AGENCY OF HUMAN SERVICES

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

November 8, 2018

Ms. Theresa Southworth, Manager
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 **October 9, 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

Pamela M. Cota, RN
Licensing Chief

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

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 10/09/2018

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 An unannounced on-site investigation of a facility reported incident was conducted on 10/9/18 by the Division of Licensing and Protection. The following regulatory violations were identified as a result:	F 000		
F 656 SS=D	Develop/Implement Comprehensive Care Plan 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	F 656		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Theresa Southworth | TITLE: Administrator | (X6) DATE: 11/2/18

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.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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F 656	Continued From page 1 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. (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 follow the care plan for 1 applicable resident in the sample (Resident #1). Findings include: Per record review Resident #1's care plan read, "Ambulate with rolling walker with line of sight supervision". On 8/14/18, Resident #1 was involved in an altercation with another resident (Resident #2). A housekeeper witnessed some of the interaction. Per interview on 10/9/18 at 10:25 AM with the Director of Nursing (DNS), s/he stated that a direct line of sight meant that the resident was in the staff's direct line of sight, with eyes on. Per interview on 10/09/18 at 4:47 AM with the housekeeper, s/he stated that no other staff was around supervising Resident #1 and Resident #2. The DNS confirmed that the staff was not able to maintain a direct line of sight for Resident #1.	F 656	F656- The day after the surveyor left the building on 10/10/18, the Director of Rehab services audited the care plans of all current residents in the building to remove the words "In line of sight." Rehab staff were educated regarding the definition of "in line of sight" due to the fact that we are not able to provide this type of supervision. The Director of Rehab will continue to monitor care plans for this wording. This will be audited for 3mo and will be a topic of QA to monitor compliance. F656 POC accepted 11/7/18 D. Wideawake RN / S. Lengyel RN	10/10/18
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that -	F 689		

Theresa Southworth Administrator 11/2/18

PRINTED: 10/22/2018
FORM APPROVED
OMB NO. 0938-0391

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F 689	Continued From page 2 §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 interview and record review the facility failed to provide supervision for 2 of 3 residents in the applicable sample (Resident #1 and Resident #2). Findings include: Per review of the nursing progress notes for Resident #2, Resident #2 was wandering into other residents rooms and upsetting other residents. S/he needed frequent redirection and monitoring from staff. Upon further record review on 8/14/18, Resident #2 was involved in an altercation with Resident #1. Per interview on 10/9/18 at 9:30 AM with the DNS, s/he stated that Resident #1 frequently walked throughout the facility with his/her walker and often would not immediately notice objects/people in his/her path; and would bump into them. S/he stated that on 8/14/18, Resident #1 was walking with his/her walker and bumped into Resident #2. Resident #2 then reacted to this interaction. Per interview on 10/9/18 at 4:47 PM with a housekeeper, s/he stated that s/he witnessed Resident #2 interacting with Resident #1 and that there were no other staff members in the area at the time of this interaction.	F 689	F689- Resident #1 has since passed away. All residents in the building have the potential to have been effected by "wandering" and "unwanted visiting" by our cognitively impaired residents. "Stop signs" were offered and were placed on the doors of those that consented to deter wandering residents. "No Parking" signs were placed by the short hall nurses station to relieve congestion allowing freer movement of all residents. All staff received education on "Managing Aggressive Behaviors." Education on abuse/neglect/reporting and prevention is provided to every staff member including housekeeping and all ancillary staff upon hire, annually and on an as needed basis. This ensures that any staff member has the ability as well as the skill set to intervene in a resident to resident situation. Education compliance will be monitored by the DNS indefinitely. Resident behaviors such as wandering will be a QA topic for the next 3mo. F-689 POC accepted 11/7/18 D. Wideawake RN/S. Curry, RN	10/31/18

Theresa Southworth Administrator 11/2/18