

Division of Licensing and Protection
103 South Main Street, Ladd Hall
Waterbury, VT 05671-2306
<http://www.dail.vermont.gov>
Voice/TTY (802) 871-3317
To Report Adult Abuse: (800) 564-1612
Fax (802) 871-3318

June 12, 2013

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

Dear Ms. Southworth:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **May 22, 2013**. 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

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PRINTED: 05/31/2013
FORM APPROVED
OMB NO. 0938-0391

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 475052 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ Licensing and Protection B. WING _____ | (X3) DATE SURVEY COMPLETED C 05/22/2013 |
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| NAME OF PROVIDER OR SUPPLIER GILL ODD FELLOWS HOME | STREET ADDRESS, CITY, STATE, ZIP CODE 8 GILL TERRACE LUDLOW, VT 05149 |
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| F 000 | INITIAL COMMENTS | F 000 | | |
| F 280 SS=E | <p>An unannounced on-site Recertification survey and investigation of facility self-reported incidents were completed by the Division of Licensing and Protection from 5/20/12 to 5/22/13. The following are regulatory violations:</p> <p>483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP</p> <p>The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.</p> <p>A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.</p> <p>This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility failed to revise the care plan for 3 of 24 Residents in the applicable stage 2 sample (Residents #41, 42, 61). Findings include:</p> | F 280 | <p>F-280 RIGHT TO KNOW PARTICIPATE PLANNING CARE – REVISE CP</p> <p>Resident # 41 UA completed with positive UTI, Rx with ABX and new bladder assessment and CP update.</p> <p>Resident #42 Pain Assessment completed and pain and ADL CP updated.</p> <p>Resident # 61 Behavior CP updated.</p> <p>All residents urinary, ADL, Pain and Behavior care plans reviewed for accuracy and updated as needed.</p> <p>LNA and nursing staff educated to monitor for changes in function and update status on CP.</p> <p>CP's and flow sheets will be reviewed monthly by MDS coordinator and/or designee and thru the quarterly QA process.</p> <p>Completion Date: June 21, 2013 F280 POC accepted 6/17/13 BBotURN/PMC</p> | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *Sheesa Southworth* TITLE *Administrator* (X6) DATE *6-7-13*

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 280 | <p>Continued From page 1</p> <p>1. Per record review on 5/22/13 at 8:00 AM, the facility did not revise the bladder incontinence care plan for Resident #41, who had experienced a decline in urinary continence. Per review of Licensed Nursing Assistant (LNA) bladder documentation, Resident #41 was incontinent only on the night shift 2/1/13 - 3/12/13. The Resident was hospitalized 3/13/13 - 4/5/13. Review of April 2013 and May 2013 LNA charting for bladder continence shows that bladder continence had declined to the point where there is incontinence on all 3 shifts. The bladder incontinence care plan stated that the Resident was to be toileted as scheduled and PRN (as needed). The Director of Nurses (DON) stated during a 5/22/13, 8:14 AM interview that given the decline in urinary continence, the Resident's toileting schedule should be changed. The DON confirmed that the Resident's bladder continence had declined and that the care plan has not been revised to reflect those changes.</p> <p>2. Per record review, Resident #42 had experienced a decline in his/her Dressing ability. The Annual MDS (Minimum Data Set) dated 2/4/2013 codes the resident as Independent in dressing. The Quarterly MDS dated 4/29/2013 codes the resident as needing Extensive assistance in Dressing. The resident's record includes both Osteoarthritis and Spinal Stenosis in the resident's Problem List. S/he receives routine doses of Oxycontin and has both Tylenol and Oxycontin as PRN (as necessary) medication</p> | F 280 | | |
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| F 280 | <p>Continued From page 2</p> <p>options. The nurses notes for the week preceding the Quarterly MDS indicate that the resident was experiencing and complaining of increased pain in both shoulders, his/her neck and his/her back on several days. During those days when s/he experienced more pain s/he also required more assistance with ADL's (activities of daily living).</p> <p>In a review of the Care Plan for this resident, neither the ADL Care Plan or the Pain Care Plan contained any indication that the resident experiences pain which limits his/her functional capacity. The ADL care plan states that the resident is either independent or minimal assist with dressing. Neither the ADL or Pain care plan contain an intervention to assure scheduled pain medications occur at times of increased activity or to encourage ADLs after the administration of pain medication becomes effective. In an interview on 5/22/2013 at 11:15 AM the Director of Nurses (DON) stated that the resident's change in functional status was related to his/her arthritis pain. S/he confirmed that the care plan did not reflect the resident's need for more assistance when having an exacerbation of pain.</p> <p>3. Per record review, Resident #61 has resided in the facility since 2/28/2013. S/he was admitted from Springfield hospital where s/he was taken for Altered Mental Status. S/he was admitted to the facility with an order for Haldol 1 mg PRN which was started in the hospital. S/he is also on Paxil, Aricept and Namenda.</p> <p>S/he was referred to a Psychiatric APRN (Advanced Practice Registered Nurse) who suggested that Haldol be tapered (lowered) to 0.5</p> | F 280 | | |
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| F 280 | Continued From page 3 mg and then discontinued and also suggested a GDR (gradual dose reduction) and discontinuance of the Paxil which may increase confusion and agitation. These recommendations have been followed. S/he has been the aggressor in several incidents of resident to resident altercations since admission to the facility. In an interview on 5/21/2013 at 3:25 PM the DON stated that the facility has done several things to prevent further incidents. These interventions include closing the doors on short hall after activities are done, closing the Dining Room door at supper once residents start being seated, using the "baby" doll as distraction, reinstating Q15M (every 15 minute) checks and trying to set up a nursery corner. They also just started having one staff in the Dining Room at supper time. They also recently started a scheduled dose of Seroquel BID (twice a day) in response to the family stating that s/he was previously on Seroquel 50 mg BID. In a review of the care plan for this resident the above interventions are not all listed in the care plan and the Q15M checks have not been listed as re-instated. This finding was confirmed by the DON in the above interview. | F 280 | | |
| F 281 SS=D | 483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff | F 281 | | |

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| F 281 | <p>Continued From page 4</p> <p>interview, the facility failed to meet professional standards by not obtaining a physician's order before discontinuing a medication for 1 of 24 residents in the stage 2 sample. (Resident #61) Per medical record review on 5/20/13, Resident #61, who has a diagnosis of depression, had a medical order dated 4/25/13 to receive Paxil (an antidepressant medication) 5 mg once daily for two weeks and then to consult with his/her physician for further orders.</p> <p>Per review of the MAR (Medication Administration Record) Paxil was discontinued as of 5/8/13. There were notations in the MAR, dated 5/9/13, 5/13/13 and 5/19/13 that faxes were sent to the resident's physician regarding Paxil orders. The medical record contained one fax to the resident's physician dated 5/9/13, requesting an order to continue Paxil 5mg or "?." There was no response to this fax documented in the medical record and this was confirmed by interview with a unit LPN on 5/20/13 at 3:37 PM. There were no copies of the faxes dated 5/13/13 and 5/19/13 found in the medical record. There was no documentation of phone calls to the physician to clarify Paxil orders in the nursing progress notes during this period (5/9- 5/19/13) and this was confirmed by interview with the unit LPN on 5/20/13 at 3:37 PM. He/she also confirmed that the last dose of Paxil was given on 5/8/13.</p> <p>Per 5/20/13 interview with the DON (Director of Nursing), he/she reported that he/she received a telephone order from Resident #61's physician on 5/16/13 to discontinue Paxil. There was a late entry in the nursing progress notes by the DON dated 5/20/13 documenting the physician contact on 5/16/13 and a late entry telephone order dated</p> | F 281 | <p>F-281 SERVICES MEET PROFESSIONAL STANDARDS</p> <p>Medication was ordered for two weeks and was stopped because we had no order to continue it. follow up with physician response was lacking.</p> <p>Resident # 61 medications were reviewed with the MD and psychiatric advance nurse practitioner for accuracy.</p> <p>All current MAR and orders reviewed for potential error with physician follow up.</p> <p>Log created for MD contact and follow up needed and process created for physician follow up.</p> <p>Logs to be reviewed monthly by DON or designee and quarterly QA process until satisfactory compliance has been achieved and maintained.</p> <p>Completion Date: June 21, 2013</p> <p><i>F281 POC accepted 6/7/13 BBortell RN/PMC</i></p> | |
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| F 281 | Continued From page 5 5/20/13 (that was unsigned by the physician) to discontinue Paxil on 5/16/13. The DON agreed that Resident 61's Paxil was discontinued on 5/8/13 without a physician order. | F 281 | | |
| F 315 SS=D | Reference: Lippincott Manual of Nursing Practice (9th ed.). Wolters Kluwer Health/Lippincott Williams & Wilkins. 483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility failed to ensure 1 of 3 applicable residents in the stage 2 sample (Resident # 41) received appropriate treatment and services to restore as much bladder function as possible. Findings include: Per record review on 5/22/13 at 8:00 AM, the facility did not revise the bladder incontinence care plan or initiate alternate treatments for Resident #41 who had experienced a decline in urinary continence. Per review of Licensed Nursing Assistant (LNA) bladder documentation, | F 315 | <p>F- 315 NO CATHETER, PREVENT UTI, RESTORE BLADDER</p> <p>Resident # 41 UA completed with positive UTI, Rx with ABX and new bladder assessment and CP update.</p> <p>All resident ADL flow sheets reviewed against CP and MDS for accuracy and updated as appropriate.</p> <p>LNA and nursing staff educated to monitor for changes in function and update status on CP.</p> <p>Flow sheets will be reviewed monthly by MDS coordinator and/or designee and thru the quarterly QA process.</p> <p>Completion Date: June 21, 2013</p> <p><i>F315 POC accepted 6/7/13 Bortell RN/ pme</i></p> | |

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| F 315 | Continued From page 6 Resident # 41 was incontinent only on the night shift 2/1/13 - 3/12/13. The Resident was hospitalized 3/13/13 - 4/5/13. Review of April 2013 and May 2013, LNA charting for bladder continence shows that bladder continence had declined to the point where there is incontinence on all 3 shifts. The bladder incontinence care plan stated that the Resident was to be toileted as scheduled and PRN (as needed). There is no indication in the clinical record that nursing staff addressed the decline in bladder continence. The Director of Nurses (DON) stated during a 5/22/13, 8:14 AM interview that given the decline in urinary continence, the Resident's toileting schedule should be changed. The DON also stated that there is no indication that nursing staff was aware of the decline in urinary continence. The DON confirmed that the Resident's bladder continence had declined, and that the care plan has not been revised to reflect those changes. | F 315 | | |
| F 323 SS=E | 483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure that the resident environment remained as free from accident hazards as possible. Findings include: | F 323 | <p>F- 323 FREE OF ACCIDENT HAZARDS/ SUPERVISION/ DEVICES</p> <p>Disposable razors and disinfectant placed in locked cabinet in Ann's Spa. Locked sharps container placed in Ann's spa and lice removal gel removed.</p> <p>Chemicals/ razors to be kept locked in cabinet in Spa and Locked sharps container mounted so if door left open to cool room there will be no hazard to residents.</p> <p>Daily checks by Sweet Maple Lane Nurse to ensure potentially hazardous chemicals are locked up.</p> <p>Ann's Spa will be monitored by DON or designee monthly and through quarterly QA process.</p> <p>Completion Date: June 21, 2013</p> <p><i>F323 POC accepted 6/7/13 BB.../AME</i></p> | |

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| F 323 | Continued From page 7 Per observation between 12:40 PM and 1:05 PM on 5/21/13, the door to a room identified by a sign as "Ann's Spa" in the long hall containing potentially hazardous chemicals and biologicals was left open. Several residents, including at least one resident with dementia were observed ambulating past the open door. The following items were found in the room: Disposable razors; Partially full sharps container; 1.5 gallons of Classic whirlpool disinfectant cleaner that contained a label stating "irreversible eye damage and skin burns"; 3 tubes lice removal gel. On 5/21/13 at 1:08 PM, a Unit Nurse stated that the spa door should be closed. Observations were made with the Unit Nurse who confirmed that there were potentially toxic chemicals in the room that could pose a danger to residents. | F 323 | | |
| F 441 SS=D | 483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective | F 441 | <p>F-441 – INFECTION CONTROL, PREVENT SPREAD, LINENS</p> <p>Dining practices will be monitored by managers 5x/week per week for Infection control until no infractions of IC.</p> <p>Staff educated on preventing spread of Infection related to dining. Hand sanitizers available on all tables in the dining room.</p> <p>Nurses, LNA's and Dietary staff participate in the monitoring of Infection control in the dining room to enhance peer awareness.</p> <p>Director of Nursing Services or designee will ensure compliance. This will be reviewed at the Quality Assurance Meetings to ensure compliance.</p> <p>Completion Date: June 21, 2013</p> | |

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*F441 POC accepted 6/7/13
BBortell RN/PMC*

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| F 441 | <p>Continued From page 8 . actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) 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. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to implement proper infection control measures to assure that foods were handled and served under sanitary conditions to prevent the spread of infection.</p> <p>Per observation during lunch in the main dining room on 5/20/13 at 12:25 PM, a staff member was assisting 2 residents with their meals. He/she was observed to handle the soiled feeding protection cloth from one resident. He/she then resumed feeding a second resident, handling and bringing the second resident's drinking cup and</p> | F 441 | | | |

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| NAME OF PROVIDER OR SUPPLIER GILL ODD FELLOWS HOME | STREET ADDRESS, CITY, STATE, ZIP CODE 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 |
|--------------------|--|---------------|---|----------------------|
|--------------------|--|---------------|---|----------------------|

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|-------|---|-------|--|--|
| F 441 | Continued From page 9 feeding utensil to his/her mouth to drink and eat without sanitizing his/her hands. When interviewed, he/she acknowledged that he/she should have sanitized his/her hands between assisting the two residents and had not done so. | F 441 | | |
|-------|---|-------|--|--|

Theresa Southworth 6-7-13