

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

November 2, 2015

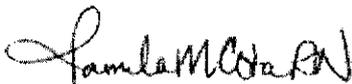
Ms. Theresa Southworth, Administrator
Gill Odd Fellows Home
8 Gill Terrace
Ludlow, VT 05149-1004

Dear Ms. Southworth:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **October 13, 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



STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 475052	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 10/13/2015
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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-441 - INFECTION CONTROL, PREVENT SPREAD, LINENS	
F 441	<p>An unannounced on-site recertification survey follow up was conducted by the Division of Licensing and Protection on 10/13/15. There was a regulatory finding.</p>	F 441	<p>Blood Glucose machines all cleaned and all oxygen tubing and nebulizer equipment is labeled and in bags if not in use, unless care planned otherwise.</p>	
SS=E	<p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS</p> <p>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.</p> <p>(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.</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>Nurses educated on preventing spread of Infection related to cleaning of glucometers and need to label and bag tubing "not in use".</p> <p>Glucometer cleaning towelettes placed in med cart to enhance use and labels purchased and stored with tubing to enhance compliance.</p> <p>Weekly checks for compliance with labeling and bagging tubing that is not in use and spot checks of nurses performing blood glucose monitoring.</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>Substantial Compliance to be obtained by November 3, 2015.</p> <p><i>F441 POC accepted 10/28/15 BBorklen/PMU</i></p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Theresa Southworth</i>	TITLE <i>Administrator</i>	(X6) DATE <i>10-28-15</i>
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A deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that 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 following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued am participation.

CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 475052	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 10/13/2015
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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 441}	<p>Continued From page 1</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 on 10/13/15, the facility failed to provide a safe and sanitary environment to help prevent the development and transmission of disease and infection involving blood glucose testing and administering of respiratory treatments for 3 of 3 residents sampled. Findings include:</p> <p>1. During observation of the licensed practical nurse (LPN) performing glucose monitoring testing it was observed that the machine used to obtain the blood sample was not cleaned or disinfected between Resident #1 and Resident #2. At 11:37 AM the LPN obtained a blood sample from the finger of Resident #1 and tested the blood glucose level with an Even Care glucometer. S/he then completed the task of documentation and placed the glucometer in the top drawer of the medication cart. At 11:47 AM, the LPN went to Resident #2 and obtained a blood sample from his/her finger and tested the blood glucose level with the same Even Care glucometer that was used for Resident #1. The LPN completed the task of documentation and placed the glucometer in the top drawer of the medication cart without cleaning it off or disinfecting it. At 11:53 AM when asked what the protocol for cleaning of the glucometer was s/he stated that s/he should have cleaned it with</p>	{F 441}		
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{F 441}	<p>Continued From page 2</p> <p>alcohol wipes and confirmed that s/he had not cleaned the glucometer between residents. S/he also confirmed that there is only one glucometer for all the residents.</p> <p>2. It was observed that there were four (4) nebulizer mask set ups in resident rooms, none of them were labeled or in protective coverings. During observation for the scheduled administration of a nebulizer treatment for Resident #3, who has a diagnosis of pneumonia and was recently readmitted to the facility with orders for nebulizer treatments. At 12:01 PM the LPN used the nebulizer mask set up that was lying on the sink counter in the resident's room. There was no date on the tubing to indicate when it was set up for the resident and it was without a protective covering. Per the Licensed Nursing Assistant the sink is used frequently by both staff and residents for hand washing, obtaining water for basins and brushing teeth. The LPN confirmed at this time that the nebulizer mask was in a highly used area of the room and was not covered and was at risk for contamination. The LPN also stated that the other three (3) nebulizer set ups were on an as needed basis for those other residents. Per interview with the Director of Nursing at 12:05 PM, s/he stated that the nebulizer masks are to be in protective settings and s/he provided the LPN with plastic bags.</p>	{F 441}		
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