

OCT 31 2011

PRINTED: 10/18/2011
FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 475062	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 09/27/2011
--	---	--	---

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
--------------------	--	---------------	---	----------------------

F 000	<p>INITIAL COMMENTS</p> <p>An unannounced on-site complaint investigation was completed on 9/27/11 by the Division of Licensing and Protection. The following citations of past non-compliance (meaning the facility has already completed necessary corrective actions) were identified.</p>	F 000		
F 221 SS=D	<p>483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS</p> <p>The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms.</p> <p>This REQUIREMENT is not met as evidenced by: Per observation, interview, and record review, the facility failed to ensure that 1 resident [Resident #1] out the sample group remained free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. Findings include:</p> <p>1). Per record review, Division of Licensing and Protection Event Reporting Form dated 9/25/11 states "reported to writer by LNA [Licensed Nursing Assistant] that resident's husband had [him/her] put gait belt around [Resident #1's] waist and around wheelchair to hold her in. Husband had not remembered that LNA had applied the belt to resident, found another gait belt, put it around resident's neck and wrapped it around wheelchair handgrips." The LNA reported this to an off-duty nurse, who did not report the incident until h/she returned to the facility the next</p>	F 221	<p>Past noncompliance: no plan of correction required.</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Theresa Southworth</i>	TITLE <i>Administrator</i>	(X6) DATE <i>10-31-11</i>
--	-------------------------------	------------------------------

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.

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

PRINTED: 10/18/2011
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 _____	(X3) DATE SURVEY COMPLETED C 09/27/2011
--	--	--	---

NAME OF PROVIDER OR SUPPLIER GILL ODD FELLOWS HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 8 GILL TERRACE LUDLOW, VT 05148
---	---

(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)	(X6) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 221	<p>Continued From page 1 morning.</p> <p>Per staff interview with a LNA on 9/27/11 at 1:20 P.M. he/she observed numerous times Resident #1's husband attaching a gait belt on the front of the resident's wheelchair. The belt was tied to one arm rest, stretched across in front of the resident and tied to the other arm rest. LNA reported the resident's husband did this every day after supper when he and Resident #1 went to the resident's room. The husband did this in order to keep the resident from falling out of the wheelchair if the husband fell asleep while watching TV together. The LNA spoke with husband 'about a month ago' and informed the resident's husband that using a gait belt like that was a restraint, and that he needed to speak with a nurse and make sure it was in the resident's Care Plan to use it like that. The LNA saw the gait belt used on Resident #1 in an identical way "every day" after h/her conversation with the husband, but did not feel it was up to him/her to check if it was in the resident's Care Plan. The LNA stated the facility's nurses saw the gait belt tied on the wheelchair when they would go into resident's room and give the resident her evening medications. The LNA stated "They [nurses] would have to see it. It happens every day".</p> <p>Per interview with the Director of Nursing Services [DNS] on 9/27/11 at 2:19 P.M., a "few" of the facility's staff were aware of Resident #1's husband tying a gait belt to the resident's wheelchair, and were aware it was a restraint but "thought it was okay because the husband was there". The DNS stated that after the LNA discovered the gait belt around the resident's neck and removed it, the staff "discussed it and</p>	F 221		
-------	--	-------	--	--

Theresa Southworth 10/31/11
Administrator

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

PRINTED: 10/18/2011
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 _____	(X3) DATE SURVEY COMPLETED C 09/27/2011
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
F 221	Continued From page 2 didn't know what to do". The DNS confirmed the facility's staff should have recognized the husband's use of the gait belt as a restraint, and removed it immediately upon seeing it the first time. Staff should have also reported the usage immediately, and had not allowed the husband to continue to use it on future visits. The DNS also confirmed after the gait belt was found on the resident's neck, the LNA should have reported it to an on-duty staff member, and the staff member should have reported the incident to DNS and the facility's Administrator immediately per facility policy. The DNS also reported h/she found gait belts in a drawer in the resident's room the morning after the incident. The DNS reported it was h/her expectation that LNA's keep the gait belts on their person, in their personal belongings, or in a drawer behind the nurse's station where residents and/or family would not have access to them. During the onsite investigation, it was determined that the facility administration, after becoming aware of the incidents, completed the necessary steps to correct this deficient practice, therefore this is a citation of past non-compliance.	F 221		
F 226 SS=D	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: Per observation, interview, and record review the	F 226	Past noncompliance: no plan of	

Theresa Southworth
Administrator 10-31-11

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

PRINTED: 10/18/2011
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 _____		(X3) DATE SURVEY COMPLETED C 09/27/2011
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	
F 226	<p>Continued From page 3</p> <p>facility failed to implement its' written policies and procedures that prohibit mistreatment, neglect, and abuse of residents for 1 resident [Resident #1] out the sample group. Findings include:</p> <p>1). Per record review, the facility's Abuse Policy includes in its' definition of Abuse "any treatment of a vulnerable adult which places life, health, or welfare in jeopardy or which is likely to result in impairment of health, Unnecessary or lawful confinement or unnecessary or unlawful restraint of a vulnerable adult."</p> <p>Per record review, the facility's Abuse In-Service Education given to the facility's Nursing and LNA staff on 5/9/11 defines abuse as "Unnecessary confinement or restraint. Conduct that is likely to cause unnecessary pain, harm, or suffering. - examples: 'tying to a chair or bed'". Per record review, the facility's Employee Orientation packet-facility's Abuse policy- "Any employee witnessing a situation will immediately report the event to DNS. Reporting staff member...will notify administrator immediately".</p> <p>Per record review, Division of Licensing and Protection Event Reporting Form dated 9/25/11 states "reported to writer by LNA [Licensed Nursing Assistant] that resident's husband had [him/her] put gait belt around [Resident #1's] waist and around wheelchair to hold her in. Husband had not remembered that LNA had applied the belt to resident, found another gait belt, put it around resident's neck and wrapped it around wheelchair handgrips." The LNA reported this to an off-duty nurse, who did not report the incident until h/she returned to the facility the next morning.</p>	F 226	correction required.		

Theresa Southworth
Administrator

10-31-11

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

PRINTED: 10/18/2011
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 _____	(X3) DATE SURVEY COMPLETED C 09/27/2011
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
F 226	<p>Continued From page 4</p> <p>Per staff interview with a LNA on 9/27/11 at 1:20 P.M. he/she observed numerous times Resident #1's husband attaching a gait belt on the front of the resident's wheelchair. The belt was tied to one arm rest, stretched across in front of the resident and tied to the other arm rest. LNA reported the resident's husband did this every day after supper when he and Resident #1 went to the resident's room. The husband did this in order to keep the resident from falling out of the wheelchair if the husband fell asleep while watching TV together. The LNA spoke with husband 'about a month ago' and informed the resident's husband that using a gait belt like that was a restraint, and that he needed to speak with a nurse and make sure it was in the resident's Care Plan to use it like that. The LNA saw the gait belt used on Resident #1 in an identical way "every day" after h/her conversation with the husband, but did not feel it was up to him/her to check if it was in the resident's Care Plan. The LNA stated the facility's nurses saw the gait belt tied on the wheelchair when they would go into resident's room and give the resident her evening medications. The LNA stated "They [nurses] would have to see it. It happens every day".</p> <p>Per interview with the Director of Nursing Services [DNS] on 9/27/11 at 2:19 P.M., a "few" of the facility's staff were aware of Resident #1's husband tying a gait belt to the resident's wheelchair, and were aware it was a restraint but "thought it was okay because the husband was there". The DNS stated that after the LNA discovered the gait belt around the resident's neck and removed it, the staff "discussed it and didn't know what to do". The DNS confirmed the facility's staff should have recognized the</p>	F 226		

Theresa Southworth 10-31-11
Administrator

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

PRINTED: 10/18/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 475062	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 09/27/2011
NAME OF PROVIDER OR SUPPLIER GILL ODD FELLOWS HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 8 GILL TERRACE LUDLOW, VT 05148		
(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	
F 226	<p>Continued From page 5</p> <p>husband's use of the gait belt as a restraint (and therefore abuse as defined by the facility policy), and removed it immediately upon seeing it the first time. Staff should have also reported the usage immediately, and had not allowed the husband to continue to use it on future visits. The DNS also confirmed after the gait belt was found on the resident's neck, the LNA should have reported it to an on-duty staff member, and the staff member should have reported the incident to DNS and the facility's Administrator immediately per facility policy. The DNS also reported h/she found gait belts in a drawer in the resident's room the morning after the incident. The DNS reported it was h/her expectation that LNA's keep the gait belts on their person, in their personal belongings, or in a drawer behind the nurse's station where residents and/or family would not have access to them.</p> <p>During the onsite investigation, it was determined that the facility administration, after becoming aware of the incidents, completed the necessary steps to correct this deficient practice, therefore this is a citation of past non-compliance.</p>	F 226			

Theresa Southworth
Administrator

10-31-11