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

December 13, 2024

Ms. Maegan McElwain, Administrator
Gill Odd Fellows Home of Vermont
8 Gill Terrace
Ludlow, VT 05149-1004

Dear Ms. McElwain:

Enclosed is a copy of your acceptable plans of correction for the complaint investigation conducted on **November 12, 2024.** 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, BS
Assistant Division Director
State Survey Agency Director

Enclosure

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 11/12/2024

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

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F 000	INITIAL COMMENTS An unannounced, on-site complaints investigations #23373, #23378, & #23438 were conducted by the Division of Licensing and Protection on 11/12/24 at Gill Odd Fellow Home to determine compliance with 42 CFR Part 483 requirements for Long Term Care Facilities. The following regulatory violations were identified:	F 000	F658 The facility failed to provide services that meet professional standards of quality regarding proper actions following a fall which resulted in harm for one resident [Res.#1]. Res #1 no longer resides in the facility. Both the LPN and LNA were terminated from their postion at the Gill Odd Fellows Home. Fall policy and assessment revised. Nursing staff in-serviced on new policy and procedure. New post fall assessment created in PCC to aid the nurses with their assessment and documentation. ADON assigned to staff education. DON or designee to monitor and review for post fall assessments and accurate documentation. Assessment and change in condition competencies reviewed, revised, and implemented, to be completed upon hire, annually, and as identified to be needed. Education and competencies to be an ongoing topic of QAPI. Facility to be in compliance by 1/3/25 **Tag F 658 POC accepted on 12/13/24 by T. Dougherty/P. Cota**	
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to provide services that meet professional standards of quality regarding proper actions following a fall which resulted in harm for one resident [Res.#1]. Findings include: Per review of the Lippincott Manual of Nursing, "The standards of care for professional nursing include assessment, diagnosis, implementation and evaluation. Departure from Standards of Care include: Failure to adhere to facility policy or procedural guidelines, failure to monitor or observe a patient's clinical status adequately, failure to make prompt, accurate entries in a patient's medical record." [Lippincott Manual of Nursing Practice-11th Edition 2018] An interview was conducted with the Director of Nursing [DON] on 11/12/24 at 2:22 PM. The DON	F 658	F726 the facility failed to ensure nursing staff possessed and implemented the appropriate competencies and skills sets to provide nursing and related services to assure resident safety for one resident [Res.#1]. Res #1 no longer resides in the facility. Both the LPN and LNA were terminated from their position at the Gill Odd Fellows Home. Fall policy and assessment revised. Nursing staff in-serviced on new policy and procedure. New post fall assessment created in PCC to aid the nurses with their assessment and documentation. ADON assigned to staff education. DON or designee to monitor and review for post fall assessments and accurate documentation. Assessment and change in condition competencies reviewed, revised, and implemented, to be completed upon hire, annually, and as identified to be needed. Needed assessments, ongoing monitoring, and change In condition to be discussed at Huddles. “Huddle” communication meetings to take place twice daily, a minimum of 5 x weekly. RN, LPN, LNA job descriptions revised and reviewed with nursing staff. Education and competencies to be an ongoing topic of QAPI. Facility to be in compliance by 1/3/25 **Tag F 726 POC accepted on 12/13/24 by T. Dougherty/P. Cota**	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: DON/CLIA Lab Director | (X6) DATE: 12/4/24

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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stated on 10/26/24 at approximately 4:00 AM, s/he received a voicemail from a Licensed Practical Nurse [LPN] at the facility. The DON provided a printed transcript of the voicemail. Per review of the transcript, the LPN reported a Licensed Nurse's Aide [LNA] was pushing Res.#1 in a wheelchair down a hallway. The LPN stated Res.#1 "had a fall ...kind of fell out of the wheelchair and [s/he] didn't land hard". The DON confirmed the information in the voicemail s/he received on 10/26/24 met the facility's definition of a fall.

Per interview with the DON on 11/12/24 and confirmed by record review, the DON reported that a 'Risk Management' form regarding Res.#1's fall on 10/26/24 the resident "appeared to be in distress". The DON stated during subsequent interviews with staff who were present after the incident it was revealed that Res.#1 suffered "instant bruising after the fall".

Per review of the facility's 'Managing of a Fall Policy and Procedure'- "Actions/ Responsibilities:
Step one: assessment. When a patient falls, don't assume that no injury has occurred-this can be a devastating mistake... conduct a comprehensive assessment.
Step two: notification and communication. Notify the physician and emergency contact.
Step three: monitoring and reassessment.
Step four: documentation: Incident note or progress notes documenting a fall. Thorough documentation helps ensure that appropriate nursing care and medical attention are given. Whether it is written on the patient's chart or entered in the electronic medical record, documentation for a fall should include:
All observations
Patient statements
Assessments

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Notifications
Interventions
Evaluation."
[Policy # 06-01 Reviewed/Revised :2/8/24]
Additionally, the facility's "Fall Protocol" lists "For any fall whether witnessed or unwitnessed, a thorough head to toe evaluation must be completed to assess for injury." The protocol lists for a "WITNESSED FALL- Initial set of vitals [heart rate, respiration rate, blood pressure] and neuros [neurological signs- confusion, pupil reaction, level of consciousness] every shift for 3 days"
Review of the Risk Management form completed by the LPN who left the fall phone message reports "Immediate Action Taken: Full assessment completed. There were no bruises or skin tears".
Review of Res.#1's medical record reveals no documentation of any evaluations, vital signs, neurological checks, or assessments conducted on the resident as a result of the fall on 10/26/24, or that a fall had even occurred.
Additionally, per interview on 11/12/24, the DON stated during subsequent interviews with staff who were present after the incident it was revealed that Res.#1 suffered "instant bruising after the fall".
The DON confirmed there was nothing in Res.#1's medical record that demonstrated any of the actions in the Fall Policy and Procedure were conducted after the fall on 10/26/24, including monitoring, assessment, notification, and documentation
The DON further stated that 2 days later, on 10/28/24, a review of Res.#1's medical record by the DON revealed that no appropriate actions, including assessments, had been implemented regarding Res.#1's fall on 10/26/24. The DON

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stated that an 'Incident Order' was then initiated on 10/28/24 that identified the incident on 10/26/24 as a fall in the medical record and triggered staff to initiate the Fall Policy and Procedure, including a comprehensive assessment of the resident. Per review of Res.#1's medical record and confirmed by the DON, on 10/28/24 there again were no actions conducted including comprehensive assessments regarding the resident's fall and the facility's Fall Policy and Procedure. The DON further stated that documentation was then added to Res.#1's medical record on 10/28/24 by the Assistant Director of Nursing [ADON]. The DON stated that the entry was dated "effective" 10/26/24, and copied from the LPN's Risk Management note. The ADON documented that Res.#1 fell out of a wheelchair, "Full assessment completed ...there were not bruises or skin tears". The DON confirmed that at the time of the record addition by the ADON, there was still no documentation of a full assessment having been conducted on Res.#1, and there had been "instant bruising after the fall".

Per record review of progress notes for Res.#1 dated 10/29/24, 3 days after the fall, reveals the resident "has not been taking anything significant by mouth on [day] shift for days. However, when [s/he] appears in pain and has nonverbal signs of pain [s/he] is able to take a scant amount of liquid Morphine [opioid pain-relieving medication] in [h/her] cheeks. Resident has been unable to arouse enough to eat or drink safely. [S/he] has not verbalized or made eye contact in days". Further progress notes later on 10/29/24 record "Resident slept entire shift. [S/he] would not take anything by mouth. Morphine given at beginning of shift. Resident very shaky ...".

Per review of a statement provided by the DON,

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and confirmed during interview on 11/12/24, the DON reported that 4 days after the fall, on 10/30/24, a "Nurse performing skin check documented old bruising on right shoulder and right upper forehead [of Res.#1] and reported to me [DON]. It is clear these bruises are days old (dark and yellow) and consistent with the fall on 10/26 ... MD was notified ...X-ray of right shoulder ordered".
Per review of LNA task documentation for Res.#1, under "Skin Observation", "Discoloration" is noted by LNAs on 2 different shifts on 10/29/24, the day before the nurse reported bruising to the DON.
Per interview with a staff LNA on 11/12/24 at 10:34 AM, if an LNA discovers any skin issues such as "discoloration" on a resident, the LNA reports those issues to the resident's nurse. Per record review, there is no documentation of any skin discoloration or bruising on Res.#1 by Nursing prior to 10/30/24, or by LNAs prior to 10/29/24, despite staff later reporting "instant bruising after the fall". Additionally, the DON confirmed that per record review, on 10/31/24, the day after the bruising was reported by nursing, LNA task documentation again recorded no issues including "discoloration" observed.

Per review of Progress Notes for Res.#1 dated 10/31/24, "Mobile Xray in facility to perform shoulder injury due to bruising from 10/26 fall. Result indicates Right clavicle fracture" [break in the collar bone].
Per interview with the facility's DON on 11/12/24 and per record review, on 10/26/24, Res.#1 suffered a fall which resulted in "instant bruising", "distress", and a fractured right clavicle. After the fall, the facility failed to ensure appropriate assessment, notification, and documentation

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F 658	Continued From page 5 occurred until 4 days later when "old" bruising prompted diagnostic testing, which identified the fracture. Additionally, documentation in the resident's record that was present or added after the fall did not accurately reflect the actions taken or resident's status.	F 658		
F 726 SS=D	Competent Nursing Staff CFR(s): 483.35(a)(3)(4)(c) §483.35 Nursing Services The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.71. §483.35(a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. §483.35(a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs. §483.35(c) Proficiency of nurse aides. The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident	F 726		

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assessments, and described in the plan of care. This REQUIREMENT is not met as evidenced by:

Based on interview and record review, the facility failed to ensure nursing staff possessed and implemented the appropriate competencies and skills sets to provide nursing and related services to assure resident safety for one resident [Res.#1].

Findings include:

An interview was conducted with the Director of Nursing [DON] on 11/12/24 at 2:22 PM. The DON stated on 10/26/24 at approximately 4:00 AM, s/he received a voicemail from a Licensed Practical Nurse [LPN#1] at the facility. The DON provided a printed transcript of the voicemail. Per review of the transcript, the LPN reported a Licensed Nurse's Aide [LNA #1] was pushing Res.#1 in a wheelchair down a hallway. The LPN stated Res.#1 "had a fall ...kind of fell out of the wheelchair and [s/he] didn't land hard".

The DON reported to the State Agency that s/he did not know or was not told that Res.#1 suffered a fall, despite confirming during interview that the statements in the voicemail received on 10/26/24 met the facility's definition of a fall.

Per interview with the ADON on 11/12/24, the ADON confirmed that s/he conducted Fall Procedure education for facility staff on 10/17/24, 9 days before the fall. The ADON confirmed that the education provided included "A progress note needs to be documented [including] explaining how you found them, vitals ['vital signs'-respirations, heart rate, blood pressure], and assessment." Per record review and confirmed by the DON, the Licensed Practical Nurse [LPN #1] who left the voicemail had attended the Fall education 9 days prior to the fall.

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Per record review and confirmed by the DON, LNA #1, who was pushing the wheelchair when Res.#1 fell, had not received any Fall education since 2023.

The ADON stated that after s/he reviewed Res.#1's record and contrary to the education provided 9 days before, s/he discovered LPN #1 provided no documentation in the medical record of the fall or that an assessment had been. The ADON confirmed that the Fall education s/he provided on 10/17/24 included "STICK TO THE FACTS ONLY, do not assume what happened". The ADON confirmed that on 10/28/24, two days after the fall, s/he added a note to Res.#1's medical record noting a "Full assessment completed ...there were not bruises or skin tears" despite staff statements regarding "instant" bruising and no documentation in the medical record of any assessment having been conducted immediately after the fall or during the following 2 days.
The ADON reported the Fall Education provided to staff included "See Policy for assessment and monitoring tips".
Per review of the facility's 'Managing of a Fall Policy and Procedure'- "Actions/ Responsibilities: Incident note or progress noted documenting a fall... Documentation for a fall should include; all observations, assessments, evaluations ..." [Policy # 06-01 Reviewed/Revised :2/8/24]
Per interview on 11/12/24, the DON stated during subsequent interviews with staff who were present after the incident it was revealed that staff observed Res.#1 suffered "instant bruising after the fall".

The DON confirmed that there was no documentation of any observations of bruising for

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Res.#1 until 3 days after the fall, on 10/29/24. The DON further confirmed that despite "instant bruising after the fall" and then LNA documentation on 10/29/24, the bruising was not reported to nursing until the evening of 10/30/24. In h/her statement to the State Agency, the DON reported that "there have been no reports of bruising as all staff assumed that it had already been reported" and that s/he "has been told that everyone assumed the bruising was from the fall". The DON confirmed that Fall education referring to Policy and Procedure provided to staff on 10/17/24, included "Documentation for a fall should include; all observations, assessments, evaluations ..." and this was not done. Additionally, during the interview conducted with the DON and ADON on 11/12/24, the DON and ADON stated they were not aware that it was possible that LNAs could and were documenting skin observations on residents' charts. After reviewing the LNA documentation on Res.#1, the DON confirmed the bruising on the resident should have been recorded on 10/26/24 but was not done until 10/29/24. The DON further confirmed that even after the bruising was finally documented, the documentation was inconsistent and the day after reporting the bruising to nursing, LNAs documented no bruising on all 3 shifts.

Summary: The DON received a voicemail on 10/26/24 from LPN#1 stating that Res.#1 "had a fall ...kind of fell out of the wheelchair and [s/he] didn't land hard". The DON reported to the State Agency that s/he did not know or was not told that Res.#1 suffered a fall, despite confirming during interview that the statements in the voicemail received on 10/26/24 met the facility's definition of a fall. LPN #1, despite receiving Fall Education 9 days prior to the fall, failed to follow facility

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F 726	Continued From page 9 procedures including assessment of the resident and documenting the incident and follow up. LNA staff who received the Fall Education on 10/17/24 failed to document and report bruising and "assumed" other staff had done so. The ADON, who conducted the Fall Education on 10/17/24, failed to follow procedures noted in the education and recorded that a "Full Assessment" had been completed despite no documentation in the medical record. Both the DON and ADON determined on 10/28/24 that no complete assessment had been documented on Res.#1 since the fall on 10/26/24 and failed to follow up until nursing reported on 10/30/24 "old bruising on right shoulder and right upper forehead [of Res.#1]". Per review of Progress Notes for Res.#1 dated 10/31/24, [5 days after the fall], "Mobile Xray in facility to perform shoulder injury due to bruising from 10/26 fall. Result indicates Right clavicle fracture" [break in the collar bone]."	F 726		