VERMONT

Department of Disabilities, Aging and Independent Living
Division of Licensing and Protection
280 State Drive/HC 2 South
Waterbury, VT 05671-2060
www.dlp.vermont.gov

[phone] 802-241-0344
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AGENCY OF HUMAN SERVICES

April 16, 2025

Ms. Maegan McElwain, Administrator
Gill Odd Fellows Home of Vermont
8 Gill Terrace
Ludlow, VT 05149-1004

Dear Ms. McElwain:

Enclosed is a copy of your acceptable plans of correction for the recertification survey conducted on **March 19, 2025.** 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, BS
Assistant Division Director
State Survey Agency Director

Enclosure

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	475052	A. BUILDING _____ B. WING _____	C 03/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GILL ODD FELLOWS HOME OF VERMONT	8 GILL TERRACE LUDLOW, VT 05149

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E 000	Initial Comments The Division of Licensing and Protection conducted an emergency preparedness review during the annual recertification survey on 3/19/25. There were no regulatory violations identified.	E 000		
F 000	INITIAL COMMENTS The Division of Licensing and Protection conducted an unannounced, onsite recertification survey from 3/17/25 through 3/19/25 to determine compliance with 42 CFR Part 483 requirements for Long Term Care Facilities. Deficiencies were cited as a result of this survey.	F 000		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)	F 580	F 580 The facility failed to notify the physician of 1 resident regarding physician orders not followed related to medications not administered as ordered. This has the potential to affect all resident's with Active scheduled medication orders. Re-education provided to nursing staff regarding Disruption of medication administration (not Available, refused, omitted, etc.) DON or Designee to review eMAR at least 5 days per Week to audit medication doses for any reason And follow up with MD to ensure timely Notification and obtain new orders, if needed. Audit results to be reviewed at QAPI x 6mo. In compliance as of 4/25/25. **Tag F 580 POC accepted on 4/16/25 by T. Davis/S. Stem**	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: DON | (X6) DATE: 4/16/25

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 580	Continued From page 1 (14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to notify the physician of 1 resident [Resident #28] of 19 sampled residents regarding physician orders not followed related to medications not administered as ordered. Findings include: Per record review, Resident #28 was admitted to the facility with diagnoses that include Parkinson's Disease [Parkinson's disease (PD) occurs when brain cells that make dopamine, a	F 580		

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chemical that coordinates movement, stop working or die. PD causes tremors, slowness, stiffness, and walking and balance problems]. Review of Physician Orders reveals the resident was ordered the medication "Amantadine- give 1 capsule by mouth in the evening related to Parkinson's Disease." Review of Res.#28's Medication Administration Record for January 2025 records Resident #28 did not receive the Amantadine medication as ordered on 6 days, including 5 consecutive days. [1/23 - 1/27/25, 1/29/25]. Nursing Progress notes record on 1/23/25 the medication is "Unable to give, incorrect dose" with no further documentation. On 1/24/25 Nursing Progress notes read "Spoke with [family member], about residents Amantadine which is 'delayed'. [S/he] is aware resident is out of medication." Notes on 1/25/25 record "medication reported as 'delayed' by family member], so unavailable at this time." Notes on 1/26/25 record "Not available (family supply's medication)." On 1/27/25, Nursing Progress notes record "see progress note," which refers to itself and contains no further documentation. Nursing Progress notes on 1/29/25 record "Medication on order."

Per review of drug information from the manufacturer of Amantadine:
"Rapid dose reduction or abrupt discontinuation of Amantadine may cause an increase in the symptoms of Parkinson's disease or cause delirium, agitation, delusions, hallucinations, paranoid reaction, stupor, anxiety, depression, or slurred speech. Avoid sudden discontinuation of Amantadine."
(https://www.gocovrihcp.com/safety)

A review was conducted of in-service education

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F 580	Continued From page 3 provided to nursing staff on 8/1/24 regarding "Medication Not Available." The education provided included "When we fail to follow an order and fail to give a medication that is ordered to a resident this can be considered a medication omission or medication error ... there is a process to be followed when a medication is unavailable." The facility process includes "If medication will not arrive in time for dose, contact Director of Nursing or Assistant Director of Nursing, they will notify the Physician. Document in a progress note the steps you just took." An interview was conducted with the Director of Nursing [DON] on 3/19/25 at 1:57 PM. The DON confirmed there was no documentation that Resident #28's physician was notified the resident's Parkinson's Disease medication was not given as ordered on 6 different occasions, including on 5 consecutive days.	F 580		
F 699 SS=D	Trauma Informed Care CFR(s): 483.25(m) §483.25(m) Trauma-informed care The facility must ensure that residents who are trauma survivors receive culturally competent, trauma-informed care in accordance with professional standards of practice and accounting for residents' experiences and preferences in order to eliminate or mitigate triggers that may cause re-traumatization of the resident. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure that 1 [Resident #43] of 4 sampled residents who are trauma survivors received culturally competent, trauma-informed care in accordance with professional standards of	F 699	F 699 The facility failed to ensure that 1 Resident who is a trauma survivor received culturally competent, trauma-informed care in accordance with professional standards of practice and accounting for residents' experience and preferences in order to eliminate or mitigate triggers that may cause re-traumatization of the resident. This has the potential to affect all trauma survivors admitting to the facility. Effective 3/18/25, a PTSD screener was added by DON to Point Click Care assessments. This Assessment will be completed for all Residents admitting to the facility and all existing Residents on an annual basis. All residents “triggering” will have a PTSD or trauma focus Added to their plan of care. This will be reviewed At each care plan meeting. Compliance will be achieved by 4/25/25. **Tag F 699 POC accepted on 4/16/25 by T. Davis/S. Stem**	

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F 699	Continued From page 4	F 699		

practice and accounting for residents' experience and preferences in order to eliminate or mitigate triggers that may cause re-traumatization of the resident.
Findings include:

Per review of the facility's "Trauma-Informed Care" policy [approval date 3/5/24]:
"The facility must ensure that residents receive culturally competent care in accordance with professional standards of practice and accounting for resident experiences and preferences to eliminate triggers that may harm the resident."
Policy procedures include: "Assessments, screening and early identification begins with the resident's admission to the facility and periodically with behavioral and/or condition changes," and "The resident's comprehensive care plan will reflect goals and approaches to address mental health, including management of triggers ..."

Per review of Resident #43's medical record, the resident was admitted to the facility on 5/14/24. Resident #43 began receiving psychiatric therapy on 7/29/24, with the physician diagnosing the resident with PTSD (post-traumatic stress disorder). Per review of Psychiatric Therapy notes from September 2024 up through the time of the recertification survey in March 2025, physician notes recorded the diagnosis of PTSD on each monthly session. Further record review revealed no assessment to identify triggers and no Care Plan for the PTSD diagnosis along with no interventions developed related the preventing possible triggers.

An interview was conducted with the Director of Nursing [DON] on 3/18/25 at 2:02 PM. The DON confirmed that despite the physician diagnosis of

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F 699	Continued From page 5 PTSD, Resident #43 did not undergo an assessment or screening to identify behavioral triggers, and was not care-planned for the PTSD diagnosis to eliminate or mitigate triggers that may cause re-traumatization of the resident.	F 699		
F 758 SS=E	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented	F 758	F 758 the facility failed to ensure as needed [PRN] orders for psychotropic drugs are limited to 14 days for 3 of residents unless the attending physician or Prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days and documents their rationale. This has the potential to affect all residents with PRN orders for psychotropic drugs. DON or designee will perform weekly audits x 6mo To ensure MD has adequate rationale present for any Order that continues beyond the initial 14 days. This will be an ongoing QAPI topic for at least 6mo. Facility is in compliance as of 4/9/25. **Tag F 758 POC accepted on 4/16/25 by T. Davis/S. Stem**	

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in the clinical record; and

§483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order.

§483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication.
This REQUIREMENT is not met as evidenced by:
Based on interview and record review, the facility failed to ensure as needed [PRN] orders for psychotropic drugs are limited to 14 days for 3 of 19 sampled residents [Resident #37, #21, and #22] unless the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days and documents their rationale.
Findings include:

1.) Review of Physician Orders for Resident #37, dated 3/18/24, reveal an order for "Lorazepam [an anti-anxiety psychotropic medication] 0.5 milligrams- give one tablet by mouth every 8 hours as needed for 365 days." Per review of Resident #37's medical record, there was no documentation of a Physician rationale for ordering the PRN psychotropic medication for longer than the 14 day limit.

2.) Review of Physician Orders for Resident #21,

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F 758	Continued From page 7	F 758		

dated 3/2/25, reveal an order for "Ativan [brand name for Lorazepam] Oral Tablet 0.5 milligrams-Give 2 tablet by mouth every 2 hours until 8/19/2025 [order is > 5 months]." Per review of Resident #21's medical record, there was no documentation of a Physician rationale for ordering the PRN psychotropic medication for greater than 5 months time.

An interview was conducted with the Director of Nursing [DON] on 3/19/25 at 1:57 PM. The DON confirmed both Resident #37 and Resident #21's PRN orders for Lorazepam/Ativan exceeded 14 days, and confirmed there was no documentation of a physician's rationale as to why the length of time for the psychotropic medication order needed to exceed the 14 day limit.

3.) Record review showed that on 8/30/24 at 1:00 PM Resident #22 was prescribed Clonazepam 0.5 MG as needed every 12 hours for post traumatic stress disorder for 365 days.

Record review of Resident #22's medical records do not include a rational from a physician or other prescriber for extending the PRN Clonazepam order to 365 days.

A facility policy titled "Policy: unnecessary drugs" which was approved on 3/5/24 stated that "PRN (as needed) orders for psychotropic drugs are limited to 14 days. If the attending physician or prescribing practitioner believes it is appropriate for the PRN order to be extended beyond 14 days, the following must be met: ... The rational for extending the PRN order for more than 14 days is documented in the resident's medical record."

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F 758	Continued From page 8 In an interview with the DON at 2:23 PM on 3/19/25, the DON was unable to provide evidence of a provider's rationale for extending Resident #22's order for Clonazepam.	F 758		
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of	F 880	F 880 the facility failed to maintain facility-wide systems for the prevention, identification, and control of infection and communicable diseases of residents, staff, and visitors through surveillance, staff training, & following established policies and procedures related to proper use of personal protective equipment (PPE) specifically Enhanced Barrier Precautions (EBP) for 4 residents. This has the potential to affect all residents within The facility. Education provided to nursing staff regarding EBP. Care plan added for all residents that require EBP (indwelling medical device, wounds, etc.) Supplies made available in these resident's rooms. Reviewed at daily huddle. Residents requiring EBP Care planned, added to assignment "tickets" and In online Kardex. ICP updated. This will be a daily topic of huddle and QAPI. In compliance as of 4/9/25. **Tag F 880 POC accepted on 4/16/25 by T. Davis/S. Stem**	

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communicable disease or infections should be reported;
(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;
(iv)When and how isolation should be used for a resident; including but not limited to:
(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.
(v) The circumstances under which 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; and
(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.

§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.

§483.80(e) Linens.
Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.

§483.80(f) Annual review.
The facility will conduct an annual review of its IPCP and update their program, as necessary.
This REQUIREMENT is not met as evidenced by:
Based on observations, interviews, and record review, it was determined that the facility failed to maintain facility-wide systems for the prevention, identification, and control of infection and communicable diseases of residents, staff, and

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visitors through surveillance, staff training, and following established policies and procedures related to proper use of personal protective equipment (PPE) specifically Enhanced Barrier Precautions (EBP) for 4 of 4 of the applicable sample (Residents #7, #11, #10, and #38). Findings include:

Per observation on 3/19/2025 at approximately 2:00 PM, a Licensed Nursing Assistant (LNA) was observed emptying an indwelling catheter bag containing urine without wearing a protective gown. When asked if gowns were available, she explained that the staff are not instructed to wear a gown when emptying urine from a catheter bag.

Per observation on 3/19/2025 at approximately 9:00 AM, a facility tour revealed no signage or indication to the staff that Enhanced Barrier Precautions (EBP) were required for residents with indwelling medical devices (urinary catheters).

Per record review, Resident # 7 has a diagnosis of specified disorders of the kidney and ureter and has an indwelling urinary catheter.
Resident #11 has a diagnosis of Parkinson's disease and has a suprapubic (a urinary catheter inserted through the abdominal wall) urinary catheter.
Resident # 10 has a diagnosis of benign prostatic hyperplasia (enlarged prostate) and has an indwelling urinary catheter.
Resident #38 has a diagnosis of neuromuscular dysfunction of the bladder and requires a urinary catheter.

A review of the care plans of Residents #7, #11, #10, and #38, there is no evidence found in the

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F 880	Continued From page 11 care plan to direct the staff to use Enhanced Barrier Precautions during high-contact resident care. The Centers for Disease Control and Prevention recommends the use of gown and gloves (EBPs) for high-contact resident care activities, when Contact Precautions do not otherwise apply, for nursing home residents with wounds and /or indwelling medical devices regardless of MDRO (multidrug resistant organisms) colonization. Per interview with the Director of Nursing (DNS) on March 19, 2025, at approximately 2:20 PM, she confirmed that the facility Infection Control Policy did contain the CDC recommendations for EBPs and that the facility was not utilizing Enhanced Barrier Precautions.	F 880		