VERMONT

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

July 1, 2019

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

Provider #: 475052

Dear Ms. Southworth:

Enclosed is a copy of your acceptable plans of correction for the Life Safety Code survey conducted on **June 4, 2019**. Please post this document in a prominent place in your facility.

We will 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

Enclosure

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	475052	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	06/04/2019

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
K 000	INITIAL COMMENTS An unannounced Life Safety Code survey was conducted by the Division of Fire Safety on June 4, 2019. The following violations were identified.	K 000		
K 211 SS=D	Means of Egress - General CFR(s): NFPA 101 Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 This REQUIREMENT is not met as evidenced by: Per observation on 6/4/19, the facility failed to ensure that the facility remained clear of all obstruction in all egresses for full use in case of emergency. The findings include the following: 1. Per observation, the Aministration corridor contains, storage, a copier machine and furniture. 2. Per observation, the basemenet corridor has storage and two freezers in the path of egress.	K 211	K211: Administration corridor contained storage, copier machine, and furniture which could cause an obstruction to exit in an emergency. All staff, residents, or visitors in need of emergent exit have the potential to be effected. By 6/13/19, all storage, furniture and copier were removed from the administration corridor. On 6/6/19, lockers and freezers were removed from the basement corridor, leaving it free of obstacles. Signs posted in the Administration and Basement corridors stating "No storage." Corrective action completed on 6/28/19. POC accepted 7/1/19 S. Dumont/RN	
K 321 SS=D	Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8 7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting	K 321	K321: Facility failed to ensure self closing/latching doors on the fire doors located in the kitchen and basement. All staff, residents, or visitors in need of protection from fire behind these doors have the potential to be effected. On 6/28/19, installed "self-closure" mechanism to the fire door to the exit stairs, located in the kitchen.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Theresa Southworth | TITLE: Administrator | (X6) DATE: 6/28/19

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	475052	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	06/04/2019

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

K 321 Continued From page 1

partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door.
Describe the floor and zone locations of hazardous areas that are deficient in REMARKS.
19.3.2.1, 19.3.5.9

Area Automatic Sprinkler
Separation N/A
a. Boiler and Fuel-Fired Heater Rooms
b. Laundries (larger than 100 square feet)
c. Repair, Maintenance, and Paint Shops
d. Soiled Linen Rooms (exceeding 64 gallons)
e. Trash Collection Rooms
(exceeding 64 gallons)
f. Combustible Storage Rooms/Spaces
(over 50 square feet)
g. Laboratories (if classified as Severe Hazard - see K322)
This REQUIREMENT is not met as evidenced by:
Per observation on 6/4/19, the facilty failed to ensure doors are self-closing or automatic closing. The findings include the following:

1. Per observation, the fire door to the exit stairs located in the Kitchen does not lock & latch.

2 Per observation, the fire door located in the basement does not lock & latch.

K 363 Corridor - Doors
SS=D CFR(s): NFPA 101

Corridor - Doors
Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or

K 321 Continued...
On 6/11/19, latch was repaired on the fire door located in the basement.
Maintenance to observe/check self closing doors on a weekly basis and report to safety/QAPI monthly for the next 6 months.
Corrective action completed 6/28/19.
POC accepted 7/1/19
S. Dumont/TDD.

K 363

Theresa Southworth
Administrator 6/28/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	475052	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	06/04/2019

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
K 363	Continued From page 2 hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. This REQUIREMENT is not met as evidenced by: Per observation on 6/4/19, facility failed to ensure that all fire doors had a two hour fire caulking in penetrations. This findings include the	K 363	K363: Facility failed to show that all fire walls had 2 hour fire caulking: Nook Corridor: caulked 6/27/19 Short Corridor: caulked 6/12/19 Wing Corridor: caulked 6/27/19 Soiled Utility: caulked 6/20/19 Office Supply Room: caulked 6/6/19 All staff, residents, or visitors in need of protection behind these walls have the potential to be effected. Corrective action completed 6/27/19 Maintenance will observe/check for areas of penetration on a monthly basis and report to safety/QAPI monthly for the next 6 months. POC Accepted 7/1/19 S. Dumont/TA	

Theresa Southwood 6/28/19
Administrator

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	475052	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	06/04/2019

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
K 363	Continued From page 3 following: 1. Per observation, the fire door in the nook corridor, requires a two hour fire caulking in the penetration in the fire wall above the door. 2. Per observation, the fire door in the short corridor, requires a two hour fire caulking in the penetration in the fire wall above the door. 3. Per observation, the fire door in teh wing corridor, requires a two hour fire caulking in the penetration in the fire wall above the door. 4. Per observation, the soiled utility room has penetrations in the ceiling. 5. Per observation, the office supply room has penetrations in the ceiling & walls.	K 363		
K 500 SS=D	Building Services - Other CFR(s): NFPA 101 Building Services - Other List in the REMARKS section any LSC Section 18.5 and 19.5 Building Services requirements that are not addressed by the provided K-tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. This REQUIREMENT is not met as evidenced by: Per observation on 6/4/19, the facility failed to ensure building service equipment that pass through fire barries shall mainaint the required	K 500	K500: Med room electrical receptacle was replaced with ground fault interrupter on 6/13/19 by Code3 Electric. Boiler room ceiling open electrical box was enclosed on 6/6/19. These were not public areas, staff with access to the med room and boiler room had the potential to be effected. Corrective action completed 6/28/19. House-wide audit conducted on 6/28/19 to ensure all electrical receptacles in close proximity to a sink are grounded or GFCI and all electrical boxes in the facility are enclosed. This audit will be done yearly. Maintenance reported findings immediately to Administrator and will at safety/QAPI meetings for 6 months. POC accepted 7/1/19 SDeMuth	

Theresa Southwood
Administrator
6/28/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	475052	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	06/04/2019

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
K 500	Continued From page 4 resistance rating. The findings include the following: 1. Per observation, the med room electrical receptacles are required to ground fault interrupter. 2. Per observation, the boiler room ceiling has open electrical boxes.	K 500		

Theresa Southwood
Administrator

6/28/19