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
Licensing Chief

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	475052	A. BUILDING _____ B. WING	C 01/03/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GILL ODD FELLOWS HOME	8 GILL TERRACE LUDLOW, VT 05149

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS	F 000		

An unannounced on-site complaint investigation was initiated by the Division of Licensing and Protection on 12/26/17 and completed on 1/3/18. Based on the investigation, the facility was found to have deficiencies which included immediate jeopardy and substandard quality of care (Refer to findings at F 689, F 835, F 868 and F 921). At the time of exit on 1/3/18 at 4:30 PM, the immediate jeopardy remained. It was determined during an onsite extended survey that the immediate jeopardy was removed as of 1/9/18.

F 686 SS=G — Treatment/Svcs to Prevent/Heal Pressure Ulcer
CFR(s): 483.25(b)(1)(i)(ii)

§483.25(b) Skin Integrity
§483.25(b)(1) Pressure ulcers.
Based on the comprehensive assessment of a resident, the facility must ensure that-
(i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and
(ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing.
This REQUIREMENT is not met as evidenced by:
Based on record review and confirmed by staff interview the facility failed to ensure that 1 sampled resident, who was admitted with pressure ulcers, received the necessary care to promote healing and avoid further breakdown (Resident #1) . The findings include the following:

F 686

F686
The resident in this deficiency was discharged prior to the survey date. He is no longer in our building.
Every resident in the building at risk for pressure ulcers had the potential to be affected.
Going forward all residents with pressure wounds (admitted with or developed in house) will have their wounds assessed and measured by a wound team on a weekly basis. This wound team with be comprised of the DON or other nurse manager, the charge nurse for the patient, a member of therapy, and LNA caring for the resident. A wound note will be found in the patient's e-record on a weekly basis and this note will include subjective and objective data including measurements and wound description. This note will also include the status of the wound (improvement or decline).

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Facility ID: 475052		1/24/18

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 686	Continued From page 1	F 686		

Resident #1 was admitted for a 6 week respite stay with multiple pressure ulcers. Diagnosis to include, but not limited to Multiple Sclerosis, Peripheral Vascular Disease and Neurogenic Bladder. Per review of the medical record, on the Admission evaluation dated 11/14/17, the Licensed Practical Nurse (LPN) documents wounds as follows:
-Right Elbow pressure (no measurements);
-Right Heel pressure 6 centimeters (cm) by 4 cm stage III;
-Right Toes pressure (no measurements);
-Left Toes pressure (no measurements);
-Sacrum pressure 5.5 cm by 4.0 cm depth 1 cm stage II;
-Multiple areas bilateral feet. Bilateral malleolous dime sized reddened areas-blanchable. Right outer foot necrotic area-unable to stage. Left foot intact large blister medial heel-unable to stage.

DNS confirms during an interview on 1/3/18, that Resident #1's sacral pressure ulcer worsened during the 20 day stay at the nursing home. On 12/1/17, Resident #1's left lateral heel blister developed a foul odor and on 12/3/17 was draining serosanguinous fluid from an opening, where it had been intact. Confirmation was also made that wounds were not measured weekly as per policy. The sacral wound was measured on admission and then again 19 days later, right heel was measured on admission then 12 days later and the left lateral heel was identified on admission and measured 15 days later.

Actual nursing notes include: A 12/1/17 LPN 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

Any wound that has worsened will have documentation to show that the MD and responsible party have been notified and what the new interventions will be. This will be monitored by the DON or her designee.

At this time we do not have any residents with pressure wounds in house.

Pressure wounds and prevention will be a topic at QAPI indefinitely.
Corrected date 1/25/2018

F686 POC accepted 2/2/18 MBertrandRN/PMC

Event ID: 59LS11 Facility ID: 475052

Theresa Dorsinworth

1/24/18 2/2/18

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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 4 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:

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.

F 689

Event ID: 59LS11 Facility ID: 475052

Theresa Southwood

1/24/18 2/2/18

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F 689	Continued From page 3	F 689		

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. A deficiency regarding hot water temperatures was also 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 was "to prevent the pipes from freezing". Temperatures were tested throughout the 3 units and the findings included the following:
Room #131 temperature registered at 138 degrees F;
Room #130 temperature registered at 132 degrees F;
Room #125 temperature registered at 124 degrees F;
Room #122 temperature registered at 140 degrees F;
Room #119 temperature registered at 126 degrees F;
Room #118 temperature registered at 138 degrees F;
Room #108 temperature registered at 128 degrees F.

The above information was brought to the attention of the Maintenance Director and the Licensed Nursing Home Administrator (LNHA). Temperatures were re-measured using a pocket thermometer and an infrared thermometer, in the presence of both the Maintenance Director and the LNHA Confirmation was made on 1/3/18 at 9:45 AM that the temperatures were elevated to the degree that residents/staff/visitors could

Mixing valves will be adjusted until all temps are below 120. If this cannot be achieved, plumbers will be called immediately.

Anytime maintenance staff is not in the building, temps will be taken by other trained staff. This includes after-hours, holidays, and weekends.

Any temp that is 120 or above will be reported to the administrator or her designee immediately.

Staff has been educated to contact maintenance if they feel hot water temps are higher than the desired temp by simple touch- alternate bathing options will be offered at this time until safe temps are achieved.

When we have maintained temps below 120 for 3 months, we will still continue to monitor hot water temps several times a week.

In the event of an injury,

- First aid will be provided
- Incident documented and all appropriate parties notified
- Water will be turned off pending adjustment

Temperatures will be reported to QA for 6 months.

Event ID: 59LS11 Facility ID: 475052

Theresa Southworth 1/24/18 2/2/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 689	Continued From page 4 sustain a 3rd degree burn in as quickly as 5 seconds with temperatures at 140 degrees F. Per inspection of water temperature logs, conducted by the Maintenance Department, dating back to 11/20/17, there have been forty-three (43) instances when water temperatures registered above 120 degrees F, and reached as high as 144.9 degrees F. On 1/1/18, facility logs identify that the water temperature in 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) rooms in the facility 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 without assistance. There are two (2) residents identified as residents who wanderer 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. 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 only 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 the reviews were conducted between the hours of 7 AM through 11:35 AM. The Maintenance Director confirms at this time that s/he did not report to administration the elevated water temperatures.	F689	This will be monitored by maintenance staff and overseen by the Administrator or her designee. Corrected by 1/25/18 F689 POC accepted 2/2/18 MBertrand RN/ PMC	

Event ID: 59LS11 Facility ID: 475052

Teresa Southworth 1/24/18 2/2/18

STATEMENT OF DEFICIENCJES AND PLAN OF CORRECT/ON	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 689	Continued From page 5	F 689		

Per interview with the LNHA on 1/3/18 at 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 thats/he did not ensure that the temperatures decreased after valve adjustments nor that the 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, s/he 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 s/he was not notified by the Maintenance Director 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, agenda did 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

Event ID: 59LS11 Facility ID: 475052

Theresa Southworth

1/24/18
2/2/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIDN	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 689 Continued From page 6

temperatures.

F 757 Drug Regimen is Free from Unnecessary Drugs
SS=D CFR(s) 483.45(d)(1)-(6)

§483.45(d) Unnecessary Drugs-General.
Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used-

§483.45(d)(1) In excessive dose (including duplicate drug therapy); or

§483.45(d)(2) For excessive duration; or

§483.45(d)(3) Without adequate monitoring; or

§483.45(d)(4) Without adequate indications for its use; or

§483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or

§483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section.
This REQUIREMENT is not met as evidenced by:
Based on record review and confirmed by staff interview the facility failed to ensure that 1 sampled resident's drug regimen is free from unnecessary drugs, defined as a drug used without adequate indications for use (Resident #1).
The findings include the following:

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

F 689

F 757;

Resident involved discharged home prior to survey and is no longer in our building.

No harm came to any resident. All residents with medication orders have the potential to be have been affected.

Upon admission all medications will be reviewed and audited for indication-indefinite

Medication review monthly by pharmacy consultant.

All medications will have an indication or associated diagnosis.

House-wide audit completed on 1/5/18, all medications have associated diagnosis and indication.

Monthly audits will continue to be completed for the next 6 months by DON or designee.
Medication review, diagnosis, indication will be QAPI topics indefinitely.

Corrected by 1/25/18

F757 POC accepted 2/2/18 MBeaudin RN/PMC

Event ID: 59LS11 Facility ID: 475052

Theresa Southworth 1/24/18 2/2/18

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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 757		
F 835 SS=K	Administration 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 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 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 Meeham RN/PME	

Event ID: 59LS11 Facility ID: 475052

Theresa Southworth 1/24/18 2/2/18

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F 835	Continued From page 8	F 835		

was "to prevent the pipes from freezing". Temperatures were tested throughout the 3 units and the findings included the following:
Room #131 temperature registered at 138 degrees F;
Room #130 temperature registered at 132 degrees F;
Room #125 temperature registered at 124 degrees F;
Room #122 temperature registered at 140 degrees F;
Room #119 temperature registered at 126 degrees F;
Room #118 temperature registered at 138 degrees F;
Room #108 temperature registered at 128 degrees F.

The above information was brought to the attention of the Maintenance Director and the Licensed Nursing Home Administrator (LNHA). Temperatures were re-measured using a pocket thermometer and an infrared thermometer, in the presence of both the Maintenance Director and the LNHA. Confirmation was made on 1/3/18 at 9A5 AM that the temperatures were elevated to the degree that residents/staff/visitors could sustain a 3rd degree burn as quickly as 5 seconds with temperatures at 140 degrees F.

Per inspection of water temperature logs conducted by the Maintenance Department, dating back to 11/20/17, there have been forty-three (43) instances when water temperatures registered as high as 144.9 degrees F. On 1/1/18, facility logs identify that the water temperature in a resident room was 144.9 degrees F. There is no evidence any action was taken after observing that

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1/24/18 2/2/18

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F 835	Continued From page 9	F 8351		

temperature, and no water temperatures were taken until 2 days later, on 1/3/18. Fourteen **(14)** rooms in the facility 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 without assistance. There are two (2) residents identified as residents who wanderer 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. 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 the reviews were conducted between the hours of 7 AM through 11:35 AM. The Maintenance Director confirms at this time that s/he did not report to administration the elevated water temperatures.

Per interview with the LNHA on 1/3/18 at 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 thats/he did not ensure that the temperatures decreased after valve adjustments nor that the 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

Event ID: 59LS11 Facility ID: 475052

Theresa Southworth 1/24/18 2/2/18

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F 835 Continued From page 10

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, s/he 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 s/he was not notified by the Maintenance Director 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 835

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 thepublic.
(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

F842

Resident involved discharged home prior to survey and is no longer in our building.

All residents have the potential to be have been affected.

Staff meeting held on 1/18/18, topic of discussion accurate documentation, wound measurement, bath notes.

Facility uses PCC for documentation, eMAR, eTAR.

24hr notes to be monitored by DON or her designee on a daily basis (Monday for 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

F842 POC accepted 2/2/18 MBurhand RN/PMC

1/24/18 2/2/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	475052	A. BUILDING _____ B. WING	C 01/03/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GILL ODD FELLOWS HOME	8 GILL TERRACE LUDLOW, VT 05149

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F 842	Continued From page 11	F 842		

except to the extent the facility itself is permitted to do so.

§483.?0(i) Medical records.
§483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are-
(i) Complete;
(ii) Accurately documented;
(iii) Readily accessible; and
(iv) Systematically organized

§483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is-
(i) To the individual, or their resident representative where permitted by applicable law;
(ii) Required by Law;
(iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506;
(iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512.

§483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use.

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

Event ID: 59LS11 Facility ID: 475052 Theresa Dorsworth 1/24/18 2/2/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	475052	A. BUILDING _____ B. WING	C 01/03/2018

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F 842	Continued From page 12	F 842		

(i) The period of time required by State law; or
(ii) Five years from the date of discharge when there is no requirement in State law; or
(iii) For a minor, 3 years after a resident reaches legal age under State law.

§483.70(i)(5) The medical record must contain-
(i) Sufficient information to identify the resident;
(ii) A record of the resident's assessments;
(iii) The comprehensive plan of care and services provided;
(iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State;
(v) Physician's, nurse's, and other licensed professional's progress notes; and
(vi) Laboratory, radiology and other diagnostic services reports as required under §483.50.
This REQUIREMENT is not met as evidenced by:
Based on record review and confirmed by staff interview the facility failed to ensure that 1 sampled resident's health record was accurately documented by the nursing staff, (Resident #1). The findings include the following:

Per review of the medical record, the Licensed Practical Nurse (LPN) documents wound measurements for Resident #1 on 11/14/17 as follows:
-Right Elbow pressure (no measurements);
-Right Heel pressure 6 centimeters (cm) by 4 cm stage III;
-Right Toes pressure (no measurements);
-Left Toes pressure (no measurements);
-Sacrum pressure 5.5 cm by 4.0 cm depth 1 cm stage II.

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

Event ID: 59LS11 Facility ID: 475052

Theresa Ashworth

1/24/18 2/2/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	475052	A. BUILDING _____ B. WING	C 01/03/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GILL ODD FELLOWS HOME	8 GILL TERRACE LUDLOW, VT 05149

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F 842	Continued From page 13 states the coccyx has a small open area. 11/26/17 RN progress notes states "Right medial heel measures 5 cc x 2.5 cc outside diameter with white edges There is a 0.5 cc of red tissue inside of the edge". Director of Nurses confirms on 12/26/17 at approximately 12:55 PM, that the RN note dated 11/26/17, is documented inaccurate, utilizing liquid measures (cc) vs. centimeters (cm) a measurement used for length/width/depth of a wound. The DNS also confirms that the RN note dated 11/16/17, also refers to the coccyx as a small open area which is inaccurate, for the wound was identified as a Stage II pressure ulcer.	F 842		
F 868 SS=K	QAA Committee CFR(s): 483.75(g)(1)(i)-(iii)(2)(i) §483.75(9) Quality assessment and assurance. §483.75(g)(1) A facility must maintain a quality assessment and assurance committee consisting at a minimum of: (i) The director of nursing services; (ii) The Medical Director or his/her designee; (iii) At least three other members of the facility's staff, at least one of who must be the administrator, owner, a board member or other individual in a leadership role; §483.75(g)(2) The quality assessment and assurance committee must: (i) Meet at least quarterly and as needed to identifying issues with respect to which quality assessment and assurance activities are necessary. This REQUIREMENT is not met as evidenced by	F 868	See pgs 3-5 for F868 plan of correction.	

Event ID: 59LS11 Facility ID: 475052

Theresa Southworth

1/24/18 2/2/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 868	Continued From page 14	F 868		

Based on observations, review of records, and staff interview, the facility Quality Assurance Committee failed to put in place a plan to ensure that hot water temperatures did not exceed 120 degrees F. These elevated hot water temperatures affect the safety of residents, staff and visitors. During the last recertification survey in July 2017, the facility was cited for accident hazards related to elevated hot water temperatures. The findings during this investigation are as follows:

Per inspection of water temperature logs conducted by the Maintenance Department, dating back to 11/20/17, there have been forty-three (43) instances when water temperatures registered as high as 144.9 degrees F. According to Centers for Medicare/Medicaid Services (CMS) State Operations Manual Interpretive Guidance, at a temperature of 140 degrees F, it takes only 5 seconds of exposure to cause a 3rd degree burn. On 1/1/18, facility logs identify that the water temperature in 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) of the forty-three (43) 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 with no assistance. One (1) resident identified that "s/he mixes cold water when the water feels too hot". There are two (2) residents identified as residents who wanderer and ambulate throughout the facility, with cognitive impairment.

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

Teresa Southworth

1/24/18 2/2/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 SS=K Safe/Functional/Sanitary/Comfortable Environ 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 POC accepted 2/2/18 MB Maint RN PML

Event ID: 59LS11 Facility ID: 475052

Theresa Bourdon RD

1/24/18 2/2/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	475052	A. BUILDING _____ B. WING _____	C 01/03/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GILL ODD FELLOWS HOME	8 GILL TERRACE LUDLOW, VT 05149

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F 921	Continued From page 16	F 921		

freely. When residents were asked why the water was running the response was "to prevent the pipes from freezing". Temperatures were tested throughout the 3 units and the findings included the following:
Room #131 temperature registered at 138 degrees F;
Room #130 temperature registered at 132 degrees F;
Room #125 temperature registered at 124 degrees F;
Room #122 temperature registered at 140 degrees F;
Room #119 temperature registered at 126 degrees F;
Room #118 temperature registered at 138 degrees F;
Room #108 temperature registered at 128 degrees F.

The above information was brought to the attention of the Maintenance Director and the Licensed Nursing Home Administrator (LNHA) Temperatures were re-measured using a pocket thermometer and an infrared thermometer in the presence of both the Maintenance Director and the LNHA. Confirmation was made on 1/3/18 at 9:45 AM that the temperatures were elevated to the degree that residents/staff/visitors could sustain a 3rd degree burn as quickly as 5 seconds with temperatures at 140 degrees F.

Per inspection of water temperature logs conducted by the Maintenance Department, dating back to 11/20/17, there have been forty-three (43) instances when water temperatures registered as low as 120.2 degrees F and/or as high as 144.9 degrees F. On 1/1/18, facility logs identify that the water temperature in

Event ID: 59LS11 Facility ID: 475052

Theresa Southworth 1/24/18 2/2/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPUER/CUA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 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

Teresa Southwood

1/24/18
2/2/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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GILL ODD FELLOWS HOME	8 GILL TERRACE LUDLOW, VT 05149

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F 921	Continued From page 18	F 921		

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".

Confirmation was also made by the Director of Nurses (DNS), who was responsible professional while the LNHA was away (12/23/17 through 1/2/18), thats/he was not notified by the Maintenance Director of the elevated water temperatures on 1/1/18.

Event ID: 59LS11 Facility ID: 475052

Teresa Southworth 1/24/18

2/2/18