



AGENCY OF HUMAN SERVICES  
DEPARTMENT OF DISABILITIES, AGING AND INDEPENDENT LIVING

Division of Licensing and Protection  
103 South Main Street, Ladd Hall  
Waterbury VT 05671-2306  
<http://www.dail.vermont.gov>  
Voice/TTY (802) 241-2345  
To Report Adult Abuse: (800) 564-1612  
Fax (802) 241-2358

May 31, 2011

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

Provider ID #:475052

Dear Ms. Southworth:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on  
**April 20, 2011.**

Follow-up may occur to verify that substantial compliance has been achieved and maintained.

Sincerely,

A handwritten signature in black ink that reads "Pamela M. Cota RN".

Pamela M. Cota, RN  
Licensing Chief

PC:jl

Enclosure



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

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Division of  
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PRINTED: 04/28/2011  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  475052	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	Licensing and Protection (X3) DATE SURVEY COMPLETED  C 04/20/2011
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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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(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 000	INITIAL COMMENTS	F 000		
F 156 SS=B	<p>The Division of Licensing and Protection conducted an unannounced on-site annual recertification survey from 4/18/11 to 4/20/11. The following deficiencies resulted from the recertification survey:</p> <p>483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES</p> <p>The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing.</p> <p>The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5) (i)(A) and (B) of this section.</p> <p>The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the</p>	F 156	<p><b>F-156</b></p> <p><b>NOTICE OF RIGHTS, RULES, SERVICES, CHARGES</b></p> <p>1. Residents # 21, 11 and 33 will be notified of their right to appeal their discharge from Medicare skilled services.</p> <p>2. All residents who have received Medicare in the past six months will receive letters to notify them of the appeals process related to termination of the skilled Medicare benefit.</p> <p>3. Denial letter with appeals process will be added to admission packet to ensure those admitted will have it even if not admitted on Medicare. It will be added to discharge Packet to ensure those discharging home will receive appeal information. Denial letters will be given 48 hours in advance to those transitioning to Level II.</p> <p>4. This process will be monitored through the facility QA process until consistent substantial compliance has been demonstrated.</p> <p>5. This will be completed by May 20, 2011</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  
*Theresa Southworth*  
TITLE Administrator (X6) DATE 5-13-11

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 156	<p>Continued From page 1</p> <p>facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate.</p> <p>The facility must furnish a written description of legal rights which includes: A description of the manner of protecting personal funds, under paragraph (c) of this section;</p> <p>A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels.</p> <p>A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements.</p> <p>The facility must comply with the requirements specified in subpart I of part 489 of this chapter related to maintaining written policies and procedures regarding advance directives. These</p>	F 156		

*Heesa Southworth*  
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F 156	<p>Continued From page 2</p> <p>requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the individual's option, formulate an advance directive. This includes a written description of the facility's policies to implement advance directives and applicable State law.</p> <p>The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care.</p> <p>The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and staff interview for 3 residents (Residents #21, #11, and #32) the facility failed to inform the residents discharged from Medicare skilled services of their right to appeal and how to appeal. Findings include:</p> <p>Per record review and staff interviews, the documents given to Residents #21, #11, and #32 at the time of discharge from Medicare skilled services and presented to the surveyor upon request, contained information regarding the reason for discharge from skilled services, but did not have information regarding the right to appeal and the appeals process. This was confirmed by the facility administrator in an interview on 4/19/11</p>	F 156			

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F 156	Continued From page 3 at 4:15 PM. During this interview, the Administrator and the Accounts Receivable manager stated that the notices provided were the only information provided to residents at the time of discharge from Medicare skilled services.	F 156		
F 157 SS=E	<b>483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC)</b>  A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).  The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.  The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.	F 157	<b>F- 157 NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ECT)</b> 1. Family/POA and MD of resident # 15 have been notified of changes. 2. Twenty four hour report will be monitored for evidence of changes and notification of family and physician. 3. Nursing Staff will be educated on family and Physician notification. 4. This process will be monitored through the facility QA process until consistent substantial compliance has been demonstrated. 5. This will be completed by May 20, 2011  <i>F157 PDC Accepted 5/25/11 P. Cummings RN / P. Mottern RN</i>	

*Theresa Southworth*  
*Administrator*

*5-13-11*

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F 157	Continued From page 4  This REQUIREMENT is not met as evidenced by: Based on record review and interview, the home failed to notify the physician and the resident's family / legal representative following a change in 1 resident's mental/psychosocial condition, manifested by several resident to resident issues involving Resident #15. Findings include:  1. Per record review on 4/18/11, Resident #15's physician and / or family was not notified of incidents of sexual aggression in a timely manner. The record indicated that this resident had engaged in inappropriate sexual advances toward other residents and staff on 11/29/10, 1/13/11, 3/25/11, 3/26/11 and 3/31/11 with indication that the physician and family was notified only on 3/31/11. Additional incidents of sexual aggression occurred on 4/6/11 and 4/16/11 with no indication of physician or family notifications. During interview on 4/20/11, the Director of Nursing confirmed that the record contained only 1 instance of physician and family notification on 3/31/11 regarding the resident's behavior issues.	F 157		
F 159 SS=C	483.10(c)(2)-(5) FACILITY MANAGEMENT OF PERSONAL FUNDS  Upon written authorization of a resident, the facility must hold, safeguard, manage, and account for the personal funds of the resident deposited with the facility, as specified in paragraphs (c)(3)-(8) of this section.  The facility must deposit any resident's personal funds in excess of \$50 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that	F 159	<b>F- 159</b> <b>FACILITY MANAGEMENT OF PERSONAL FUNDS</b> 1. Resident trust quarterly statements went out to all residents with an account in April 2011. 2. Each resident trust account was reviewed and interest was accrued. 3. Business Office personnel to balance account monthly and report to Facility Administrator. Quarterly Statements will be sent out furthermore. 4. This process will be monitored through the facility QA process until consistent substantial compliance has been demonstrated. 5. This will be completed by May 20, 2011	

F159 POC Accepted 5/25/11 P. Cummings RN / P. McKeown RN

*Theresa Southworth*  
*Administrator*

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F 159	<p>Continued From page 5</p> <p>account. (In pooled accounts, there must be a separate accounting for each resident's share.)</p> <p>The facility must maintain a resident's personal funds that do not exceed \$50 in a non-interest bearing account, interest-bearing account, or petty cash fund.</p> <p>The facility must establish and maintain a system that assures a full and complete and separate accounting, according to generally accepted accounting principles, of each resident's personal funds entrusted to the facility on the resident's behalf.</p> <p>The system must preclude any commingling of resident funds with facility funds or with the funds of any person other than another resident.</p> <p>The individual financial record must be available through quarterly statements and on request to the resident or his or her legal representative.</p> <p>The facility must notify each resident that receives Medicaid benefits when the amount in the resident's account reaches \$200 less than the SSI resource limit for one person, specified in section 1611(a)(3)(B) of the Act; and that, if the amount in the account, in addition to the value of the resident's other nonexempt resources, reaches the SSI resource limit for one person, the resident may lose eligibility for Medicaid or SSI.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to hold funds in excess of \$50 in an interest bearing account that is separate from any of the</p>	F 159		

*Heeresa Southworth*  
Administrator

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F 159	Continued From page 6 facility's operating accounts or provide quarterly statements for 10 of 10 residents with a positive balance in their resident fund accounts. (Residents # 28, 17, 7, 3, 14, 36, 25, 34, 31, 18 & 2) Findings include:  Per interview with Resident #7 on the morning of 4/20/11, the resident has not been receiving quarterly statements on his facility resident funds account. During interview later the same morning, the business office manager and the administrator confirmed that they had not been providing residents with quarterly statements for fund accounts since June of 2010. In addition, 7 of the resident fund balances reviewed were over \$50.00 and there was no evidence that these funds were presently accruing interest, per regulatory requirements. In reviewing the total balance of the money in the resident fund account, it was noted that the total amount listed exceeded the total amount of the resident fund balances by several thousand dollars and the administrator and the business office manager were not able to explain the discrepancy.	F 159		
F 223 SS=D	483.13(b), 483.13(b)(1)(i) FREE FROM ABUSE/INVOLUNTARY SECLUSION  The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion.  The facility must not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion.  This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility	F 223	<b>F-223</b> <b>FREE FROM ABUSE/INVOLUNTARY SECLUSION</b> 1. Resident #25 protected by late incident report with reported to Adult protective Services, Licensing, and to Ombudsman. 2. Staff to be educated on Abuse/Neglect Policy and any future instances will be reported to the state. 3. In-Service held by APS, Janice Bradley regarding Abuse /Neglect. ALL staff to review her presentation. 4. This process will be monitored through the facility QA process until consistent substantial compliance has been demonstrated. 5. This will be completed by May 20, 2011	

*F223 POC Accepted 5/25/11 P. Cummings RN / P. McArthur RN*

*Theresa Southworth*  
*Administrator*

*5-13-11*

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F 223	Continued From page 7 failed to assure that 1 identified resident (Resident # 25) was free from sexual abuse. Findings include:  1. Per record review on 4/19/11, Resident #25, who was identified through assessment as having cognitive impairment / dementia, was observed by staff in a sexually compromising situation with Resident #15 in a public location on 4/16/11. Resident #15's record indicated prior episodes of sexually aggressive behavior; however, no plan of care to address these behaviors had been developed. During interview on 4/19/11 at 4:30 PM, the staff nurse who documented the incident in the record indicated that no incident report had been generated as a result of this observation by an LNA (Licensed Nursing Assistant) nor had the respective families, the physician, or the Administrator been notified following the incident. No report to Adult Protective Services, per Vermont Statute, nor the State Survey Agency had been made. During interview on the morning of 4/20/11, the Director of Nursing confirmed this information.	F 223		
F 226 SS=E	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES  The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.  This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to implement their abuse policy protocol on 8 occasions regarding the sexual aggression of Resident #15 toward other residents. Findings	F 226	<b>F-226</b> <b>DEVELOP/IMPLEMENT ABUSE NEGLECT POLICIES</b> 1. Resident #15 has a care plan to address ↑ sexual behaviors. 2. Staff has been in-serviced on effective behavior techniques for this resident and the need to implement an incident report with a call to DON or Administrator. 3. Staff attended Abuse/Neglect in-service sponsored by APS on May 9, 2011. All other staff reviewed the presentation. 4. This process will be monitored through the facility QA process until consistent substantial compliance has been demonstrated. 5. This will be completed by May 20, 2011	

*Theresa Southworth*  
Administrator

*F226 POC Accepted 5/25/11 P. Cummings RN*  
*5-13-11* *AMotars*

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F 226	Continued From page 8 include:  1. Per record review on 4/19/11, Resident #15 had exhibited sexually aggressive behaviors on 8 documented occasions toward staff and other residents beginning 11/29/10, with the most recent incident documented on 4/16/11. There were no internal incident reports as required by facility policy following each behavioral episode nor was there indication of an internal investigation and follow up of these incidents. There were no reports of any of these potentially abusive behaviors by Resident #15 toward other residents to the required state agency and there was no modification of the plan of care for Resident #15 to provide instruction to staff regarding strategies to prevent further incidents toward other residents. During interview on the morning of 4/20/11, the Director of Nursing confirmed that there were no documented incident reports of any of the incidents, there was no plan of care for Resident #15 to address these behaviors, and the appropriate state agency had not been notified of any of the resident to resident incidents.	F 226		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS  A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.  The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.	F 279	<b>F-279</b> <b>DEVELOP COMPREHENSIVE CARE PLANS</b> 1. Resident #15 has a comprehensive care plan with a plan that is effectively modifying his increased sexual behaviors and Resident #28 has a comprehensive care plan reflecting his psychotropic drug use. 2. All resident have an updated psychotropic drug use care plan. MDS coordinator and DON to review every care plan for accuracy. 3. Twenty-four hour report to be reviewed at morning meeting for potential care plan updates by DON and MDS coordinator. 4. This process will be monitored through the facility QA process until consistent substantial compliance has been demonstrated. 5. This will be completed by May 20, 2011 <i>F279 POC Accepted 5/25/11 P.Cummings RN / P.McLarn</i>	

*Theresa Southworth  
Administrator*

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F 279	<p>Continued From page 9</p> <p>The care plan must describe 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 §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to develop a comprehensive plan of care that includes measurable objectives and timetables to meet the medical, nursing, and mental and psychological needs for 2 of 29 residents in the applicable Stage 2 sample (Residents #15 and #28). Findings include:</p> <p>1. Per record review on 4/19/11, Resident #15 had exhibited sexually inappropriate behaviors toward staff and residents of the opposite sex on 11/29/10, 1/13/11, 3/25/11, 3/26/11, 3/31/11, 4/6/11 and 4/16/11. Per review of the plan of care, there was no indication of the resident's sexual aggression nor was direction given to staff regarding strategies to monitor / reduce / eliminate the resident's sexually inappropriate behaviors. During interview on the afternoon of 4/19/11, the Director of Nursing confirmed that the record indicated that the resident is sexually aggressive toward staff and residents and that there was no plan of care for this issue.</p> <p>2. Per record review on 4/20/11 and confirmed with the Director of Nursing (DNS) at 2:02 PM,</p>	F 279			

*Theresa Southworth*  
*Administrator*

5-13-11

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>475052</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>04/20/2011</b>
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F 279 Continued From page 10  
Resident #28 is on psychoactive medications (Lorazepam 0.5 mg (milligram) 1/2 hour before bath, Haloperidol 20 mg twice a day, Valproic Acid 500 mg twice per day, and Lorazepam 1.5 mg four times per day) and there is no plan of care that addresses the use of psychoactive medications.

F 279

F 281  
SS=D 483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS

F 281

The services provided or arranged by the facility must meet professional standards of quality.

This REQUIREMENT is not met as evidenced by:  
Based on staff interview and record review, nursing staff failed to implement a physician order regarding blood sugar monitoring and physician notification for 1 applicable resident in the sample (Resident #17). Findings include:

1. Per record review on 4/18/11, Resident #17's physician was not notified of a blood sugar (BS) measuring 446 on 4/10/11 at 4 PM. The physician order dated 2/18/11 stated "call MD BS <60 or greater than 400". The BS flow sheet showed that the BS was not rechecked until 2100 (9 PM, 5 hours after the elevated result of 446). The order to notify the MD had not been transcribed to the current MAR (Medication Administration Record) per observation with the nurse at 4:45 PM. There was no evidence in the medical record that the physician had been made aware of the high BS result, as ordered. This was verified during interview with the day shift nurse at 4:50 PM on 4/18/11.

Reference: Lipincott Manual of Nursing Practice

**F-281**  
**SERVICES PROVIDED MEET PROFESSIONAL STANDARDS**

1. Further review of record of resident #17 revealed MD order was prior to recent hospitalization so order not current. MD and family notified and parameters in place.
2. DON/ADON to review month end order to ensure accuracy.
3. Twenty four hour chart checks were initiated on every resident.
4. This process will be monitored through the facility QA process until consistent substantial compliance has been demonstrated.
5. This will be completed by May 20, 2011

*F281 POC Accepted 5/25/11  
P. Cummings RN / J. McArthur*

*Theresa Southworth  
Administrator      5-13-11*

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F 281	Continued From page 11 (9th ed.). Wolters Kluwer Health / Lippincott, Williams & Wilkins. pg. 17	F 281		
F 282 SS=D	<b>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</b>  The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.  This REQUIREMENT is not met as evidenced by: Based upon record review and interview, the facility failed to provide range of motion services in accordance with the resident's total plan of care for one applicable resident with limited range of motion. (Resident #33). Findings include:  Per review of Resident #33's medical record and Rehabilitation/Restorative Services Delivery Record on 4/20/11, and confirmed during an interview with the Director of Nursing (DNS) at 10:05 AM, Resident #33 is on a restorative program due to a limited range of motion in bilateral upper and lower extremities. Per review of the Rehabilitation/Restorative Services Delivery Record, staff are to provide range of motion to bilateral lower and upper extremities to maintain strength and flexion 6 times per week, and there is no documentation in the medical record or on the Rehabilitation/Restorative Services Delivery Record that range of motion services were provided by staff from April 1, 2011 to April 10, 2011.	F 282	<b>F-282</b> <b>SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</b> 1. Resident #33 evaluated and received PT services. 2. All residents to be screened and reviewed by PT/DON/MDS coordinator to ensure appropriate RNP and care plan. 3. Annual Screen by PT with each annual MDS. 4. This process will be monitored through the facility QA process until consistent substantial compliance has been demonstrated. 5. This will be completed by May 20, 2011  <i>F282 POC Accepted 5/25/11 P.Cummings RN / DMcota RN</i>	
F 318 SS=D	Also see F318 <b>483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION</b>	F 318		

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*Administrator*

*5-13-11*

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NAME OF PROVIDER OR SUPPLIER  <b>GILL ODD FELLOWS HOME</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>8 GILL TERRACE LUDLOW, VT 05149</b>
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F 318	<p>Continued From page 12</p> <p>Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion.</p> <p>This REQUIREMENT is not met as evidenced by: Based upon staff interview and record review, the facility failed to ensure that one applicable resident in the sample with limited range of motion received appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion (Resident #33). Findings include:</p> <p>Per record review on 4/20/11 and confirmed with the Director of Nursing (DNS) at 2:51 PM, there is no documentation that ongoing periodic nursing assessments were conducted to evaluate the effectiveness of the restorative program for Resident #33. Per record review on 4/20/11 and confirmed with the DNS at 1:57 PM, the last physical therapy evaluation was conducted on 11/4/09.</p> <p>Per review of Resident #33's medical record and Rehabilitation/Restorative Services Delivery Record on 4/20/11, and confirmed during an interview with the Director of Nursing (DNS) at 10:05 AM, the resident is on a restorative program due to a limited range of motion in bilateral upper and lower extremities. Staff are to provide range of motion to bilateral lower and upper extremities to maintain strength and flexion</p>	F 318	<p><b>F-318</b> <b>INCREASE/PREVENT</b> <b>DECREASE IN RANGE OF</b> <b>MOTION</b></p> <ol style="list-style-type: none"> <li>1. Resident #33 evaluated and received PT services and RNP reviewed.</li> <li>2. RNP placed on LNA tickets and all residents to be screened by PT to ensure appropriate RNP</li> <li>3. Medical Records to audit RNP documents weekly and review with DON.</li> <li>4. This process will be monitored through the facility QA process until consistent substantial compliance has been demonstrated.</li> <li>5. This will be completed by May 20, 2011</li> </ol> <p><i>F318 POC Accepted 5/25/11 P. Cummings RN / P. Motorn RN</i></p>	
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*Theresa Southworth*  
*Administrator*      *5-13-11*

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NAME OF PROVIDER OR SUPPLIER  <b>GILL ODD FELLOWS HOME</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>8 GILL TERRACE</b> <b>LUDLOW, VT 05149</b>	
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F 318	Continued From page 13 6 times per week, and there is no documentation in the medical record or on the Rehabilitation/Restorative Services Delivery Record that range of motion services were provided by staff from April 1, 2011 to April 10, 2011.	F 318		
F 323 SS=E	Also see F282 <b>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES</b>  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 interview, the facility failed to ensure that hazardous chemicals were stored in secure locations. Findings include:  1. Per observation on 4/18/11 during initial tour, Resident #45 had a container of liquid jewelry cleaner stored on an open bathroom shelf. This observation was confirmed with a staff nurse immediately following the observation. On 4/19/11 at 5:35 PM, Resident #44, who is cognitively impaired, was observed visiting unattended with Resident #45. The chemical remained in the bathroom at this time. During interview on the afternoon of 4/20/11, the Director of Nursing stated s/he had not been advised of this finding, acknowledged that this was unsafe, and immediately removed the jewelry cleaner from the	F 323	<b>F-323</b> <b>FREE OF ACCIDENT HAZARDS/SUPERVISION/ DEVICES</b> 1. Tub room locked and Jewelry cleaner returned to family. 2. Safety rounds will be completed randomly on a weekly basis with two of the managers one of whom must be DON or environmental services. 3. Staff will be educated related to safety awareness in the environment. 4. This process will be monitored through the facility QA process until consistent substantial compliance has been demonstrated. 5. This will be completed by May 20, 2011  <i>F323 POC Accepted 5/25/11 P. Cummings RN / Dncota RN</i>	

*Theresa Southworth*  
*Administrator*

*5-13-11*

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F 323	Continued From page 14 room of Resident #45.	F 323		
F 371 SS=E	<p>2. Per observation on 4/18/11 at 1:50 PM, there were 1 and 1/2 gallons of 'total disinfectant' in an unlocked cabinet in the unlocked tub room. During observation and interview at 1:53 PM, the Director of Nursing confirmed that there are current residents who wander, that the disinfectant should be in a secure location and stated that the tub room door should be locked.</p> <p>483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY</p> <p>The facility must -</p> <p>(1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and</p> <p>(2) Store, prepare, distribute and serve food under sanitary conditions</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations and staff interview, the facility failed to assure that foods were stored under sanitary conditions in accordance with accepted safe food handling practices. Findings include:</p> <p>Per observation and confirmed by interview with the Food Service Manager (FSM) on 4/18/11, commencing at 10:45 AM, the following areas of concern were noted:</p> <p>a. Stove back and hood filters were heavily soiled with grease build up.</p>	F 371	<p><b>F-371</b></p> <p><b>FOOD PROCURE STORE/ PREPARE SERVE- SANITARY</b></p> <p>1. Stove back and hood filters cleaned, trash cans cleaned, dish machine cleaned, floor washed. Dented cans returned to supplier for credit, honey bottle cleaned and downstairs storage floor cleaned. Thermometers placed in all refrigerators and freezers.</p> <p>2. Kitchen staff will ensure clean food prep and storage area and monitor temps. Cleaning schedule developed for Kitchen staff</p> <p>3. Kitchen to attend infection control in-services related to breaking the spread of illness. Random weekly rounds related to cleanliness and safety.</p> <p>4. This process will be monitored through the facility QA process until consistent substantial compliance has been demonstrated.</p> <p>5. This will be completed by May 20, 2011</p>	

*F371 POC Accepted 5/2/11 P. Cummings RN/D. McCall RN*

*Theresa Southworth*  
*Administrator*      *5-13-11*

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
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F 371	Continued From page 15 b. Bases of the trash cans were soiled. c. Area under the dish machine was was soiled, as well as the perimeter floor areas in the kitchen. d. In the pantry, a bottle of honey was stored with honey drips on the outside and 2 dented cans of food were observed. e. The floor in the down stairs dry food storage area was soiled.  Additionally, there was no freezer temperature monitoring evidence for the snack refrigerator on the short hall wing (and no thermometer in the freezer). In the kitchen, a 3 door reach-in refrigerator had a broken thermometer. The above observations were verified by the FSM during the tour.	F 371			

*Theresa Southworth*  
Administrator

5-13-11

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER # <b>475052</b>	MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	DATE SURVEY COMPLETE: <b>4/20/2011</b>
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NAME OF PROVIDER OR SUPPLIER <b>GILL ODD FELLOWS HOME</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>8 GILL TERRACE LUDLOW, VT</b>
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ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
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F 278	<p><b>483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED</b></p> <p>The assessment must accurately reflect the resident's status.</p> <p>A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.</p> <p>A registered nurse must sign and certify that the assessment is completed.</p> <p>Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.</p> <p>Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$5,000 for each assessment.</p> <p>Clinical disagreement does not constitute a material and false statement.</p> <p>This REQUIREMENT is not met as evidenced by: Based upon interview and record review, the facility failed to assure the assessment accurately reflected the status of one resident with a functional impairment. (Resident # 33) Findings include:</p> <p>Per record review on 4/20/11 of Resident #33's MDS (Minimum Data Set) assessments, dated 12/19/10 and 1/22/11, the Functional Limitation in Range of Motion is coded as impairment on one side for both upper and lower extremities. Per review of Resident #33's medical record and Rehabilitation/Restorative Services Delivery Record on 4/20/11, and confirmed during an interview with the Director of Nursing (DNS) at 10:05 AM, the resident is on a restorative program due to a limited range of motion in bilateral upper and lower extremities.</p>
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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

The above isolated deficiencies pose no actual harm to the residents

*Theresa Southworth*  
*Administrator* 5-13-11