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

September 4, 2018

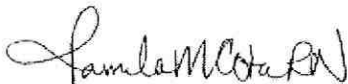
Ms. Theresa Southworth, Administrator
Gill Odd Fellows Home
8 Gill Terrace
Ludlow, VT 05149-1004

Dear Ms. Southworth:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **August 8, 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

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

PRINTED: 08/14/2018
FORM APPROVED
OMB NO. 0938-0391

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 08/08/2018

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
E 000	Initial Comments During an unannounced onsite re-certification survey on 8/5 through 8/8/18, the facility was found in substantial regulatory compliance regarding emergency preparedness planning activities	E 000		
F 000	INITIAL COMMENTS An unannounced onsite re-certification survey and a self-report investigation was conducted on 8/5 through 8/8/18 by the Division of Licensing and Protection. The findings include the following:	F 000		
F 637 SS=D	Comprehensive Assessment After Signifcant Chg CFR(s): 483.20(b)(2)(ii) §483.20(b)(2)(ii) Within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a "significant change" means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by: Based on observation, record review and confirmed by staff interview, the facility failed to ensure that 1 of 15 sampled residents had a significant change in condition assessment completed after the resident suffered a fractured hip. (Resident #2). The findings include the following:	F 637	F637: At the time of survey when this was brought to the DONs attention, the missed MDS was started immediately and completed prior to survey exit. In compliance as of 8/9/18. The staff member responsible for the opening, scheduling, & ultimate completion of MDS at the time of this omission, is no longer in the MDS coordinator position. At this time all MDS are opened, scheduled, and completed by the DON, this will remain in place until the position is filled. We understand that all residents have the potential of being affected by a similar occurrence. To ensure this does not happen again, upon hiring of a new MDS coordinator, education will be provided during orientation, both	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Theresa Southworth
TITLE: administrator
(X6) DATE: 8/24/18

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 637	Continued From page 1 Per medical record review Resident #2 fell on 6/21/18. The resident was hospitalized and diagnosed with a fractured left hip. S/He returned to the facility on 6/24/18. A significant change of assessment was not conducted on return from hospitalization. The last assessment completed was a quarterly review date of 5/7/18. Confirmation was made by the Director of Nurses on 8/7/18 at 11:25 AM that a significant change of assessment should have been completed on return from the hospitalization, since the resident care needs had changed	F 637	verbal and written understanding will be obtained from the orientee. All MDSs completed by the new coordinator will be reviewed by the DON prior to submission for accuracy the first 90 days this coordinator is in the position. All MDS will be reviewed by the IDT group during Medicare meeting to ensure assessments are not missed. F-637 POC accepted 8/29/18 M. Bertrand, RN/S. Remy, RN	
F 641 SS=B	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility failed to ensure that resident assessments accurately reflect the resident's status for 10 of 15 sampled residents (Residents # 29, 14, 26, 31 ,16, 28, 27, 32, 33,20). Findings include: Per record review for Residents # 29, 14, 26, 31, 16, 28, 27, 32, 33, 20. the Minimum Data Set (MDS) had bed rails (section P0100, restraints) coded as restraints. On 8/7/18 at 11:23 AM, the Director Of Nurses (DON) stated that h/she had been told that all side rails were to be coded as restraints The DON confirmed that the side rails were not being used as restraints and that the MDS's named above were incorrectly coded.	F 641	F641: The staff member responsible for the opening, scheduling, & ultimate completion of MDS at the time of the miscoding of the MDS, is no longer in the MDS coordinator position. At this time all MDS are opened, scheduled, and completed by the DON, this will remain in place until the position is filled. We understand that all residents have the potential of being affected by a similar occurrence. To ensure this does not happen again, upon hiring of a new MDS coordinator, education will be provided during orientation, both verbal and written understanding will be obtained from the orientee. All MDSs completed by the new coordinator will be reviewed by the	
F 656	Develop/Implement Comprehensive Care Plan	F 656		

Theresa Southworth 8/24/18

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F 656 Continued From page 2
SS=D CFR(s): 483.21(b)(1)

§483.21(b) Comprehensive Care Plans
§483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following -
(i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and
(ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6).
(iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record.
(iv)In consultation with the resident and the resident's representative(s)-
(A) The resident's goals for admission and desired outcomes.
(B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.

F 656

DON prior to submission for accuracy the first 90 days this coordinator is in the position. All residents that experience a significant change will have a comprehensive assessment completed in a timely manner as scheduled in the ARD planner. Compliance was achieved on 8/10/18. F641 POC accepted 8/29/18 M.Burtrand RN/S.Perry, RN

F656: The staff member responsible for the opening, modifying, & ultimate completion of care plans at the time of the inaccurate care planning is no longer in the ADON position. At this time all care plans are opened, modified, and completed by the DON. This will remain in place until the position is filled. We understand that all residents have the potential of being effected by a similar occurrence. All residents will have a comprehensive review with any significant change, quarterly, or hospital discharge and readmission to us. To ensure this does not happen again, upon hiring of a new ADON, education will be provided during orientation, both verbal and written understanding will be obtained from the orientee. All care plans completed/modified by new ADON will be reviewed by the DON

Theresa Southworth 8/24/18

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F 656	Continued From page 3 (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to develop a care plan for 1 of 15 residents in the applicable sample (Resident #20). Findings include: Per record review Resident #20 was admitted to the hospital on 9/13/17 for a gastrointestinal bleed and gall bladder problems; on 3/11/18 s/he was admitted for pneumonia; and on 5/20/18 s/he was admitted for a gastrointestinal bleed. Per interview on 8/7/18 at 10 35 AM with a Registered Nurse (RN), s/he stated that Resident #20 was also treated in January of 2018 for pneumonia. There was no evidence in the medical record that a care plan was developed to monitor the resident for gastrointestinal bleeding and/or infections. Per interview on 8/8/18 at 8.54 PM with the Director of Nursing (DNS), s/he confirmed that there was no care plan developed to monitor the resident for gastrointestinal bleeding and/or infections.	F 656	for accuracy the first 90 days this coordinator is in the position. Compliance was achieved on 8/10/18. F656 POC accepted 8/29/18 M.Bertrand RN / S. Perry RN	
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician.	F 657		

Theresa Southworth 8/24/18

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F 657 Continued From page 4

(B) A registered nurse with responsibility for the resident.
(C) A nurse aide with responsibility for the resident.
(D) A member of food and nutrition services staff.
(E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan.
(F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident.
(iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.
This REQUIREMENT is not met as evidenced by:
Based on observation, record review and confirmed by staff interview, the facility failed to revise/update the interdisciplinary care plan for 1 of 15 sampled residents, after health care needs changed, (Resident #2). The findings include the following:

Per medical record review, Resident #2 had a fall on 6/21/18. The fall resulted in a fractured hip and hospitalization. The resident was treated conservatively and returned to the facility on 6/24/18, with direction to be keep the resident comfortable.

Per medical record review, Resident #2 had two further (2) unwitnessed falls: On 7/30/18 at approximately 1 PM, the resident was found on the floor at the bathroom door and again, on

F 657

F657: The staff member responsible for the opening, modifying, & ultimate completion of care plans at the time of the inaccurate care planning is no longer in the ADON position. At this time all care plans are opened, modified, and completed by the DON and will remain in place until the position is filled. We understand that all residents have the potential of being effected by a similar occurrence. To ensure this does not happen again, upon hiring of a new ADON, education will be

provided during orientation, both verbal and written understanding will be obtained from the orientee. All care plans completed/modified by new ADON will be reviewed by the DON or accuracy the first 90 days this coordinator is in the position. Compliance was achieved on 8/10/18.

F657 POC accepted 8/29/18
M. Bertrand RN/S. Perry, RN

Theresa Southworth 8/24/18

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F 657 Continued From page 5
8/3/18 at approximately 3 PM, the resident was found on the floor at the bathroom door.

Per review of Resident #2's interdisciplinary care plan dated 1/22/18, identifies the resident as being at risk for falls. Staff are directed to anticipate his/her needs and to place the call bell within reach. The plan also identifies that the resident has limited physical mobility, staff are to assist with mobility needs and provide supportive care. On 6/27/18 the plan does identify 2 staff to assist to transfer to commode.

The Director of Nurses (DNS), confirms on 8/7/18 at approximately 12:31 PM, that the Interdisciplinary Care Plan has not been updated/revised since 6/18/18 and 6/27/18. The care plan does not identify the recent fractured hip and/or changes in the resident's physical needs pertaining to transfer and toileting.

F 657

F 761 SS=D Label/Store Drugs and Biologicals
CFR(s): 483.45(g)(h)(1)(2)

§483.45(g) Labeling of Drugs and Biologicals
Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.

§483.45(h) Storage of Drugs and Biologicals

§483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.

F 761 F761: All medications will be stored according to the medication storage policy provided by the pharmacy, labeling, or package insert accompanying the medication. The medications found on the day of survey were disposed of and replaced by the pharmacy at facility expense. Medications requiring refrigeration until the day opened will remain in the refrigerator in the med room until they are needed for first administration. All multidose medications that requiring opening will be labeled with the date they were opened and with a "DO NOT USE AFTER" date. Staff education provided to RNs/ LPNs citing the Omnicare Pharmacy policy on storage.

Theresa Southworth 8/24/18

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F 761	Continued From page 6 §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to label drugs and biologicals in accordance with accepted professional principles for 1 of 2 medication carts. Findings include: Per observation on 8/6/18 at 3:48 PM of the short hall medication cart, a bottle of nasal spray containing Calcitonin-Salmon 200 units (medication used to treat osteoporosis) for Resident #28, was found open and unlabeled. The label from the pharmacy read, "Discard 35 days after opening". The date the prescription was sent to the facility was 4/30/18. Upon further observation, a second bottle of Calcitonin-Salmon for Resident #19 was unopened and the label from the pharmacy read, "Refrigerate until opened". The date the prescription was sent to the facility was 7/29/18. Per interview on 8/6/18 at 4:07 PM with a Registered Nurse (RN), s/he confirmed that the medication for Resident #28 should have been labeled with a date opened and should have been discarded; and that the medication for Resident #19 should have been refrigerated until it was needed. Per review of the facility's policy (5.3 Storage and	F 761	We understand this had the potential to affect all of the residents of The Gill Home. To ensure this does not happen in the future, going forward we will have the night shift charge nurse go through each of the med carts looking for medications close to expiration, medication labels, and that proper storage of medications is in compliance with policy. The results of these weekly audits will be reported to the DON or her designee. This will be a topic of discussion at all QA and safety meetings for the next 3 months to monitor compliance. Date of compliance 8/23/18. F761 POC accepted 8/29/18 M. Bertrand RN / S. Remy RN	

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

Event ID: E50G11 Facility ID: 475052

Theresa Southworth 8/24/18

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F 761 Continued From page 7

Expiration Dating of Drugs, Biological's, Syringes and Needles) section 3.1 read, "Once any drug or biological package is opened, the Facility should follow manufacturer/supplier guidelines with respect to expiration dates for opened medications."

F 883 Influenza and Pneumococcal Immunizations
SS=B CFR(s): 483.80(d)(1)(2)

§483.80(d) Influenza and pneumococcal immunizations
§483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that-
(i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization;
(ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period;
(iii) The resident or the resident's representative has the opportunity to refuse immunization; and
(iv)The resident's medical record includes documentation that indicates, at a minimum, the following.
(A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and
(B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal.

§483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure

F 761

F 883

F883: In this case it was influenza consent forms, our consent forms that were signed by either the resident or their responsible party, gave consent for the current year influenza vaccine and all future years that the resident resided at the Gill Home. Since survey we have updated our form and removed that line. We are sending out letters to our families (see attached) requesting them to send back the signed forms either consenting or declining the vaccine along with a information sheet regarding the vaccine. We will do this on an annual basis for every resident that resides with us or is admitted during the many months of the flu season. All immunization statuses are up to date in PCC and will remain up to date throughout this new flu season. Most of our residents come from outside facilities and are up to date with their pneumococcal vaccinations, when a resident is not up to date, the vaccine is offered, information sheet provided and consent obtained prior to administration. The infection preventionist or her designee will keep a spreadsheet of all consent forms sent out, consents/declinations, and administrations. We will continue to discuss our compliance at each QA/Safety meeting for the next 3 months.

F883 POC accepted 8/29/18
M. Bertrand RN/S. Perry, RN

Theresa Southworth 8/24/18

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F 883 Continued From page 8

F 883

that-

(i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization;

(ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized;

(iii) The resident or the resident's representative has the opportunity to refuse immunization; and

(iv)The resident's medical record includes documentation that indicates, at a minimum, the following:

(A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and

(B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal.

This REQUIREMENT is not met as evidenced by:

Based on record review and confirmed by staff interview the facility failed to develop influenza immunization policies, ensuring that residents/resident representatives receive education pertaining to the benefits and potential side effects associated with the annual immunization. The facility also failed to provide the resident/resident representative with the opportunity to refuse the administration of the annual immunization and failed to obtain informed consent for the administration of the annual influenza vaccine, from residents and/or their representative, during the 2017 flu season, for 5 of 5 sampled residents, (Residents #1, #17, #20,

Theresa Southworth 8/24/18

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F 883	Continued From page 9 #27, and #32). Confirmation was made by the Director of Nurses (DNS) on 8/8/18 at 9:30 AM, that the facility did not develop policies regarding immunization practices. Nor was there evidence that any of the residents who reside in the facility or their representative, provided written/verbal informed consent for the influenza vaccine to be administered.	F 883		

Theresa Southworth 8/24/18