VERMONT

Department of Disabilities, Aging and Independent Living
Division of Licensing and Protection
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AGENCY OF HUMAN SERVICES

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

March 12, 2026

Regan Smith, Manager
Mayo Residential Care
610 Water Street
Northfield, VT 05663-5640

Dear Ms. Smith:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **January 29, 2026.** 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.

If you have any questions, please feel free to contact me at (802) 585-0995.

Sincerely,

Carolyn Scott, LMHC, MS
State Long Term Care Manager
Division of Licensing & Protection

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0199	A. BUILDING: _____ B. WING _____	C 01/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAYO RESIDENTIAL CARE	610 WATER STREET NORTHFIELD, VT 05663

R225 and R443 Accepted
3-12-2026
Susan Canas Gregoire RN

(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) COMPLETE DATE
R100	Initial Comments On January 29, 2026, the Division of Licensing and Protection conducted an unannounced, on-site annual survey, which included the investigation of two separate complaints. The following deficiencies were identified:	R100	This Plan of Correction (POC) is submitted to meet the requirements of established federal and state laws and does not constitute admission of deficiencies.	1/29/2026
R225 SS=F	5.12. b (4) Records/Reports The home must keep and maintain the following records: The results of the criminal record and adult abuse registry checks for all staff: This REQUIREMENT is not met as evidenced by: Based on staff interview and record review there is a failure to ensure all background checks were completed as required for two out of five staff. Findings include: The home's Background Checks Policy states that background checks are done "Annually, &/or when performance evaluation is due" and randomly if issues are suspected. On the morning of January 29, 2026, documentation of criminal record and abuse registry checks was requested for a sample of five staff. Per record review, yearly background checks were not completed as required for two out of five sampled staff. This finding was confirmed by the Manager of the home on the afternoon of January 29, 2026.	R225	See attached Plan of Correction.	
R443 SS=F	9.11.d Disaster and Emergency Preparedness	R443		

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R443	Continued From page 1 There must be an operable telephone on each floor of the home, available to residents at all times. A list of emergency telephone numbers must be posted by each telephone. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the home failed to ensure that a list of emergency telephone numbers was posted next to an operable telephone that was available to residents of the home at all times. Findings include: The home did not have a policy addressing the availability of a resident accessible telephone with posted emergency numbers. During a tour of the home on the morning of January 29, 2026, an operable telephone accessible to residents was observed on the first floor, without emergency contact numbers posted as required by State Rules. Per staff interview on the afternoon of January 29, 2026, the Manager acknowledged this finding.	R443		

Deficiency Statement Plan of Correction (POC)

Survey Date: 01/29/2026

Facility Name: Mayo Residential Care

Deficiency Tag	How the deficiency was corrected	How other potential residents identified, and corrective action taken	Date corrected	System changes to ensure compliance of the regulation	Who will monitor to ensure compliance
R225	Background checks were performed immediately on the two employees who were outside the 12-month window.	A house wide audit of staff was conducted to identify any staff who had not received a background check within the 12-month window. No further corrective action was needed.	01/29/2026	The background check process has been altered to ensure background checks are completed within the initial 12-month window. R225 Accepted 3-12-2026 Susan Canas Gregoire RN	Administrator or designee will conduct random monthly audits to monitor compliance with regulation 5.12. b (4). The results of these audits will be brought to the QAPI team for review and to determine if further intervention is required.
R443	Signage was hung indicating emergency numbers next to the operable phone, available to residents always.	The facility is single level. No other phones or emergency number list is required per regulation 9.11. d.	1/29/2026	R443 Accepted 3-12-2026 Susan Canas Gregoire RN	Administrator or designee will conduct random monthly audits to ensure emergency phone lists are present and legible.