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

February 7, 2023

Ms. Theresa Southworth
Trustees Of The Gill Odd Fellows Home Of Vermont
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 11, 2023.** 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 ______	01/11/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GILL ODD FELLOWS HOME OF VERMONT	**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 The Division of Licensing and Protection conducted an emergency preparedness review during the annual recertification survey on 1/9 - 1/11/23. There were no regulatory violations identified.	E 000		
F 000	INITIAL COMMENTS An unannounced on-site annual recertification survey was conducted by the Division of Licensing and Protection at the Trustees of Gill Odd Fellows Home on 1/9 - 1/11/23. The following regulatory findings were identified:	F 000		
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. (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	F 657	The facility failed to review and/or revise the Care Plan regarding fall prevention for 1 resident. Following each fall, the residents will have a comprehensive review of their care plan and interventions will be added as needed to ensure resident centered care. In compliance as of 2/6/23. Risk management to be reviewed daily for falls, care plan review. Weekly audit to follow up on review. Overseen by DON or designee. Indefinite QAPI topic on the agenda under falls.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Theresa Southworth   TITLE: NHA   (X6) DATE: 2/6/23

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 657	Continued From page 1 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 upon interview and record review, the facility failed to review and/or revise the Care Plan regarding fall prevention for 1 resident [Res. #17] of 19 sampled residents. Findings include: Per review of Res #17's medical record, the resident was admitted to the facility with diagnoses that include Alzheimer's Disease and Dementia with behavioral disturbance. Review of Res. #17's Care Plan reveals the resident is identified as "at risk for falls related to shuffling gait, unaware of surroundings". Per review of Progress Notes for Res. #17: 8/2/2022 "Resident found on floor in front of recliner chair by Long Hall RN [Registered Nurse]." 10/13/2022 "Resident was "washing" the table when she slipped and fell, she bumped the right side of her head near the forehead on the window frame." 10/15/22 "Writer was called into resident room, observed resident on the floor." 11/23/22 "LNA [Licensed Nursing Assistant] reported that resident was observed on the floor." 12/13/22 "found resident lying on her back on the floor with her feet up on the bed." 1/3/2023 "Witnessed fall - slide to floor between sofa and table - next to piano." An interview was conducted with the facility's Director of Nursing [DON] on 1/11/23 at 9:30 AM.	F 657		

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F 657	Continued From page 2 The DON stated the facility reviews the resident's Care Plan after each fall and revises the Care Plan interventions as needed to prevent future falls. The DON demonstrated how Care Plan reviews are noted and documented in the resident's medical record. Per record review and confirmed by the DON, there was no documented reviews of Res. #17's Care Plan after falls on 11/23/22, 12/13/22, and 1/3/23. During the interview, the DON also confirmed that no new interventions to prevent future falls were added to Res. #17's Care Plan after any of the 6 falls in the past 5 months listed above. The DON stated that "there really is nothing we can do" in Res. #17's case, and "I can't think of anything we are not providing". Per interview with the DON on 1/11/23 at 9:30 AM, the DON confirmed that Res. #17's Care Plan was not reviewed after 3 of 6 falls between August 2022 and January 2023, and that there were no new interventions added to prevent future falls after any of the 6 falls. Additionally, during the interview with the DON on 1/11/23, it was revealed that Res. #17 had suffered a 7th fall earlier that morning.	F 657	**Tag F 657 POC Accepted on 2/7/23 by T. Dougherty/P. Cota**	
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 - §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	F 689	The facility failed to ensure each resident receives adequate supervision and assistance devices to prevent accidents for 1 resident. Following each fall, with a MORSE fall scale score >50, a screen request will be given to the therapy department. This screen is will evaluate if the resident is in need of additional devices or increased supervision for safety. This screen will be documented in the electronic medical record.	

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F 689	Continued From page 3 by: Based upon interview and record review, the facility failed to ensure each resident receives adequate supervision and assistance devices to prevent accidents for 1 resident [Res. #17] of 19 sampled residents. Findings include: Per review of Res #17's medical record, the resident was admitted to the facility with diagnoses that include Alzheimer's Disease and Dementia with behavioral disturbance. Review of Res. #17's Care Plan reveals the resident is identified as "at risk for falls related to shuffling gait, unaware of surroundings". Per review of Progress Notes for Res. #17: 8/2/2022 "Resident found on floor in front of recliner chair by Long Hall RN [Registered Nurse]." 10/13/2022 "Resident was "washing" the table when she slipped and fell, she bumped the right side of her head near the forehead on the window frame." 10/15/22 "Writer was called into resident room, observed resident on the floor." 11/23/22 "LNA [Licensed Nursing Assistant] reported that resident was observed on the floor." 12/13/22 "found resident lying on her back on the floor with her feet up on the bed." 1/3/2023 "Witnessed fall - slide to floor between sofa and table - next to piano." An interview was conducted with the facility's Director of Nursing [DON] on 1/11/23 at 9:30 AM. The DON stated that the facility conducts a "Morse Fall Scale" assessment after each resident fall. [Per record review, Res. #17's most recent Morse Fall Scale score is '75', identifying the resident as "High Risk for falling"] The facility	F 689	Falls and screens to be reviewed weekly at RISK. This will be overseen by the DON and Director of Therapy. QAPI topic under fall agenda- Indefinitely In compliance by 2/6/2023.	

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F 689	Continued From page 4 also reviews the resident's Care Plan after each fall, and revises the Care Plan interventions as needed to prevent future falls. The DON demonstrated how Care Plan reviews are noted and documented in the resident's medical record. Per record review and confirmed by the DON, there was no documented review of Res. #17's Care Plan after falls on 11/23/22, 12/13/22, and 1/3/23. Further review revealed no Morse Fall Scale assessments conducted after falls on 11/23/22 and 1/3/23. During the interview, the DON confirmed that no new interventions to prevent future falls were added to Res. #17's Care Plan after any of the 6 falls in the past 5 months listed above. The DON stated that "there really is nothing we can do" in Res. #17's case, and "I can't think of anything we are not providing". The DON stated the Care Plan goal "is preventing significant or major injury" and "that goal is being met". Per review of Res. #17's Care Plan, the resident is identified as at risk for falls, with the goal "Resident will not sustain injury from fall through review date", with the review date of 3/9/2023. Review of Incident Notes for Res. #17 after a fall on 12/13/22 record "Petechiae noted on left side of face and neck". [According to the Mayo Clinic, Petechiae are pinpoint, round spots that appear on the skin as a result of bleeding. The bleeding causes the petechiae to appear red, brown, or purple]. (https://www.mayoclinic.org/symptoms/petechiae/basics/definition/sym-20050724) Review of Incident Notes after the fall on 1/3/23 record "Tiny hematoma appeared above left eye and a small scratch on left cheek", and "left eyelid noted to have a line of reddish bruising, under left	F 689		

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F 689	Continued From page 5 eye area with little scratch and slightly puffy" [A hematoma is an abnormal collection of blood outside of a blood vessel. It occurs because the wall of a blood vessel wall, artery, vein, or capillary, has been damaged and blood has leaked into tissues] (https://www.medicinenet.com/hematoma/) Per interview with the DON on 1/11/23 at 9:30 AM, the DON confirmed that Res. #17's Care Plan was not reviewed after 3 of 6 falls between August 2022 and January 2023, and that there were no new interventions added to prevent future falls after any of the 6 falls. Additionally, during the interview with the DON on 1/11/23, it was revealed that Res. #17 had suffered a 7th fall earlier that morning.	F 689	**Tag F 689 POC Accepted on 2/7/23 by T. Dougherty/P. Cota**	
F 880 SS=F	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual	F 880	During the onsite survey, The RN confirmed that they had not performed hand hygiene before or after administering medications to the resident immediately following this administration. This deficiency could affect all residents dependent on staff for medications, food, care. All direct care staff will receive training in proper use of hand hygiene to prevent the spread of infection. Education materials: Gill Home Hand Hygeine Policy All direct care staff will have their hand washing competency completed via return demonstration by 2/6/2023, as well as upon hire, annually, and as needed. To be completed by DON or designee.	

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F 880

Continued From page 6

arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;

§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:
(i) A system of surveillance designed to identify possible communicable diseases or
infections before they can spread to other persons in the facility;
(ii) When and to whom possible incidents of communicable disease or infections should be reported;
(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;
(iv)When and how isolation should be used for a resident; including but not limited to:
(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.
(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and
(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.

§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.

§483.80(e) Linens.
Personnel must handle, store, process, and

F 880

The facility failed to develop and implement measures to prevent the growth of Legionella and other opportunistic waterborne pathogens in the buildings water system. This deficiency has the potential to affect all residents residing in the facility.

Administrative and maintenence staff, responsible for the physical plant and water supply, will receive training in water management programs to include how to mitigate risk of legionella.This will be overseen by the NHA.

Education materials:
https://www.cdc.gov/legionella/downloads/toolkit.pdf

https://www.cdc.gov/HAI/pdfs/Water-Management-Checklist-P.pdf

https://cha.com/wp-content/uploads/2019/03/Water-Management-Program-Template.pdf

The facility has created a water management program as of 2/6/23, which includes mitigation of risk of legionella and testing for legionella.

The Gill Home has contracted with Analytical Services for lab testing- first samples taken 1/25/23 (awaiting results)

This will be a quarterly topic of QAPI, indefinitely.

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F 880	Continued From page 7 transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on Observations and interviews, the facility failed to develop and implement measures to prevent the growth of Legionella and other opportunistic waterborne pathogens in the buildings water system, as well as follow proper hand hygiene procedures during medication administration. Findings include: 1. Per observation of medication administration at approximately 11:30 AM on 1/10/2023, the Infection Prevention RN administering a mealtime injection of Novalog Insulin and two tablets of the oral medication Gabapentin did not perform hand hygiene (handwashing or alcohol-based rub) prior to donning gloves and entering a resident's room to administer the injection and tablets. Administration of the injection required direct contact with the resident. The RN also did not perform hand hygiene after leaving the resident's room and removing their gloves. The RN confirmed that they had not performed hand hygiene before or after administering medications to the resident immediately following this administration. Per the provided facility policy titled Hand Hygiene Policy and Procedure, the policy states, "B. Indications for handrubbing ... before having direct contact with patients ... after removing gloves." The policy also states, "The use of	F 880		

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F 880	Continued From page 8 gloves does not eliminate the need for hand hygiene." 2. Per the Mayo Clinic: 'Legionnaires' disease is a serious type of pneumonia you get when Legionella bacteria infect your lungs. Symptoms include high fever, cough, diarrhea, and confusion. You can get Legionnaires' disease from water or cooling systems in large buildings, like hospitals or hotels. Legionnaires' disease can be life-threatening.' (https://www.mayoclinic.org/diseases-conditions/legionnaires-disease/symptoms-causes) An interview was conducted with Director of Nursing (DON), whom is also the facility Certified Infection Preventionist (CIP) on 1/10/23 at 2:05 PM. The DON/CIP revealed that s/he is unaware of the Centers for Disease Control and Center for Medicare and Medicaid Services required Legionella prevention policies or procedures and refered to the Maintenance Director. Per interview on 1/11/23 at 7:45 AM the facility's Maintenance Director stated that the facility does not perform testing for Legionella. S/he reported that the town does the testing for Legionella, but S/he does not have the testing results. Review of the facilities Water Supply Policy reveals "approach to controlling waterborne microorganisms will be consistent with current Centers for Disease Control (CDC), Health Care Infection control practices advisory committee (HCICPAC), and the Food and Drug administration (FDA) recommendation or state and local Health Departments" Per interview with the facility's Administrator	F 880		

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F 880	Continued From page 9 (ADM) on 1/11/23 confirmed that the facility does not perform Legionella testing. The ADM reported that S/he had contacted the town regarding Legionella testing and confirmed that the town has no record of Legionella testing for the facility.	F 880	**Tag F 880 POC Accepted on 2/7/23 by T. Dougherty/P. Cota**	
F 908 SS=E	Essential Equipment, Safe Operating Condition CFR(s): 483.90(d)(2) §483.90(d)(2) Maintain all mechanical, electrical, and patient care equipment in safe operating condition. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, and record review, the facility failed to ensure that all mechanical, electrical, and patient care equipment is maintained and in safe operating condition. Findings include: 1. Per interview on 1/9/2023 (Monday) at approximately 11:15 AM, Resident #22 shared that their call light is not working and has not worked since the Saturday. They stated that an LNA (licensed nursing assistant) tested the light with them to confirm it was not working. The LNA then told Resident #22 that they would pass the issue along to maintenance for Monday and instructed them to share their roommate's call light in the meantime. Resident #22 stated that their call light has malfunctioned in the recent past as well. During the interview, this surveyor visually confirmed that the call light was not functioning during a test of the call light with Resident #22. Per interview on 1/9/2023 at approximately 11:45 AM, the Maintenance Director confirmed that they were not made aware of the malfunctioning call	F 908	The facility failed to ensure that all mechanical, electrical, and patient care equipment is maintained and in safe operating condition. All mechanical, electrical, and patient care equipment (in use) is in maintained and safe operating condition. Gill Home has created a new policy, added education for all new hires, existing staff, and temporary agency staff- regarding maintenance and reporting damaged or equipment in disrepair. New log created with the additional space for maintenance staff to document "word of mouth" reports or requests. Any completed work, to be signed off by the staff member that fixed the issue or equipment. In compliance by 2/6/23. Education completed. Overseen by NHA and Maintenance Dir.	

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F 908	Continued From page 10 light, but that they did know that the same call light malfunctioned about a month ago and was fixed. The Maintenance Director stated that the units have "Maintenance Logs" in which staff are expected to document facility issues that require maintenance. Once the Maintenance Department fixes the issue, they are to sign off that the issue has been completed in the log. Per review of the facility's maintenance log, there is no evidence of any documentation reporting Resident #22's call light malfunction from the weekend or from a month ago. Per interview on 1/10/2023 at approximately 9:00 AM, the Maintenance Director confirmed that there is no record of the call light issue being logged by staff in the maintenance log, nor is there any record of the reporting/resolution of the call light malfunction from a month ago. The Maintenance Director stated that not all maintenance issues are reported via the log. Many of the issues they are informed of are by word-of-mouth. These word-of-mouth reports are not documented anywhere, nor is there documentation of resolution once the issue has been fixed.	F 908	**Tag F 908 POC Accepted on 2/7/23 by T. Dougherty/P. Cota**	