

DEPARTMENT OF DISABILITIES, AGING AND INDEPENDENT LIVING

Division of Licensing and Protection
HC 2 South, 280 State Drive
Waterbury, VT 05671-2060
http://www.dail.vermont.gov
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

February 6, 2018

Ms. Theresa Southworth, Administrator Gill Odd Fellows Home 8 Gill Terrace Ludlow, VT 05149-1004

Dear Ms. Southworth:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **January 3, 2018.** 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

mlaMCotaBN

Licensing Chief



PRINTED: 01/16/2018 FORM APPROVED

CENTERS FOR MED	ICARE	& MEDICAID SERVICES			0	MB NO 0938-039
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	S	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION	(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SU	DOLIED	475052	B.WING	D.T.(C 01/03/2018
GILL ODD FELLOWS H				8 G	REET ADDRESS, CITY, STATE, ZIP CODE	
				LU	DLOW, VT 05149	
PREFIX (EACH DEF	ICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLANOF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETION
F 000 INITIAL COM	MENT	S	FOC	00		
was initiated Protection of Based on the to have defice jeopardy and to findings at the time of elimmediate jeogrammediate jeo	by the n 12/26 e invesciencie d substit F 689 xit on copardy site expandy ves to I .25(b)(Skin Interest e comp facility it receives the irrest that it with permeters and expendent with a standard ers and expendent expendent expendent expendent with permeters and expendent ex	egrity are ulcers. brehensive assessment of a must ensure that- are care, consistent with ards of practice, to prevent a does not develop pressure adividual's clinical condition they were unavoidable; and pressure ulcers receives and ards of practice, to revent infection and prevent	F 6	86	F686 The resident in this deficiency discharged prior to the survey longer in our building. Every resident in the building pressure ulcers had the poter affected. Going forward all residents wi wounds (admitted with or dev house) will have their wounds measured by a wound team with the DON or other nurse mananurse for the patient, a memb and LNA caring for the reside note will be found in the patie a weekly basis and this note will also include the statu (improvement or decline).	at risk for a sees sed and a sees sed and an a weekly be comprised of ager, the charge er of therapy, at A wound at risk e-record on will include including escription. This

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE acidity 10: 475052...

(Resident #1) . The findings include the

TITLE

1/24/18

Any deficiency statement ending with an asterisking 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 9D 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.

following:

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_CENTE	RS FOR MEDICARE	& MEDICAID SERVICES			0MB NO 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MULTIPLI A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	•	475052	B. Wing		C 01/03/2018
NAME OF I	PROVIDER OR SUPPLIER		S.	TREET ADDRESS, CITY, STATE, ZIP CODE	
GILL OD	D FELLOWS HOME			GILL TERRACE UDLOW, VT 05149	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES MUST BE PRECEOED BY FULL SCIDENTIFYING INFORMATION)	PREFIX .	PROVIDER'S PLANOF CORRECTION (EACH CORRECTIVE ACTIONSHOULI CROSS-REFERENCED TO THE APPROP DEFICIENCY)	
	stay with multiple post include, but not lim Peripheral Vascula Bladder. Per review Admission evaluati, Licensed Practical wounds as follows: -Right Elbow pressions -Right Heel pressurated III; -Right Toes pressurated -Sacrum pressurated II; -Multiple areas bilated dime sized redden outer foot necrotic a intact large blister DNS confirms during Resident #1's sacraduring the 20 day sacraduring the 20 day sacraduring the 20 day sacraduring serosangulated where it had been in made that wounds per policy. The sacradmission and then was measured on and the left lateral admission and measured and measured on and the left lateral admission and measured on and measured	dmitted for a 6 week respite pressure ulcers. Diagnosis to ited to Multiple Sclerosis, in Disease and Neurogenic of the medical record, on the on dated 11/14/17, the Nurse (LPN) documents. The Nurse (LPN) documents (cm) by 4 cm (no measurements); in the centimeters (cm) by 4 cm (cm) measurements); in the centimeters (cm) by 4 cm (cm) measurements); in the centimeters (cm) by 4 cm (cm) measurements); in the centimeters (cm) by 4 cm (cm) measurements); in the centimeters (cm) by 4 cm (cm) measurements); in the centimeters (cm) by 4 cm (cm) measurements); in the centimeters (cm) by 4 cm (cm) measurements); in the centimeters (cm) by 4 cm (cm) measurements); in the centimeters (cm) by 4 cm (cm) measurements); in the centimeters (cm) by 4 cm (cm) measurements); in the centimeters (cm) by 4 cm (cm) measurements); in the centimeters (cm) by 4 cm (cm) measurements); in the centimeters (cm) by 4 cm (cm) measurements); in the centimeters (cm) by 4 cm (cm) measurements); in the centimeters (cm) by 4 cm (cm) measurements); in the centimeters (cm) by 4 cm (cm) by 4 c	F 686	Any wound that has worsened documentation to show that responsible party have been what the new interventions who be monitored by the DON or At this time we do not have a with pressure wounds and preventopic at QAPI indefinitely. Corrected date 1/25/2018 1886 for accepted 212/18 mber	the MD and notified and vill be. This will her designee. any residents use. Intion will be a

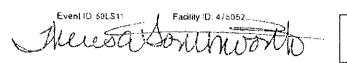
FORM CMS-2567(02-99) Previous Versions Obsolete

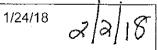
progress note identifies the wound at the left lateral foot area has a very foul odor. A 1213/17 RN progress note identifies the sacrum wound

Event ID:59LS11

Facility ID: 475052

If continuation sheet Page 2 of 19





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

PRINTED: 01/16/2018 FORM APPROVED 0MB NO 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A BUILDING		1, ,	ATE SURVEY OMPLETED
		475052	B WING		01	C 1/ 03/2018
NAME OF P	ROVIDER OR SUPPLIER		,	STREET ADDRESS, CITY, STATE, ZIP CO	DE	
GILL ODD	FELLOWS HOME		:	8 GILL TERRACE LUDLOW, VT 05149		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CORE X (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE

F 686 Continued From page 2

5.5 cm x 0.85 cm wide with a 0.8 deep area at one point, with a foul odor. RN describes the wound bed as having several small brown areas mixed with red areas and copious amount of serosanguinous drainage. There is also a 4 cm x 1 d cm red excoriated area below the above area.

A MD progress note dated 11/24/17, documents that the patient refuses position change. Nurses notes throughout the 20 day stay, evidence only 2 occasions the resident requested to not be disturbed and one occasion refused a bath. There is no further evidence documented in the medical record, identifying that Resident #1 refused care. Interviews with Licensed Nurse Aides (LNAs), do not confirm that the resident refused care.

The facility skin care policy identifies, if pressure in nature, wounds will be assessed, measured and documented on a weekly basis by the wound team.

F 689 Free of Accident Hazards/Supervision/Devices SS=K CFR(s) 483.25(d)(1)(2)

§483.25(d) Accidents.
The facility must ensure that §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and

§483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents.

This REQUIREMENT is not met as evidenced by:

Based on observation, review of records, and confirmed by staff interview the facility failed to ensure that the residents' environment remains

F 686:

F 689'

F689, F868, F835

No residents were injured due to the increased water temperatures.

Every resident, staff member, visitor, or vendor had the potential for harm due to these temperatures.

Plumbers advised us we needed to turn down the mixing valves. They assisted us with this on January 4. This did not work. Another company was called for a second assessment also on Jan. 4, and they determined that our expansion tanks needed to be replaced. These were replaced on Jan. 9. Since the replacement of the two tanks, we have taken temps several times a day and have remained at safe temperatures. Our hot water temps have run at approximately 113 degrees.

Hot water temps will be taken randomly throughout the home on a daily basis and these temps will be tracked on a spreadsheet. If any temp is 120 or above, the mixing valve to that area will be adjusted and the temp will be rechecked within 2hrs.

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Event ID:59LS11

Facility ID: 475052

If continuation sheet Page 3 of 19

Levent 1D: 53LS11 Facility 10: 475052

Mere Facility 10: 475052

1/24/18 2218

PRINTED: 01/16/2018

		& MEDICAIDSERVICES			0	MB NO 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER.	1 ' '	LTIPLE C	(X3) DATE SURVEY COMPLETED	
AUD LEAN O	CONTRACTOR		A, BUILI	JING		С
		475052	EMING			01/03/2018
NAME OF F	NAME OF PROVIDER OR SUPPLIER			STRE	ET ADDRESS, CITY, STATE, ZIP CODE	V1100/2010
	0.55111110.41-445			8 GII	LL TERRACE	
GILL OD	D FELLOWS HOME			LUD	LOW, VT 05149	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	ID PREF TAC	·ΙΧ	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPROFICIENCY)	D BE COMPLETION
F 000			_			
F 689	Continued From pa	-	F	689	Mixing valves will be adjuste	
		ent hazards as possible. Hot			are below 120. If this cannot	· ·
		s have been documented			plumbers will be called imme	ediately.
		20 degrees Fahrenheit (F), in				
•		ed back to 11/20/17. A g hot water temperatures was			Anytime maintenance staff is	
1		he 7/11/17 annual recertification			building, temps will be taken	
	-	gs include the following;			staff. This includes after-hou weekends.	rs, holidays, and
	Per facility tour on	1/3/18 at 8:57 AM by the				
		er was identified as running			Any temp that is 120 or above	•
		oms. When residents were			to the administrator or her de	esignee
		ter was running the response epipes from freezing".			immediately.	
		e tested throughout the 3 units			Staff has been educated to	contact
		cluded the following:			maintenance if they feel hot	
		erature registered at 138			higher than the desired temp	
	. degrees F;	erature registered at 132			alternate bathing options wil	
	degrees F;	stature registered at 102			time until safe temps are ac	
Í		erature registered at 124				
	degrees F;	3-1			When we have maintained t	emps below 120
	Room #122 tempe	erature registered at 140			for 3 months, we will still cor	•
	degrees F;				hot water temps several time	
		erature registered at 126			,	
	degrees F;	proture registered at 139			In the event of an injury,	
	degrees F;	erature registered at 138				
		erature registered at 128			First aid will be provide	ed
	degrees F.	3			Incident documented	
					parties notified	
		ation was brought to the			Water will be turned or	off pending
		aintenance Director and the			adjustment	
		Home Administrator (LNHA).			, adjustinent	
		re re-measured using a pocket an infrared thermometer, in the			Tomporetures will be	roported to OA
		an infrared thermometer, in the the Maintenance Director and			Temperatures will be for 6 months.	reported to QA

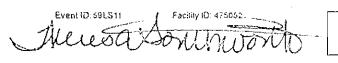
FDRM CMS-2567(02-99) Previous Versions Obsolete

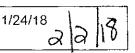
the LNHA Confirmation was made on 1/3/18 at g:45 AM that the temperatures were elevated to the degree that residents/staff/visitors could

Event ID:59LS11

Facility ID: 475052

If continuation sheet Page 4 of 19





PRINTED: 01/16/2018 FORM APPROVED 0MB NO 0938-0391

CENTE	RS FOR MEDICARE	& MEDICAID SERVICES				OMB NO 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER!SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A.BUILDING			(X3) DATE SURVEY COMPLETED
		475052	E€NING			C 01/03/2018
NAME OF I	PROVIDER OR SUPPLIER		-	STRE	ET ADDRESS, CITY, STATE, ZIP CODE	
GILL OD	D FELLOWS HOME			Į.	LL TERRACE LOW, VT 05149	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS REFERENCED TO THE APPRO DEFICIENCY)	ALD BE COMPLETION
	Per inspection of woonducted by the Mating back to 11/2 forty-three (43) institemperatures registand reached as hig 1/1/18, facility logs intemperature in a residegrees F. There taken after observing water temperatures on 1/3/18. Fourteer occupied by reside confirm (on 1/3/18 are independent and assistance. There as residents who with the taken the taken after one occupied by reside confirm (on 1/3/18 are independent and assistance. There as residents who with the taken the taken after one occupied by the taken after one occupied by reside occupied by reside as residents who with the taken after one of the taken	ee burn in as quickly as 5 eratures at 140 degrees F. atter temperature logs, Maintenance Department, 10/17, there have been tances when water tered above 120 degrees F, h as 144.9 degrees F. On dentify that the water sident room was 144.9 is no evidence any action was ing that temperature, and no, were taken until 2 days later, in (14) rooms in the facility are ents whom the nursing staff at approximately 12:30 PM) dican use the sink without are two (2) residents identified vanderer and ambulate lity with cognitive impairment. The Maintenance Director on 1, confirmation is made that at the has been adjustments to the wever, there has been no insure that hot water	F	689	This will be monitored by staff and overseen by the her designee. Corrected by 1/25/18 FB9 PDC accepted AAI's Meet	Administrator or
	made, nor were ter consistently. Water checked on 11/20, 12/15, 12/20, 12/20 of which registered degrees F. All tempreviews were cond AM through 11:35	reased by the adjustment imperatures checked in temperatures were only 11/30, 12/1, 12/4, 12/7, 12/11, 13, 12/29/17, 1/1 and 1/3/18 all it temperatures above 120 perature logs identify the ucted between the hours of 7 AM. The Maintenance Director is that s/he did not report to				

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administration the elevated water temperatures.

Event ID:59LS11

Facility ID: 475052

If continuation sheet Page 5 of 19



DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARES MEDICALD SERVICES

PRINTED: 01/16/2018 FORM APPROVED 0MB NO 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION AND PROVIDERS CLUD ON VT 05149 STREET ADDRESS, CLTY, STATE, ZIP CODE 3 CILL TERRACE LUDLOW, VT 05149 EXAMINARY STATEMENT OF DEFICIENCIES PREFIX PROVIDERS PLAN OF CORRECTION PREFIX RESULATORY OR SUPPLIER AND PLAN OF THE ADDRESS, CLTY, STATE, ZIP CODE 3 CILL TERRACE LUDLOW, VT 05149 PROVIDERS PLAN OF CORRECTION PREFIX RESULATORY OR SUPPLIER F 689	CENTER	RS FOR MEDICARE	& MEDICAID SERVICES	·		0MB	NO 0938-0391
NAME OF PROVIDER OR SUPPLIER GILL ODD FELLDWS HOME (74) ID SUMMARY STATEMENT OF DEPICIENCIES (FACH CORRECTOR) (FACH CORRECT				1		(X3)	
GILL ODD FELLOWS HOME CALL DODD SUMMARY STATEMENT OF DEFICIENCIES CALL DUDLOW, VT 05149			475052	B. WING	; 		_
ILUDLOW, VT 05149 [X4] ID SUMMARY STATEMENT OF DEPICIENCIES (EACH DEPICIENCY MUST BE PRECEDED BY PULL REGULATORY DRISCIDENTIFYING IN FORMATION) F 689 Continued From page 5 Per interview with the LNHA on 1/3/18 at approximately 1:40 PM, confirmation is made that she was aware that water temperatures had registered above 120 degrees F, in resident rooms and that mixing valves were being adjusted. The LNHA confirms that there is no policy/process directing staff to log temperatures at specific times, only what had been identified on the plan of correction dated 7/11/17. The plan documents that "room water temperatures will be taken daily, randomly throughout the building and randomly at different times during the day. The temperatures will be monitored to be below 120 degrees". Per interview with the LNHA on 1/3/18 at approximately 3 PM, she was questioned as to the content of the education provided to the staff of at the time of the citation in July 2017. The LNHA responded "Staff were told to put their hands under the running water from the faucet and if it was hot they were to let someone know". Confirmation was also made by the Director of Nurses (DNS), who was in charge while the LNHAwas away (12/23/17 through 1/2/18), that she was not notified by the Maintenance Director of the elevated water temperatures on 1/1/18. Per interview with the DNS confirmation is made	NAME OF F	ROVIDER OR SUPPLIER	· · · · · · · · · · · · · · · · · · ·		STREET ADDRESS, CITY, STATE, ZIP COD	E	
FREFIX REGULATORY DRISCIDENT/FYING INFORMATION) F 689 Continued From page 5 Per interview with the LNHA on 1/3/18 at approximately 1:40 PM, confirmation is made that, sifte was aware that water temperatures were being adjusted. The LNHA confirms that she can be indentified on the plan of correction dated 7/11/17. The plan documents that "come water temperatures were being checked inconsistently. S/He confirms that there is no policy/process directing staff to log temperatures at specific times, only what had been identified on the plan of correction dated 7/11/17. The plan documents that "room water temperatures will be taken daily, randomly throughout the building and randomly at different times during the day. The temperatures will be monitored to be below 120 degrees." Per interview with the LNHAon 1/3/18 at approximately 3 PM, she was questioned as to the content of the education provided to the staff at the time of the citation in July 2017. The LNHA responded "staff were told to put their hands under the running water from the faucet and if it was hot they were to let someone know". Confirmation was also made by the Director of Nurses (DNS), who was in charge while the LNHAwas away (12/23/17 through 1/2/18), that she was not notified by the Maintenance Director of the elevated water temperatures on 1/1/18. Per interview with the DNS confirmation is made	GILL OD	D FELLDWS HOME	,				
Per interview with the LNHA on 1/3/18 at approximately 1:40 PM, confirmation is made that, sifne was aware that water temperatures had registered above 120 degrees F. in resident rooms and that mixing valves were being adjusted. The LNHA confirms thats/he did not ensure that the temperatures decreased after valve adjustments nor that the temperatures were being checked inconsistently. Sifhe confirms that there is no policy/process directing staff to log temperatures at specific times, only what had been identified on the plan of correction dated 7/11/17. The plan documents that "room water temperatures will be taken daily, randomly throughout the building and randomly at different times during the day. The temperatures will be monitored to be below 120 degrees". Per interview with the LNHAon 1/3/18 at approximately 3 PM, sifhe was questioned as to the content of the education provided to the staff at the time of the citation in July 2017. The LNHA responded "staff were told to put their hands under the running water from the faucet and if it was hot they were to let someone know". Confirmation was also made by the Director of Nurses (DNS), who was in charge while the LNHAwas away (12/23/17 through 1/2/18), that sifhe was not notified by the Maintenance Director of the elevated water temperatures on 1/1/18. Per interview with the DNS confirmation is made	PRÉFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREF	IX (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP	OULD BE	COMPLETION
that Quality Assurance meetings takes place quarterly. Meeting on 7/18/17, agenda did include discussion pertaining to the citations cited during the annual recertification survey.		Per interview with tapproximately 1:40 s/he was aware that registered above 12 rooms and that mit adjusted. The LNHA ensure that the tensure that the tensure that the tensure that the tensure adjustments is being checked incomplete the period of the peri	he LNHA on 1/3/18 at PM, confirmation is made that t water temperatures had 20 degrees F. in resident ixing valves were being A confirms thats/he did not imperatures decreased after nor that the temperatures were consistently. S/He confirms that irocess directing staff to log ecific times, only what had the plan of correction dated documents that "room water the taken daily, randomly ding and randomly at different y. The temperatures will be allow 120 degrees". The LNHA on 1/3/18 at M, s/he was questioned as to ducation provided to the staff tation in July 2017. The LNHA were told to put their hands water from the faucet and if it to let someone know". The lass made by the Director of D was in charge while the 2/23/17 through 1/2/18), that and by the Maintenance Director er temperatures on 1/1/18. The DNS confirmation is made ance meetings takes place on 7/18/17, agenda did pertaining to the citations cited		589		

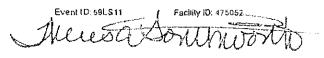
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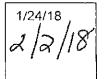
is no documented agenda, related to hot water

Event ID:59LS11

Facility ID: 475052

If continuation sheet Page 6 of 19





PRINTED: 01/16/2018 FORM APPROVED 0MB NO 0938-0391

CENTERS FOR MED	ICARE& MEDICAID SERVICES			0MB NO 0938-039			
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	S (X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER	(X2) MULTIPLE C A. BUILDING	(X2) MULTIPLE CONSTRUCTION A. BUILDING				
	475052	B.WING		C 01/03/2018			
NAME OF PROVIDER OR SU	PPLIER	1	EET ADDRESS, CITY, STATE, ZIP CODE	· · · · · · · · · · · · · · · · · · ·			
GILL ODD FELLOWS H	OME _.	\$	LL TERRACE DLOW, VT 05149				
PREFIX (EACH DE	IARY STATEMENT OF DEFICIENCIES FICIENCY MUST BE PRECEDED BY FULL RY OR LSCIDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	OULD BE COMPLETIO			
F 689 Continued Fi	· -	F 689					
temperatures							
SS=D CFR(s) 483.	en is Free from Unnecessary Drug 45(d)(1)-(6)	s F 757;	Resident involved dischar survey and is no longer in				
Each reside	Jnnecessary Drugs-General. nt's drug regimen must be free froi / drugs. An unnecessary drug is a sed-		No harm came to any res with medication orders ha be have been affected.	ident. All residents			
	1) In excessive dose (including ug therapy); or		Upon admission all medic reviewed and audited for				
' §483,45(d)(2) For excessive duration; or		indefinite				
§483.45(d)(3) Without adequate monitoring; or	· r	Medication review monthl consultant.	y by pharmacy			
) Without adequate indications for	its					
use; or §483.45(d)(5) In the presence of adverse		All medications will have a associated diagnosis.	an indication or			
reduced or o	es which indicate the dose should discontinued; or		House-wide audit comple medications have associa				
	6) Any combinations of the reason agraphs (d)(1) through (5) of this	S	indication.	un to be			
	REMENT is not met as evidenced		Monthly audits will continu completed for the next 6 r designee.				
interview the sampled res	ecord review and confirmed by star e facility failed to ensure that 1 ident's drug regimen is free from	ff	Medication review, diagno be QAPI topics indefinitely				
without aded #1).	/ drugs, defined as a drug used quate indications for use (Resident	t	Corrected by 1/25/18				
The findings	include the following:		F757 POL accepted 2/2/18 mose	Arand Pall Price			

FDRM CMS-2667(02-99) Previous Versions Obsolete

Resident #1 was admitted on 11/14/17 for a 6 week respite stay. Physician orders dated

Event ID:59LS11

Facility ID: 475052

If continuation sheet Page 7 of 19



STATEMENT OF DEFICIENCIES (X1) PRDVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER-COMPLETED A BUILDING----475052 **EW**JNG 01/03/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **8 GILL TERRACE** GILL ODD FELLOWS HOME LUDLOW, VT 05149 SUMMARY STATEMENTOF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID Ci. (X\$)
COMPLETION PREFIX PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY)

F 757 Continued From page 7

11/3/17, direct staff to administer Amitriptyline 50 mg by mouth at bed time for insomnia. Amitriptyline is a medication used to treat nerve pain and depression. Physician progress notes do not include a diagnosis with adequate indications for use.

The Director of Nurses confirms on 12/26/17 at approximately 1 PM that the resident does not have an appropriate diagnosis for the administration/use of Amitriptyline.

F 835 Administration SS=K CFR(s): 483.70

§483.70 Administration.

A facility must be administered in a manner that, enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.

This REQUIREMENT is not met as evidenced by:

Based on observation, review of records, and confirmed by staff interview the facilities. Administrator failed to utilize resources effectively I and efficiently to ensure that the residents' environment remains as free from accident hazards as possible. Hot water temperatures have been documented registering above 120 degrees Fahrenheit (F), in resident rooms dated back to 11/20/17. This was cited during the 7/11/17 annual recertification survey. The findings include the following:

Per facility tour on 1/3/18 at 8 57 AM by the surveyor, hot water was identified as running freely in resident rooms. When residents were asked why the water was running the response

F 757

F 835

F 835

Administrator and Maintenance received "write-ups" to be placed in the permanent record. IJ and "write ups" reported to the board of directors immediately.

Administration of facility reported on to the board on an every other month basis at board meetings.

QAPI meeting held 1/18/18

To report more frequently than just QA, our first Safety Meeting will be held on 2/9/18 and subsequently on the second Friday of each month on non-QA meeting months.

See F 689 for plan to monitor.

Corrected 1/25/18

F835 POC accepted 2/2/18 Mberhaui PN/PME

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:59LS11

Facility ID: 475052

If continuation sheet Page 8 of 19

Event ID: 59LS 11 Facility ID: 475052

PRINTED: 01/16/2018 FORM APPROVED

CENTE	RS FOR MEDICARE	& MEDICAID SERVICES			(OMB NO 0938-0391		
	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/C AND PLAN OF CORRECTION IDENTIFICATION NUMB		(X2) MUL A. BUILD		DNSTRUCTION	(X3) DATE SURVEY COMPLETED		
		475052	IE ₩ING				C 03/2018	
NAME OF I	PROVIDER DR SUPPLIER		·	STRE	ET ADDRESS, CITY, STATE, ZIP CODE			
GILL OD	D FELLOWS HOME				L TERRACE L ow, VT 05149			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 835	Temperatures were	ge 8 pipes from freezing". e tested throughout the 3 units cluded the following:	F 8	35				
	Room #131 tempe degrees F; Room #130 tempe degrees F;	rature registered at 138						
	'degrees F; Room #122 tempe degrees F;	ature registered at 124 rature registered at 140 rature registered at 126		ļ				
	degrees F; Room #118 temper degrees F;	rature registered at 138			·			
	The above informa attention of the Ma Licensed Nursing I Temperatures were thermometer and a presence of both the LNHA Confirms 9.45 AM that the tethe degree that ressustain a 3rd degree station and the Market Ma	tion was brought to the intenance Director and the Home Administrator (LNHA). The re-measured using a pocket in infrared thermometer, in the ne Maintenance Director and ation was made on 1/3/18 at imperatures were elevated to idents/staff/visitors could be burn as quickly as 5 eratures at 140 degrees F.		· · · · · · · · · · · · · · · · · · ·				
	conducted by the M dating back to 11/2 forty-three (43) insi temperatures regis degrees F. On 1/1/2 the water temperat	vater temperature logs Maintenance Department, 20/17, there have been tances when water tered as high as 144.9 18, facility logs identify that ture in a resident room was here is no evidence any						

FORM CMS-2567(02-99) Previous Versions Obsolete

action was taken after observing that

Event ID:59LS11

Facility ID: 475052

If continuation sheet Page 9 of 19

Event ID: 59LS11 Facility ID: 475052.

Mere Salvanov Months

PRINTED: 01/16/2018

		IAMD HOMAN SERVICES				FUR	M APPROVED
CENTER	RS FOR MEDICARE	& MEDICAID SERVICES				0MB1	VO 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER	(X2) MUI A.BUILD		CONSTRUCTION		ATE SURVEY EMPLETED
		475052	E⊞SWING			0	C 1/ 03 /2018
NAME OF F	PROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP COD	Œ	
GILL OD	D FELLOWS HOME				BILL TERRACE DLOW, VT 05149		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRI (EACH CORRECTIVEACTION SHOULD CRDSS-REFERENCED TO THE AP DEFICIENCY)	BE	(X5) COMPLETION DATE
	taken until 2 days I rooms in the facility whom the nursing approximately 12:3 can use the sink two (2) residents ic wanderer and amb with cognitive impa. Per interview with 1,1/3/18 at 10:15 AM, various times there i mixing valves. How follow through to en temperatures decrimade, nor were te consistently. Water to checked on 11/20, 112/15, 12/20, 12/28 of which registered degrees F. All tem reviews were concided.	ater, on 1/3/18. Fourteen (14) of are occupied by residents staff confirm (on 1/3/18 at 0 PM) are independent and without assistance. There are dentified as residents who coulate throughout the facility irment. The Maintenance Director on a confirmation is made that at the has been adjustments to the vever, there has been no	F	3351			
	Per interview with approximately 1:40 s/he was aware the registered above 1 rooms and that mit adjusted. The LNF ensure that the tervalve adjustments being checked inc	elevated water temperatures. the LNHAon 1/3/18 at PM, confirmation is made that at water temperatures had confirmation is made that at water temperatures had confirms F. in resident xing valves were being A confirms thats/he did not mperatures decreased after nor that the temperatures were onsistently. S/He confirms that process directing staff to log					

FORM CMS-2567(02-99) Previous Versions Obsolete

temperatures at specific times, only what had been identified on the plan of correction dated

Event I0:59LS11

Facility ID: 475052

If continuation sheet Page 10 of 19

DEPARTMENT OF HEALTH	AND HUMAN SERVICES				FORM APPROVED
CENTERS FOR MEDICARI	E & MEDICAID SERVICES				OMB NO 0938-039
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER	(X2) MUL A. BUILD		(X3) DATE SURVEY COMPLETED	
	475052	B. WING			C 01/03/2018
NAME OF PROVIDER OR SUPPLIER		1	STRE	ET ADDRESS, CITY, STATE, ZIP CODE	
GILL ODD FELLOWS HOME		:		L TERRACE LOW, VT 05149	
PREFIX (EACH DEFICIENCY	ATEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SCIDENTIFYING 1NFORMATION)	ID PREFI TAG	Κ	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TD THE APPRO DEFICIENCY)	LD BE COMPLÉTION
temperatures will b	ige 10 documents that "room water be taken daily, randomly ding and randomly at different	F 8	35	F842 Resident involved discharg	
	ay. The temperatures will be			to survey and is no longer All residents have the pote	
	the LNHAon 1/3/18 at , s/he was questioned as to	1		been affected.	
at the time of the o responded "staff w	education provided to the staff itation in July 2017. The LNHA ere told to put their hands water from the faucet and if it		l	Staff meeting held on 1/18 discussion accurate docur wound measurement, bath	nentation,
' was hot they were Confirmation was a Nurses (DNS), who LNHAwas away (1)	to let someone know". also made by the Director of was in charge while the 2/23/17 through 1/2/18), that ad by the Maintenance Director			Facility uses PCC for docueMAR, eTAR. 24hr notes to be monitored designee on a daily basis	d by DON or her

of the elevated water temperatures on 1/1/18.

Per interview with the DNS confirmation is made that Quality Assurance meetings takes place 'quarterly. Meeting on 7/18/17, agendadid include discussion pertaining to the citations cited during the annual recertification survey. The next meeting occurred on 10/17/17 and there is no documented agenda, related to hot water temperatures.

F 842 Resident Records - Identifiable Information SS=D CFR(s): 483.20(1)(5), 483.70(i)(1)-(5)

> §483.20(1)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public.

(ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information

F 842

weekend documentation)

Any documentation that is unable to be verified or found to be inaccurate will be discussed with the nurse and a late entry note to be added with correct documentation. Depending on the inaccuracy it may result in a counseling.

Accurate documentation to be discussed at QA for the next 6mo as well as safety meeting monthly for 6mo.

Corrected on 1/18/18 PSTA POC accepted 2/2/18 mourhander PML

FORM CMS-2567(02

Facility ID: 475052

If continuation sheet Page 11 of 19

1/24/18

PRINTED: 01/16/2018 FORM APPROVED 0MB NO 0938-0391

CENTER	& MEDICAID SERVICES			MB NO 0938-0391		
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MUL A.BUILD		CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		475052	B.WING			C 01/03/2018
NAME OF F	PROVIDER OR SUPPLIER	ı	' l		REET ADDRESS, CITY, STATE, ZIP CODE	
GILL ODI	FELLOWS HOME				DLOW, VT 05149	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CRDSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION
F 842	Continued From pa	ge 11	F 8	342		
	except to the exten to do so.	t the facility itself is permitted				
	professional standar must maintain med that are- (i) Complete; (ii) Accurately docur ' (iii) Readily accessidiv) Systematically §483.70(i)(2) The final information contained are regardless of the formation, except which is the individual representative where the individual represen	cordance with accepted ands and practices, the facility dical records on each resident mented; ble; and organized acility must keep confidential ained in the resident's records, mor storage method of the sen release is-l, or their resident ere permitted by applicable law; w; cayment, or health care mitted by and in compliance				

FORM CMS-2567(02-99) Previous Versions Obsolete

for-

§483.70(i)(4) Medical records must be retained

Event ID; 59LS11

Facility ID: 475052

If continuation sheet Page 12 of 19

Event ID: 59LS11 Facility ID: 475052

Wee5a Sourmon

2/2/18

PRINTED: 01/16/2018 FORM APPROVED 0MB, NO 0938-0391

CENTERS FOR MEDICARE & MEDICAID SERVICES					OMB NO 0938-0391		
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		475052	B.WING			C 01/03/2018	
NAME OF F	PROVIDER OR SUPPLIER		J	STRE	ET ADDRESS, CITY, STATE, ZIP CODE	A	
GILL ODI	FELLOWS HOME				L TERRACE LOW, <i>VT</i> 05149		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETIO	
F 842	Continued From pa	ge 12	F	842			
	(i) The period of tin (ii) Five years from there is no requirer (iii) For a minor, 3 y legal age under Standard (iii) For a minor, 3 y legal age under Standard (iii) The comprehend (iii) The comprehend (iii) The comprehend (iv) The results of a land resident review determinations correctly (v) Physician's, nu professional's progressional's progressional's progressional's reports as This REOUIREME by: Based on record interview the facility I sampled resident's documented by the The findings including Per review of the repractical Nurse (Limeasurements for follows: -Right Elbow pressional resident end of the pressional standard end of the pres	the date of discharge when ment in State law; or years after a resident reaches ate law. medical record must containation to identify the resident; resident's assessments; resident's and other licensed gress notes; and idelegy and other diagnostic arequired under §483.50. NT is not met as evidenced review and confirmed by staff failed to ensure that 1 is health record was accurately a nursing staff, (Resident #1).		;			
	-Left Toes pressur	ure (no measurements); re (no measurements); 5.5 cm by 4.0 cm depth 1 cm				·	

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11/16/17 Registered Nurse (RN) progress note

Event ID: 59L\$11

Facility ID: 475052

If continuation sheet Page 13 of 19

Event ID: 59LS11 Facility ID: 475052...

HULES CONTOUR WORK

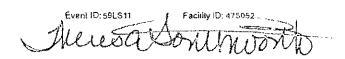
CENTERS FOR MEDICARI	& MEDICAID SERVICES			0MB NO 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MULT A BUILDIN	IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	475052	B. WING		C 01/03/2018
NAME OF PROVIDER OR SUPPLIER		Ĺ	STREI::T ADDRESS. CITY, STATE, ZIP (CODE
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PREFIX (EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLANOF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE COMPLÉTION
F 842 I Continued From pa	-	F 84	42 i	
states the coccyx l	nas a small open area.			
heel measures 5 c with white edges The inside of the edges of the edge	confirms on 12/26/17 at 6 PM, that the RN note dated ented inaccurate, utilizing c) vs. centimeters (cm) a for length/width/depth of a also confirms that the RN note orefers to the coccyx as a which is inaccurate, for the ed as a Stage II pressure ulcer. (1)(i)-(iii)(2)(i) If assessment and assurance collity must maintain a quality assurance committee consisting the surance committee consisting the surance of the facility so ther members of the facility so the facility assessment and assurance corrections of the facility so the facility of the facili	· F86	8 See pas 3-5 for f	868 plan of convention.

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Event ID: 59LS11

Facility IO: 475052

If continuation sheet Page 14 of 19



	_	AND HUMAN SERVICES 8 MEDICAID SERVICES				FC	TED: 01/16/2018 DRM APPROVED
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER		MULTIPLE CONSTRUCTION UILDING		OMB NO 0938-0 (X3) DATE SURVEY COMPLETED	
		475052	IE ₩ING				C 01/03/2018
NAME OF PROVIDER OR	SUPPLIER			STF	REET ADDRESS, CITY, STATE, ZIP CODE		
GILL ODD FELLOWS	HOME		İ		BILL TERRACE DLOW, VT 05149		
PRÉFIX (EACH	DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL IC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPROF DEFICIENCY)	LD BE	(X5) COMPLETION DATE
staff intent Committee that hot we degrees if temperature and visitor in July 201 hazards in July 201 hazards in temperature investigat. Per inspect conducted dating back forty-three temperature degrees if Medicare. Operation temperature seconds of Con 1/1/18 temperature degrees if taken after water temperature on 1/3/18 rooms are nursing staff. 2:30 PM with no as that "s/he	observative, the efailed to ater temp. These affects. During 7, the failed to are a discount of which to 11/2 (43) instances regist Accord Medicaids Manual facility I facility I from the efficacy occupies afficing in a reinal reconstruction of the efficacy occupies afficing are independent of the efficacy occupies afficing are independent of the efficacy occupies afficing are independent of the efficacy of the efficient of the effi	stions, review of records, and facility Quality Assurance or put in place a plan to ensure peratures did not exceed 120 elevated hot water at the safety of residents, staff of the last recertification survey cility was cited for accident elevated hot water findings during this shollows: Pater temperature logs Maintenance Department, 20/17, there have been ances when water stered as high as 144.9 ling to Centers for di Services (CMS) State di Interpretive Guidance, at a didegrees F, it takes only 5 are to cause a 3rd degree burn. Logs identify that the water esident room was 144.9 is no evidence any action was ing that temperature, and no is were taken until 2 days later, in (14) of the forty-three (43) and by residents whom the im (on 1/3/18 at approximately lependent and can use the sink. One (1) resident identified old water when the water feels	F8				
too hot". 1	here are	two (2) residents identified as					

FORM CMS-2567(02-99) Previous Versions Obsolete

residents who wanderer and ambulate throughout

Water temperatures were randomly checked by the maintenance department on 11120, 11130,

the facility, with cognitive impairment.

Event ID: 59LS11

Facility ID: 475052

If continuation sheet Page 15 of 19

1/24/18

PRINTED: 01/16/2018 FORM APPROVED

CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CUA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY ANO PLAN OF CORRECTION IDENTIFICATION NUMBER COMPLETED A BUILDING----475052 **B.WING** 01/03/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS. CITY, STATE, ZIP CODE 8 GILL TERRACE GILL ODD FELLOWS HOME LUDLOW, VT 05149 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) CDMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LISCIDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)

F 868 'Continued From page 15

12/1, 12/4, 12/7, 12111, 12/15, 12/20, 12/28, 12/29/17, 1/1 and 113/18 all of which registered temperatures above 120 degrees F. All temperature logs identify review between the hours of 7 AM through 11:35 AM, no oft-hour reviews.

Per interview with the DNS confirmation is made that Quality f-ssurance meetings takes place quarterly. The meeting on 7/18/17, had an agenda that included a discussion pertaining to the citations cited during the annual recertification survey. The next meeting occurred on 10/17/17 and there was no documented agenda, related to hot water temperatures. The next quarterly meeting is scheduled of the 3rd week of January 2018.

F 921 Safe/Functional/Sanitary/Comfortable Environ SS=K CFR(s): 483.90(i)

§483.90(i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.

This REQUIREMENT is not met as evidenced by:

Based on observation, record review and confirmed by staff interview the facility failed to provide a safe environment for residents, staff and the public. Hot water temperatures have been documented registering above 120 degrees Fahrenheit (F), in resident rooms dated back to 11/20/17. This was cited during the 7/11/17 annual recertification survey. The findings include the following:

Per facility tour on 1/3/18 at 8:57 AM by the surveyor, hot water was identified as running

F 868

F 921

No residents were harmed due to increased water temperatures.

All residents, visitors, staff, and vendors had the potential for injury.

See tag F689 for plan to monitor.

All temperatures above 120 will be immediately reported to the administrator or her designee.

To be monitored by maintenance and overseen by Administrator or her designee.

F921 PCC accepted 212/18 MBcAranderil PM

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 59LS11

Facility ID: 475052

If continuation sheet Page 16 of 19

Event ID: 59LS11 Facility ID: 475052.

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CENTERS	FOR MEDICARE	& MEDICAID SERVICES				DMB NO 0938-0391	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		475052	1⊞3vinG			C 01/03/2018	
NAME OF PRO	OVIDER OR SUPPLIER			STRE	EET ADDRESS, CITY, STATE, ZIP CODE		
OUT ODD SELLOWS HOME			8 GI	ILL TERRACE			
GILL ODD	FELLOWS HOME			LUD	DLOW, VT 05149		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION	
F 921 : C	Continued From pa	ge 16	F	921			
	· ·	ents were asked why the water					
	•	sponse was "to prevent the					
		". Temperatures were tested					
		its and the findings included					
	ne following:						
	Room #131 tempe legrees F;	rature registered at 138					
		rature registered at 132					
	legrees F;	ratare registered at 102					
		rature registered at 124					
	legrees F;	•					
, F	Room #122 temper	ature registered at 140			•		
: F	legrees F; Room #119 temper legrees F;	ature registered at 126					
	- ·	ature registered at 138					
	egrees F;	210.0 (03.010)00 21 (05					
F		rature registered at 128					
		ition was brought to the					
		ntenance Director and the					
		lome Administrator (LNHA) e re-measured lusing a pocket					
	•	in infrared thermometer in the					
		ne Maintenance Director and			•		
		ation was made on 1/3/18 at					
9	3:45 AM that the t	emperatures were elevated to					
		esidents/staff/visitors could	-				
		burn as quickly as 5					
ı S6	econds with tempe	eratures at 140 degrees F.					
ş	Per inspection of v	vater temperature logs					
		Maintenance Department,					
C	dating back to 11/	20/17, there have been					
		tances when water					
		stered as low as 120.2 degrees is 144.9 degrees F. On 1/1/18.					

FORM CMS-2567(02-99) Previous Versions Obsolete

facility logs identify that the water temperature in

Event ID: 59LS11

Facility ID: 475052

If continuation sheet Page 17 of 19

Event ID: 59LS11 Facility IO: 475052.

Wees a South Work

PRINTED: 01/16/2018 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES 0MB NO 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPUER/CUA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING \mathbf{C} 475052 R WING 01/03/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **8 GILL TERRACE** GILL ODD FELLOWS HOME LUDLOW, VT 05149 PROVIDER'S PLANOFCORRECTION (X4) ID PREFIX SUMMARY STATEMENT OF DEFICIENCIES (X5) COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSCIDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) F 921 Continued From page 17 F 921 a resident room was 144.9 degrees F. There is no evidence any action was taken after observing that temperature, and no water temperatures , were taken until 2 days later, on 1/3/18. Fourteen (14) resident rooms are occupied by residents whom the nursing staff confirm (on 1/3/18 at approximately 12:30 PM) are independent and can use the sink independently and there are two (2) residents identified as residents who wander and ambulate throughout the facility, with cognitive impairment. Per interview with the Maintenance Director on 1/3/18 at 10:15 AM: confirmation is made that at various times there has been adjustments to the mixing valves as documented. However, there has been no follow through to ensure that hot water temperatures decreased by the adjustment made, nor were temperatures checked consistently. Water temperatures were randomly checked on 11/20, 11/30, 12/1, 12/4, 12/7, 12/11, 12/15, 12/20, 12/28, 12/29/17, 1/1 and 1/3/18 all of which registered temperatures above 120 degrees F. All temperature logs identify review , between the hours of 7 AM through 11:35 AM. The Maintenance Director confirms at this time thats/he did not report to administration the elevated water temperatures. Per interview with the LNHA on 1/3/18 at

FORM CMS-2567(02-99) Previous Versions Obsolete

approximately 1:40 PM, confirmation is made that 's/he was aware that water temperatures had registered above 120 degrees .F. in resident rooms and that mixing valves were being adjusted. The LNHA confirms that s/he did not ensure that the temperatures decreased after valve adjustments nor that the temperatures were being checked consistently. S/He confirms that there is no policy/process directing staff to log

Event ID: 59LS11

Facility ID: 475052

If continuation sheet Page 18 of 19

Heresa Southworth.

2/2/18

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

PRINTED: 01/16/2018 FORM APPROVED 0MB NO 0938-0391

CENTER	(3 LOK MEDICAKE	E & MICHICAID SERVICES				Olylic	140 0930-0391		
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1		(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3	(X3) DATE SURVEY COMPLETED		
		475052	B.WING				C 01/03/2018		
NAME OF P	RDVIDER OR SUPPLIER			STREE	T ADDRESS, CITY, STATE, ZIP COD	Ę			
CILL ODI	D FELLOWIC HOME			8 GILL	. TERRACE				
GILL ODI	D FELLOWS HOME			LUDL	OW, VT 05149				
(X4) ID PREFIX TAG	(EACH DEFICIENC	TEMENT_ OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CRDSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(XS) COMPLETION E DATE		
F 921	been identified on 7/11/17. The plan of temperatures will be throughout the builtimes during the damonitored to be be Confirmation was a Nurses (DNS), while the LNHA was 1/2/18), thats/he was 1/2/18), thats/he was 1/2/18).	pecific times, only what had the plan of correction dated documents that "room water be taken daily, randomly alding and randomly at different ay. The temperatures will be elow 120 degrees". also made by the Director of o was responsible professional as away (12/23/17 through as not notified by the eter of the elevated water	FS	021					
AL	ent ID: 59LST1 F	actility ID: 475062			2/2/18				