

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

December 7, 2011

Ms. 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 **November 2, 2011**. 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

PC:ne

Enclosure



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

RECEIVED

Division of

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PRINTED: 11/15/2011

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 _____ Licensing and Protection	(X3) DATE SURVEY COMPLETED 11/02/2011
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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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F 000 F 272 SS=D	<p>INITIAL COMMENTS</p> <p>An unannounced on-site re-certification survey was conducted by the Division of Licensing and Protection from 10/31/11 to 11/2/11. The following are regulatory findings.</p> <p>483.20(b)(1) COMPREHENSIVE ASSESSMENTS</p> <p>The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity.</p> <p>A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and</p>	F 000 F 272	<p>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.</p> <p>F-272 The nurse assigned to Resident #4 has been re-educated on Mayo Healthcare's policies and procedures for completing all comprehensive assessments, including complete skin assessments. Since all residents have the potential to be affected by the same deficient practice all licensed RN/LPNs will attend a Mandatory In-Service education session to review our current policies and procedures pertaining to this issue conducted by our Staff Development Coordinator or designee.</p>	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Christine Scott</i>	TITLE <i>Administrator</i>	(X6) DATE <i>11/22/11</i>
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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 272	<p>Continued From page 1 Documentation of participation in assessment.</p> <p>This REQUIREMENT is not met as evidenced by: Based upon interview and record review, the facility failed to conduct a complete skin assessment for 1 of 13 residents in the stage 2 sample, following a readmission from the hospital to the facility (Resident # 4). Findings include:</p> <p>Per record review of the 8/26/11 nursing skin assessment sheet and confirmed with the Unit Manager on 11/1/11 at 12:58 PM, an incomplete skin assessment was conducted for Resident # 4 and did not include the coccyx area after his/her readmission to the facility on 8/26/11. Per review of the 8/29/11 nursing notes and confirmed with the Unit Manager on 11/1/11 at 12:58 PM, a Stage 3 pressure ulcer was identified on Resident # 4's coccyx on 8/29/11 three days after readmission to the facility. Per 8/29/11 nursing note, the pressure ulcer measured 3.0 centimeter by 2.4 centimeter with a 0.2 centimeter bruised ridge on right side of wound and slough covered wound base.</p> <p>Per interview with the staff nurse on 11/1/11 at 2:30 PM, s/he performed a skin assessment for Resident #4 on 8/26/11 while the resident was sitting in a chair and did not visualize the coccyx area. Per review of the "Pressure Ulcer</p>	F 272	<p>All new Admissions and readmissions medical records will be audited daily by the DNS or designee to assure that all skin assessments have been completed. Any omissions will be researched & 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.</p> <p>F272 POC accepted 12/1/11 SEMMONS RN / ANCOBARN</p>	12/27/11
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F 272	Continued From page 2 Prevention" facility policy and confirmed with the Director of Nursing (DNS) on 11/1/11 at 1:57 PM, a comprehensive skin assessment will be completed on all new admissions and readmissions within 2 hours of admission. Also see F314.	F 272		
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based upon interview and record review, the facility failed to ensure that 1 of 3 applicable residents received necessary treatment and services to promote healing and prevent infection of a Stage 3 pressure ulcer which was identified three days after readmission to the facility from the hospital. (Resident #4) Findings include: Per record review and confirmed with the Unit Manager on 11/1/11 at 12:58 PM, Resident #4 was admitted to the hospital on 8/20/11 and readmitted to the facility on 8/26/11. The readmission nursing skin assessment conducted on 8/26/11 did not indicate any skin changes or pressure area on the coccyx. On 8/29/11, the	F 314	F-314 Mayo Healthcare's current Admission/Readmission policies and procedures direct the RN/LPN staff to review Physician Orders and Transfer forms upon admission to assure that Physician orders are transcribed and any information on the Transfer form is taken into consideration when developing all necessary treatments and services to meet the resident's needs.	

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F 314	<p>Continued From page 3</p> <p>Unit Manager stated s/he identified a Stage 3 pressure ulcer on Resident #4's coccyx during routine wound rounds. The pressure ulcer measured 3.0 centimeters by 2.4 centimeters with a 0.2 centimeter bruised ridge on the right side of the wound with slough covering the wound. In addition, the Unit Manager found an "Allevyn" brand dressing on the resident's coccyx which is used by the hospital and not used by the facility.</p> <p>Per record review and confirmed with the Unit Manager on 11/1/11 at 12:58 PM, the hospital Faxed resident # 4's discharge instructions dated 8/26/11 which state "Change Allevyn dressing on back every 3 days and as needed".</p> <p>Per record review and interview with the DNS on 11/1/11 at 1:57 PM, it is the DNS's expectation that Resident #4's coccyx should have been assessed on 8/26/11 after readmission to the facility, that the skin assessment conducted on 8/26/11 does not contain any documentation that an Allevyn pressure ulcer dressing was present on the coccyx or that a pressure ulcer was present. The Unit Manager also confirmed on 11/1/11 at 1:57 PM that Resident #4's Stage 3 pressure ulcer was not identified until 3 days following readmission.</p> <p>Per review of the "Admission and Readmission" facility policy and confirmed with the Director of Nursing on 11/1/11 at 1:57 PM, upon readmission to the facility the RN/LPN will Complete a Nursing Admission Assessment, Review Physician Orders and Transfer Form that arrives with the resident, Assure that Physician orders are transcribed according to policy, and Discuss resident's needs</p>	F 314	<p>The nurse assigned to complete the Readmission protocol for Resident #4 was unaware of the need to obtain necessary treatment to promote healing and prevent infection of the pressure ulcer because the pressure ulcer was not discovered upon readmission on 8/26/11. By virtue of this nurse receiving re-education on Mayo Healthcare's policies and procedures for completing all comprehensive assessments, including complete skin assessments, this nurse fully understands the importance of completing these assessments so that Physician Orders for necessary treatment and services can be obtained.</p> <p>All Residents have the potential to be affected by this deficient practice. Therefore, all licensed RN/LPNs will attend a Mandatory In-service Education session to review our current policies and procedures pertaining to this issue.</p> <p>Additionally, all RN/LPNs will be reminded not to completely rely on the information provided by the Admission/Readmission and Transfer paperwork from the referring institution. Timely completion of Mayo Healthcare's assessments is required.</p>	

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F 314	Continued From page 4 with nursing team and inform team of any changes in care as a result of readmission. Also see F272	F 314	All new admissions and readmissions medical records will be audited weekly by the DNS or designee to determine that all comprehensive assessments have been completed and all necessary Physician orders for treatment and services have been obtained to meet the resident's needs. Results of these audits will be reviewed by the Quality Assurance Committee. The frequency & duration of further audits will be determined by the committee. <i>F314 POC accepted 12/11/11 S. Emmons RN / P. Motorn</i>	12/21/11
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection	F 441	F-441 Mayo Healthcare's Infection Control program is designed to provide a safe, sanitary and comfortable environment and help to prevent the development and transmission of disease and infection. Our policy states that if any resident is using a bedpan, urinal or specimen collection device on a routine basis, the device should be labeled with the residents name, cleaned and disinfected and returned to the resident's bedside stand after each use. Specimen collection devices that are used once will be labeled and discarded after the specimen is collected to prevent cross-contamination.	

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F 441	<p>Continued From page 5</p> <p>(1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.</p> <p>(2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.</p> <p>(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to provide a sanitary environment to prevent potential for contamination. Findings include:</p> <p>1. Per observation on 10/31/11 at 11:25 AM during the initial tour and on the morning of 11/01/11 there was a failure to assure urinary measuring devices were labeled and/or disinfected. Per observation during the initial tour on 10/31/11 at 11:15 AM and on the morning of 11/01/11, several un-labeled urinary measuring devices were found in 5 shared bathrooms, with one device having a dark stained residue in it. In the shared bathrooms, which 4 potential residents use per bathroom, there were</p>	F 441	<p>On the evening of 10/31/11 an LNA was assigned to collect and disinfect all urinary measuring devices that had been distributed throughout the facility. This LNA did not collect all devices as assigned.</p> <p>The one device having the dark stained residue has been discarded. All residents have the potential to be affected by this deficient practice. Therefore, all nursing staff will attend a Mandatory In-service Education session to be re-educated on the importance of collecting specimens in a timely manner and removing urinary collection devices after use.</p> <p>Random audits and observations of each resident's bathroom will be conducted by the DNS or designee to assure that all urinary collection devices are either labeled for routine use or removed after one time use.</p> <p>Results of these audits will be reviewed by the Quality Assurance Committee. The frequency & duration of further audits will be determined by the committee.</p> <p><i>F441 POC accepted 12/1/11 S. Emmons RN/Pharmacian</i></p>	<i>12/29/11</i>

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F 441	Continued From page 6 un-labeled devices in the bathrooms between rooms 9&10, 12&13, 14&15, 21& 22, and in the shared bathroom between 19 & 20 there was an un-labeled and dirty device. Per interview on 11/01/11 at 9:20 AM the Infection Control Coordinator confirmed the above findings did not meet the policy and procedure for infection control practices.	F 441		
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