

Division of Licensing and Protection

103 South Main Street

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

September 30, 2015

Ms. Theresa Southworth, Administrator  
Gill Odd Fellows Home  
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 **September 2, 2015**. 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

PRINTED: 09/10/2015  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  476052	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  09/02/2015
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	<p>INITIAL COMMENTS</p> <p>An unannounced, on site recertification survey and an investigation of self reported incidents were conducted by the Division of Licensing and Protection from 08/31/2015 to 09/02/2015. The following findings were identified:</p> <p>F 280 483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP</p> <p>SS=D</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 record review and staff interviews the facility failed to assure that the care plan was revised for a resident with new pain for Resident #12 in a Stage 2 sample of 3 residents reviewed for pain. Findings include:</p>	F 000	<p>F 280 Right to Participate Planning Care - Revise' CP Resident # 12 had a Care Plan Update and will have new pain assessment. Therapy department reviewed all residents on their caseload and their care plans. Therapy will update care plans as appropriate and then print the most current CP for chart and DON as nursing still not utilizing PCC for CP. IDT to review updated CP at weekly utilization review meeting and will be reviewed at a minimum of quarterly at Quality Assurance meetings. Substantial compliance obtained by October 2, 2015.</p> <p>F280 POC accepted 9/16/15 G Coleman RN/PMC</p>

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Theresa Southworth TITLE: administrator (X6) DATE: 9/28/15

-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 309	<p>Continued From page 2</p> <p>highest practicable physical well-being of two of three residents with pain. (Residents #12 &amp; #43). Findings include:</p> <p>1. Per record review, Resident #43 experiences chronic pain largely orthopedic in origin related to the previous hip fracture and his/her arthritis. S/he states that s/he is always in pain and that the medications don't help. In an interview on 9/2/15 the RN (Registered Nurse) on the unit confirmed that the resident was admitted 11/8/15 and it is stated that the resident has not had good pain control since admission.</p> <p>The resident receives Oxycontin ER 40 mg PO (by mouth) BID (twice daily) and Oxycodone 30 mg PO BID. The dose of scheduled Oxycodone 30 mg was changed from Dally at HS (bedtime) to BID and Q4H (every 4 hours) PRN (when needed) on August 11th. In review of the MAR (medication administration record) s/he requests the PRN medication constantly once daily usually between 2-4 PM. The PRN dose is recorded as administered daily during the month of August however the result (effectiveness) is not recorded in the MAR or In the Nurses Notes except for one day (Aug 1st) when it was recorded on the MAR.</p> <p>In an interview on 9/2/15 at 1:30 PM the Director of Nursing Services (DNS) confirmed that the results of the pain medication administration were not recorded and should have been and that there was no evidence of the reassessment of pain levels after the administration of a PRN pain medication. In an interview on 9/2/15 at 12:40 PM the RN on the unit confirmed that pain assessments are done minimally each shift and when administering medications for residents with</p>	F 309	<p>F 309 Continued DON or designee to complete pain assessment on three residents weekly. Pain assessments and flow sheets will be reviewed at least quarterly through the Quality Assurance program. Substantial compliance will be achieved by October 2, 2015</p> <p><i>F309 POC accepted 9/28/15 G Coleman RN PRN</i></p>	

*Meresa Southworth Administrator 9/28/15*

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F 309	Continued From page 3 frequent complaints of pain. S/he stated that nurses are required to document PRN medication administration including time and the effectiveness of the medication. In the interview s/he confirmed that the effect of the pain medication was not documented and it should have been.  2). Per medical review on 09/02/2015 at 8:24 AM, Resident #12 was admitted in February 2015 with chronic back pain, among other diagnoses. S/he reported in a resident interview during Stage 1 of the survey process on 08/31/2015, that his/her pain is never relieved despite the use of analgesics. An order dated 8/20/2015 requests a physical therapy referral for pain modalities and functional training. Physical therapy staff report during interview on 09/02/2015 at 8:43 AM that this referral is for the recurrence of knee pain. A brace has been ordered for Resident # 12. There is no revision to the pain management care plan to indicate the presence of knee pain or the interventions requested by the physical therapy department. This is confirmed by the DNS during interview on 09/02/2015 at 9:04 AM. The DNS further reports that aspects of care by other disciplines should be included in the working care plan.	F 309	
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS  The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically	F 431	F 431 DRUG RECORDS, LABEL/STORE DRUGS, & BIOLOGICALS Medication room and medication carts reviewed by pharmacist on Sept 21, 2015 and issues resolved. All insulin bottles labeled on top of cap and Reg FSBG sheets were highlighted with expiration dates of insulins and nurses were educated on each insulin & expiration dates. Med room inspection to be done by night nurse weekly and also to complete a daily check of insulins. Don or designee to spot check at least monthly and be reviewed at least quarterly at Quality Assurance Mtg. Substantial compliance by October 2, 2016.  PBI POC accepted 9/28/15 @Coleman RN/PML

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F 431	<p>Continued From page 4 reconciled.</p> <p>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1970 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and staff interviews the facility failed to assure that medications were stored according to currently accepted professional principles. Findings include:  Per observation on 9/1/15 of medications stored in the medication room on Sweet Maple Lane Unit, 3 bottles of Extra Strength Antacid tablets were in the supply cupboard with an expiration date of April 2015. In observation of the</p>	F 431		

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F 431	Continued From page 5 medication cart on the same unit on 9/1/15 there was a bottle of Lantus Insulin which was opened on 7/25/15 and with a discard date 28 days later (August 22). The insulin was still in use and was last administered on 8/31/15 at bedtime. A second bottle of Humalog insulin opened 7/20 with a discard date 28 days later (August 17) labeled and used for a resident discharged on 7/14/15 also remained in the cart. In an interview on 9/1/15 the nurse on the unit confirmed that expired medications were found and removed from the medication storage room and the medication cart. In an interview on 9/1/15 the Director of Nursing Services (DNS) confirmed that nurses should be checking medication expiration dates with every medication administration and that the night nurse is expected to check the medication storage room for outdates.	F 431	
F 441 SS=E	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 actions related to infections.	F 441	F 441 INFECTION CONTROL, PREVENT SPREAD, LINENS Housekeeper counseled by RN on floor and later by DON.  Nurses will be educated about policy for clean dressing change and demonstrate competency with this technique. Sign posted by ice chest detailing process maintaining proper infection control techniques. Spot checks of dressing changes at least weekly to ensure proper infection control by peers. A staff member will be chosen to do spot infection control rounds with DON at least twice a month. DON or designee to ensure compliance and will be reviewed at least Quarterly at Quality Assurance Mtgs. Substantial compliance by October 2, 2015.  F441 POC accepted 9/28/15 Coleman RN, PMU

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F 441	<p>Continued From page 6</p> <p>(b) Preventing Spread of Infection</p> <p>(1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.</p> <p>(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.</p> <p>(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 direct observation and confirmed by staff during interviews between 8/31/2015 and 09/02/2015, the facility failed to provide a safe and sanitary environment to help prevent the development and transmission of disease and infection during 2 of 3 dressing changes for Residents #38 and #52 and in filling a water jug improperly from a common ice chest. The specifics are as follows:</p> <p>1. Per observation at the nurses' station on 9/02/2015 at 11:36 AM a housekeeper was observed filling a water jug with ice taken from a large ice cannister that is used for residents. The container of ice is located at the nurses' station. The housekeeper is observed and it is confirmed</p>	F 441	

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F 441	<p>Continued From page 7</p> <p>by a staff nurse during interview that the water jug was filled by putting it inside the larger cannister. Staff report that the proper way to fill resident glasses is to wear the gloves that are available by the side of the ice chest and only remove the ice from the chest with the scoop that is in a covered container next to the ice chest. Staff are not to dip glasses or water jugs directly into the cannister. The water jug of the housekeeper was immediately noticed being placed on the hand rail by the housekeeper and then inside his/her work bucket with cleaning supplies. The floor nurse tried, unsuccessfully to intervene with the housekeeper to prevent this and then alerted the kitchen staff who removed the ice cannister, cleaned it out and re-filled it with ice before returning it to the nurses' station.</p> <p>2. Per observation of a dressing change for Resident #38 on 9/1/15 at 09:23 AM, the Registered Nurse (RN) put on gloves and removed the old dressing from the resident's left lower leg. Wearing the same gloves that were used to remove the old dressing, the RN cleansed the resident's wound with wound cleanser. The RN then removed the dirty gloves, and without sanitizing hands, applied new gloves and proceeded to apply cream to the wound. With the same gloved hands, the RN applied the dressing to the wound. He/she then removed his/her gloves and proceeded to wash his/her hands. The facility procedure was not followed as it states remove old dressing, discard, remove gloves, wash hands, and apply clean gloves. On 9/1/15 at 9:30 AM the RN confirmed that the facility protocol was to wash hands prior to putting on gloves and after gloves are removed.</p> <p>3. Per observation of a dressing change for</p>	F 441		

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F 441	<p>Continued From page 8</p> <p>Resident #52 on 9/2/15 at 10:38 AM, the Registered Nurse (RN) put on clean gloves and removed the old dressing from the resident's left heel. The RN removed his/her gloves and without sanitizing hands put on new gloves, dated the dressing material and stated the dressing was wrinkled and he/she needed to get another dressing. The RN removed gloves, touched the doorknob without sanitizing hands and left room to get a new dressing. The RN reentered the room with a new dressing. He/she washed his/her hands, applied clean gloves, and applied the new dressing to the resident's left heel. He/she then proceeded to remove the dirty gloves and wash his/her hands. On 9/2/15 at 10:53 AM the RN confirmed that when gloves are removed, hands are to be washed before putting on new gloves.</p> <p>Per interview on 9/2/15 at 11:03 AM, the Director of Nursing confirmed that hands are to be washed when gloves are removed during dressing changes and that the facility procedure for clean dressing technique was not followed.</p>	F 441	

*Theresa Southworth Administrator 9/28/15*