speak for [the nurse]." The Unit Manger acknowledged that [she/he] would have given pain medication for that level of pain.

F 514 483.75(l)(1) RES

F 282
To ensure that all staff remains aware of this potential for deficient practice care plans will be audited weekly by the DNS or designee. Any problem areas that are not clearly defined will be corrected. Education will be provided to those involved. Results of these audits will be reviewed by the Quality Assurance Committee. The frequency & duration of further audits will be determined by the committee.

F 282 POC accepted 10/2/15 SEMMUNRN/PML 10/31/15

F 514

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F 514 SS=D	<p>Continued From page 2</p> <p>RECORDS-COMPLETE/ACCURATE/ACCESSIBLE</p> <p>The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.</p> <p>The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.</p> <p>This REQUIREMENT is not met as evidenced by: The facility failed to maintain clinical records for one applicable in the sample resident in accordance with accepted professional standards and practices that are complete and accurate. (Resident #1) Findings include:</p> <p>During record review on 08/18/15 there is not a representation of the actual experience of the individual in the facility and there is missing information. Resident #1 was admitted on 03/26/15 with diagnoses of dementia, neoplasm of brain, cerebral degeneration without psychosis, osteoarthritis, reflux, HTN, hypothyroidism and wandering. The resident was placed on an anti-psychotic medication, Seroquel on 05/27/15. Per the Facility's self report and subsequent telephone interview with Division of Licensing and Protection on 06/01/15 the DNS [Director of Nursing] stated "Although [resident] is pleasant enough, [the resident's] behavior is exhibited by</p>	F 514	<p>F-514</p> <p>Review of the medical record reveals documentation from the NP on 06/15/15 of "dementia with agitation and paranoia". The PCP documented "becoming agitated and violent at times" on 07/08/15 and "poor short term memory and can be aggressive" on 08/06/15. Dementia with behaviors and paranoia has been added to the Master Diagnosis list.</p> <p>Since all Residents have the potential for this same deficient practice all RN/LPNs will be educated on the importance of transcribing any new diagnosis written by the PCP or NP be transcribed to the Master Diagnosis list.</p> <p>Nurse's notes reflect incidents of agitated behavior on 06/27/15 and 07/19/15. However, all RN/LPNs will be re-educated on the need to document specific instances regarding behaviors that might put a resident at risk of self or others. In-service education will be provided by the DNS, Staff development Coordinator or designee.</p>	
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F 514 Continued From page 3
wandering". And "can be intrusive in other resident rooms as evidenced by rearranging personal items of others". Per the interview on the morning of 08/18/15 the DNS stated the resident's personality can be blunt but not aggressive. "Some of the incidents are what we viewed as [the resident] being in someone's space but not necessarily intrusive just being curious and of course some other residents do not tolerate that well". The nurse surveyor asked if there were any instances other than wandering, which put the resident at risk of self or others. The DNS stated that the resident showed aggressive behavior by "pounding on the glass door almost breaking it". However, there was no evidence in the chart or any incident report that could collaborate that. The DNS confirmed that there was no documentation of that incident.

In addition, during the review of the MAR, nursing note and an As Needed Administration Report missing information was noted. The Unit Manager at 4:45 PM stated "We have been having problems with (PharMercia-software program) and sometimes the MAR sheets don't match up with what staff have given".

F 514 The DNS, Unit Manager or designee will conduct weekly audits to be sure all Master Diagnosis lists are current and complete and documentation reflects behaviors that may require more monitoring. Results of these audits will be reviewed by the Quality Assurance Committee. The frequency & duration of further audits will be determined by the committee.

10/31/15

F514 POC accepted 10/2/15 SEMMONS Pdl/AME