



AGENCY OF HUMAN SERVICES  
DEPARTMENT OF DISABILITIES, AGING AND INDEPENDENT LIVING  
Division of Licensing and Protection

103 South Main Street, Ladd Hall  
Waterbury VT 05671-2306  
<http://www.dail.vermont.gov>  
Voice/TTY (802) 241-2345  
To Report Adult Abuse: (800) 564-1612  
Fax (802) 241-2358

July 12, 2010

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

Provider #: 475053

Dear Ms. Scott:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **June 17, 2010**. 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,

A handwritten signature in cursive script that reads "Suzanne E. Leavitt RN, MS".

Suzanne Leavitt, RN, MS  
Assistant Director

Enclosure



PRINTED: 06/28/2010  
FORM APPROVED  
OMB NO. 0938-0391

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

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 06/17/2010
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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 000	INITIAL COMMENTS	F 000	The submission of this plan of correction does not imply agreement with the existence of a deficiency. It is submitted in the spirit of cooperation, to demonstrate our commitment to continued improvement in the quality of our resident's lives.	
F 157 SS=D	<p>483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC)</p> <p>A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).</p> <p>The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.</p> <p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p>	F 157	<p>Review of the Medical Record for Resident #1 for the fall on 9/9/09 @ 4:20 PM shows no documentation of the MD being notified until 9/10/10 @ 10:45 AM as cited. Interview of the RN who notified the family and initiated Neuro checks, reports that the physician was notified within the hour of the incident, but she did not document notification in the Nurses notes. This RN has been re-educated to the appropriate practice.</p> <p>Since all Residents have the potential to be affected by this same deficient practice, all RN/LPN staff will be In serviced to notify physicians immediately of falls with injury.</p>	7/7/10

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Christine Scott Administrator</i>	TITLE	(X6) DATE 7/7/10
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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 157	Continued From page 1  This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to immediately notify the physician of a fall with injury for or e resident (Resident #1). Findings include:  Per record review on 6/09/10, Resident # 1 sustained a fall on 9/9/09 at 4:20 PM that resulted in a hematoma to the right side of the head. The Nurse Progress Notes document that the resident was assessed and neurological checks were done as standard protocol for trauma to the head. The documentation stated that the physician was notified by fax on 9/10/09 at 10:45 AM, over 18 hours after the fall occurred. Per interview on 6/9/10 at 4:00 PM, the Director of Nursing confirmed that there was no other documentation to indicate that the physician had been contacted before the fax was sent on 9/10/09.	F 157	The Fall Incident report form has been revised to include directions for staff to notify the Physicians immediately of all falls with injury and to document such notification in the Nurses Notes.  All Fall Incident reports will be reviewed by the DNS and submitted to the QAA Committee to assure continued compliance.	7/17/10
F 157 POC accepted Karen Campa RN 7/8/10				