STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	475053	A. Building B. Wing	03/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mayo Healthcare Inc.	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)
F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48017 Based on record reviews and interviews, the facility failed to clarify code status and review care plan instructions and determine if the resident wishes to change or continue these instructions related to Advanced Directives, for 1 of 25 Residents in the sample. (Resident #15). Findings include: Per a record review, Resident #15 has resided at the facility since 12/13/2016 with the following diagnoses: Hemiplegia and Hemiparesis (A severe or complete loss of strength or paralysis on one side of the body) following a cerebral infarction (a stroke) and Dysphagia (Difficulty swallowing) related to the cerebral infarction. Another record review indicates a COLST (clinician orders for life-sustaining treatment) form that is dated 2/13/24 and signed by the Nurse Practitioner (NP) and Resident# 15's Power of Attorney (POA). The form indicates that the resident should be resuscitated, including chest compression, intubation, mechanical ventilation, defibrillation, and transfer to the hospital. Another record review reveals the Medication Administration Record (MAR) indicates Resident #15 is a Full Code (If the heart stops beating and/or breathing stops, all resuscitation procedures will be implemented to sustain life) A record review of Resident 15's care plan revealed the following entry: [name] has an advance directive of DNR/DNI (Do not resuscitate/Do not intubate), with an entry date of 1/24/24. Per an interview with the Unit Manager on 3/13/24 at 8:51 AM, s/he confirmed there is a discrepancy in the medical record; the care plan does not match the COLST or the MAR, s/he indicated Resident # 15 had a procedure that required her to have a code status that allowed resuscitation, and the correct status was not updated to reflect the resident's wishes of DNR/DNI.

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.

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

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44192 Based on observation, interview, and record review the facility failed to ensure that there was a care plan in place related to behaviors for 1 of the 3 sampled residents (#28), related to pressure ulcers for 1 of 4 sampled residents (Resident #31), and related to end-of-life care for 1 of 2 sampled residents (Resident #17). findings included: 1. Per observation of an interaction on 3/11/24 at approximately 12:00 PM, Resident #28 was overheard saying I'm going to deck you! to a nurse while staff attempted to draw blood from them. Per observation of an interaction on 3/12/24 at approximately 11:00 AM, Resident #28 was observed making a gesture toward a nurse giving them medications as if they would dump water on the nurse. Per record review, Resident #28 has exhibited a pattern of aggressive and labile behaviors since their initial admission to the facility on [DATE]. The following progress notes were found in Resident #28's chart: - 11/3/2023 15:14 Activity Note When writer was assisting [Resident #28] to make a phone call [Resident #28] hollered several times to 'get that Goddamn mask of my face' she also hollered that the operator knew where to find the 'goddamn number' [Resident #28] flailed [their] arms around in a way that made me leave to diffuse the situation. - 11/17/2023 13:42 Activity Note Activity Assistant was playing cards with [Resident #28] and another resident. [Resident #28] started to get disruptive with activity assistant, grabbing at her hands and cards. [Resident #28] used profanity and called the activity assistant names, activity assistant stopped the game and had to walk away to give [Resident #28] space. Social worker was made aware of the situation. - 11/21/2023 05:01 Behavior Note Resident was heard slamming the door over and over and screaming for help, when this scribe went to resident's door, bottom half was closed and resident stated open this damn door before I break it down door opened and resident sitting in wheelchair without [their] oxygen at this time. Resident was asked to put oxygen back on where [they] became agitated and stated 'when will you people understand, i don't need to wear that all the time'. - 12/3/2023 02:43 Nursing/Health Status Note . Resident hitting [their] bed and flailing [their] arms and body around and grabbing at this writer . - 1/25/2024 15:54 Activity Note [Resident #28] was in the hallway stating that she was very mad, using profanity, that [their] new roommate has 'a lot of junk in the room' . [Resident #28] was raising [their] voice in anger about having a roommate. - 2/11/2024 16:05 Behavior Note [Resident #28] was playing cards with other resident, where [they] began to yell at [other] resident saying [they weren't] smart enough to be playing so [they] shouldn't play anymore. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Per interview on 3/12/2024 at approximately 12:00 PM, an LPN who works with Resident #28 regularly stated that Resident #28 generally has a gruff and dry sense of humor, but at times can smack and grab staff when upset. When they first started working with Resident #28, they needed a lot of help from other staff who knew Resident #28 well in order to learn how to effectively manage Resident #28's behaviors. Per review of Resident #28's care plan, Resident #28 has no care plan focus or care plan interventions that address Resident #28's behaviors or what interventions can be used by staff when Resident #28 exhibits maladaptive behaviors. Per interview on 3/13/24 at approximately 1:00 PM, The Director of Nursing confirmed that Resident #28 does not have a care plan for behaviors despite exhibiting a pattern of behaviors. 46442 2. Per Record review, Resident #31 has a provider order started on 3/5/24 for Stage 2 (an open wound) sacral region (the area at the top of the buttocks); Cleanse with soap and water, pat dry apply collagen powder (a treatment used to encourage healing) to 2 open areas, and cover with Mepliex foam border dressing every day shift every 3 days for stage 2 wound care and as need for soiled or dislodged dressing. A progress note written by the Nurse Practitioner (NP) on 3/4/24 reveals there are 2 small round open areas. The note indicates these are stage 2 pressure ulcers with 100% epithelial tissue which is a thin, continuous, protective layer of compactly packed cells. The note includes measurements of 1.62 centimeters (cm) in length and 0.61 cm in width and scant depth. Further record review reveals a skin and wound evaluation dated 3/4/24 related to the stage 2 pressure ulcers, including the above wound measurements. Per an interview with the Unit Manager Licensed Practical Nurse on 3/13/24 at 12:22 p.m. s/he confirms that there was not a care plan for Resident# 31 pressure ulcers, the care plan was added after the facility was made aware that there was not one in place earlier this morning 3/13/24. 48017 3. Per an interview on 3/12/23 at approximately 9:00 AM, Resident #17's family indicated Resident# 17 had been refusing food and medications for several days. The decision was made to start end-of-life care. The family did not want complete Hospice care; rather, they felt the facility could provide adequate pain control and allow the family to be present. The resident was moved to a designated space that the facility provided for end-of-life care. Per record review, Resident #17 has a diagnosis of Alzheimer's Dementia and chronic pain related to spinal stenosis (when the space inside the backbone is too small, putting pressure on the spinal cord and nerves that travel through the spine). A progress note written by the Nurse Practitioner (NP) on 3/4/24 reveals a discussion with Resident 17's family regarding the recent decline and the family's decision to move Resident #17 to end-of-life care. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A record review of Resident#17's care plan reveals no evidence of a comprehensive care plan developed specifically for end-of-life care. Per an interview on 3/12/24 at approximately 1:30 PM with the Unit Manager, a Licensed Practical Nurse (LPN), when asked about the care plan, s/he indicated the nursing staff knew how to care for the resident because [s/he] was in that room. Per an interview with the Director of Nursing on 3/13/24 at approximately 1:10 PM, s/he confirmed that the care plan was not developed to reflect Resident#17's care change. S/he agreed the care plan should have been updated to reflect the resident's person-centered goals at the end of life.

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F 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Plan the resident's discharge to meet the resident's goals and needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 29776 Based upon interview and record review, the facility failed to develop a discharge care plan to identify goals and needs prior to discharge for 1 resident [Res.#40] of 4 residents reviewed. Findings include: Per review of Physician notes dated 12/5/23, Res. #40 was admitted to Mayo initially after a fall and femur fracture in September. [S/he] was discharged home in early November. A few days later [s/he] had a fall and went back to the Emergency Department. Res. #40 was admitted back to Mayo on 11/17/23, where the physician noted Res.#40 is making some progress with physical therapy and plan is to return home. Review of Res.#40's medical record after their admission on 11/17/23 reveals no documentation involving the resident and/or a resident representative in the development of the discharge plan. Review of Res.#40's Care Plan reveals no mention of discharge or that the discharge needs of the resident were identified and the resident or representative informed of a final plan. Per review of Res. #40's medical record, there are no Social Services notes after h/her admission to the facility on [DATE]. Res.#40 was discharged from the facility on 12/20/23. Physician notes prior to the resident's discharge recommend on-going Physical Therapy after discharge, along with blood pressure monitoring related to h/her recent hospitalization due to blood pressure issues, and additional support at home for safety concerns related to the resident's diagnosis of Alzheimer's dementia with mood disturbance. Review of Res.#40's discharge summary contains only a referral to a local Home Health Agency made on the day of discharge, with no listing of the recommended services in place. Further review of the Discharge Summary reveals Occupational Therapy recommendations for meals on wheels and a 'Life Alert' telecommunication system. The Discharge Summary lists meals on wheels, Lifeline, as well as the physician's recommendation for Outpatient Therapy as support services available, with none marked as arranged prior to discharge. An interview was conducted with the Director of Nursing [DON] on 3/13/24 at 9:59 AM. The DON reported they would investigate Res.#40's Care Plan regarding discharge planning. The DON was unable to produce any documentation that the discharge needs of the resident were identified and a discharge plan developed to address the resident's discharge goals and needs.

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F 0712 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that the resident and his/her doctor meet face-to-face at all required visits. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44192 Based on staff interview and record review, the facility failed to ensure that every resident is seen by a provider, who assesses the residents' total program of care, once every 30 days for the first 90 days after admission and then every 60 days thereafter for 6 of 25 sampled residents (Residents #28, #38, #30, #31, #29, and #22). Findings include: 1. Per record review, Resident #28 was admitted on [DATE]. Records of physician visits, during which they assessed the Resident's total program of care, were found for the dates of 9/29/23 and 3/10/24. A Nurse Practitioner note is also present with a date of 1/2/24. There were no other physician visit notes of this type in Resident #28's record. Per interview on 3/12/24 at approximately 1:45 PM, The Unit Manager confirmed that there were not enough provider visit notes in Resident #28's chart to meet the regulation. 2. Per record review, Resident #38 was admitted on [DATE]. No physician notes that contained a review of the total program of care could be located in Resident #38's record. 3. Per record review, Resident #30 was admitted on [DATE]. Only one physician/provider note that contained a review of the total program of care could be located in the chart on 1/3/24. 4. Per record review, Resident #31 was admitted on [DATE]. No physician notes that contained a review of the total program of care could be located in Resident #31's record. 5. Per record review, Resident #29 was admitted on [DATE]. No physician notes that contained a review of the total program of care could be located in Resident #29's record. 6. Per record review, Resident #22 was admitted on [DATE]. No physician notes that contained a review of the total program of care could be located in Resident #22's record. Per interview on 3/13/24 at approximately 1:00 PM, the Administrator confirmed that resident records did not reflect the appropriate amount of physician/provider visit notes that include a review of the total program of care for each Resident.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44192 Per observation, interview, and record review, the facility failed to maintain an Infection, Prevention, and Control Program (IPCP) that reduces the risk of Residents contracting communicable diseases to the greatest extent possible as evidenced by an IPCP that is not updated annually, a lack of transmission-based precaution signage, and a lack of a water management program for Legionella. Findings include: 1. Per review of the provided IPCP polices and procedures, all policies and procedures had a last revised date in the year 2022. Per interview on 3/13/24 at approximately 12:00 PM, the Administrator confirmed that the facility's IPCP has not been reviewed or updated within the last year as required. 2. Per observation on 3/12/24 at approximately 11:00 AM, there was a Personal Protective Equipment (PPE) cart outside of Resident #3's room. A sign on the door said check with nurse prior to entering and another sign said wash hands with soap and water. A housekeeper inside the resident room is wearing PPE (gown, gloves). There is no signage on the door to indicate which type of transmission-based precautions staff/visitors should use or what PPE to use in the room. Per observation on 3/13/24 at approximately 9:00 AM, Resident #3's room had no change in signage. Per record review, Resident #3 is currently diagnosed with Clostridioides Difficile (a gastrointestinal infection that is very contagious and that resists common treatments) and contact precautions are to be used when in the room or providing Resident #3 with care. Per interview on 3/13/24 at approximately 1:30 PM, the Director of Nursing confirmed that the proper signage to indicate which PPE items to use in Resident #3's room was missing. 3. Per interview on 3/13/24 at approximately 1:20 PM, the facility Maintenance Manager stated that they have been in the role since the summer of 2023. When they came on board, they decided to test the water for legionella at 16 previously identified risk sites within their water system. In August 2023, two of these tests came back positive for Legionella. The access points at the positive sites were shut off and disconnected. All other areas that had not tested positive for legionella remained accessible to staff and residents. The Maintenance Director confirmed that there were no additional measures implemented to treat the water system. The Maintenance Director stated that the facility uses water from the town's Department of Public Works. The Maintenance Director stated that he believes that the town water is chlorinated by the Department of Public Works, but confirms that the facility does not monitor the town's chlorination levels or testing and cannot validate that the town's mitigation measures are within acceptable parameters to prevent growth of Legionella. They were not aware of the facility having any formal Water Management Program or policy. Per review of the facility policy titled Water Management Program, the policy states the following: II) [The Facility's] building water system description includes: (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	a) Water originates from the Town of Northfield's Department of Public Works b) Testing and treatment (chlorination) is performed at the DPW facility . The policy also describes the following procedure in the event of legionella in the water system: PROCEDURE: 1. Upon notification that a resident has been diagnosed with Legionnaires' disease, notify the [NAME] Department of Health for direction. 2. If [The facility]'s water system is suspected as having Legionella, the [NAME] Department of Health will work with Mayo to collect samples of water for them to test. (Typically, test results take 10 days). 3. Notify DLP (Division of Licensing and Protection) 4. Until test results are available the following steps will be taken: a. Restrict bathing in all century tubs and showers b. Restrict use of all ice machines; empty all ice machines and discard all ice stock from the machine. c. Ask the Dept of Health if we should move to using bottled water versus tap water 5. Call [contracted services] to schedule an eradication of the building's water system. If possible, schedule this in advance of the results on a contingency basis. Here is a sample process that is followed when eradication) occurs. When scheduled, this should be reviewed and agreed on with the firm doing the eradication. In addition, all managers and staff need to be alerted in advance. The evening of the eradication: 1. 5:00pm: [Facility] Maintenance Staff, including director, are scheduled to work overnight. The maintenance director increases water temperature on water heaters to 170 degrees and bypasses the mixing valve. All water use in building is secured except for toileting. To secure the water supply, we post signs over all faucets and on any equipment to note use the water. 2. At the same time, the technician from the eradication group arrives and begin: preparations, installing a chemical feed pump to the main infeed of town water. 3. 5:30pm -The eradication group begins pumping a 12.5% sodium hypochlorite solution (or equivalent) into the water infeed. [Facility] Maintenance staff proceed to run water at the end of each water branch through the building until chlorine is detected in both hot and cold water lines. Water is run at preceding fixtures to ensure chlorine is present at all points of the branches. Chlorine levels were monitored by serial dilution method as instructed by the eradication group. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	4. 6:00pm-5:00am - Every hour on the hour, Maintenance Staff run water at all fixtures for 2 minutes introducing a fresh chlorine solution into the system at all points. The eradication group continues to monitor solution injection and running water in fixtures and plumbing in basement. 5. Next Morning, 5:30 am - The eradication group stops chlorine injection. [Facility] Maintenance Staff begin flushing the water system, ensuring there is less than .1 mg/l of chlorine at all fixtures using serial dilution method. 6. 6:30 am - Maintenance Staff adjust water heaters down to normal temperature of 160 degrees and mixing valve adjusted to provide normal temperature of 110 degrees. Water use is returned to normal. 7. 3:00 pm - Maintenance Director collects water samples and swabs from all fixtures/areas that tested positive at earlier testing done by [NAME] Department of Health. Samples are then driven to lab for testing. Lab testing must be arranged in advance.