VERMONT

Department of Disabilities, Aging and Independent Living
Division of Licensing and Protection
280 State Drive/HC 2 South
Waterbury, VT 05671-2060
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AGENCY OF HUMAN SERVICES

September 18, 2025

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

Provider ID #: 475052

Dear Ms. McElwain:

Enclosed is a copy of your acceptable plans of correction for the complaint investigation conducted on **August 6, 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
Pamela M. Cota, RN, BS
Assistant Division Director
State Survey Agency Director

Enclosure

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 475052	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Gill Odd Fellows Home of Vermont	8 Gill Terrace , Ludlow, Vermont, 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
F0000	INITIAL COMMENTS The Division of Licensing and Protection conducted an unannounced, onsite investigation of 1 complaint and 1 facility reported incident including reports #163145 & 2562719 on 8/6/25 to determine compliance with 42 CFR Part 483 requirements for Long Term Care Facilities. The following regulatory deficiencies were identified:	F0000		
F0609 SS = D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is NOT MET as evidenced by: Based on interview and record review, the facility	F0609	Resident was interviewed and confirmed feeling safe at facility. Res to res incident reported to all appropriate parties. Resident was offered and agreed to a stop sign to deter unwanted visitors. Care plan of resident was reviewed and updated. All residents have the potential to be affected by the stated deficiency; no similar findings and/or negative affects have been identified by this alleged deficient practice. staff were educated on the findings and requirements of F609: Reporting of Alleged Violations. Specifically, this education focused on reporting all allegations of abuse and substantiate according to policy and regulation. DON or designee will maintain record of abuse reportables ensuring every allegation is reported timely so that solutions and sustained. Abuse Prevention Committee Meetings will be held within 72hr of alleged incidents to ensure ongoing and sustained compliance with this alleged deficient practice. Any adverse findings will be immediately addressed will be reported to QAPI Committee further review and consideration. **Tag F 609 POC accepted on 9/17/25 by T. Dougherty/S. Stem**	8/31/25

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 reverse for further 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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
	Director of Nursing	8/26/25

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F0609 SS = D	Continued from page 1 failed to ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services) in accordance with State law through established procedures for 1 resident [Resident #1] of 3 sampled residents. Findings include: Per review of Physician Assessment Notes for Resident #1, dated 7/17/25 and 7/24/25, Resident #1 “has a primary medical history of dementia, depression and insomnia,” “does not evidence any signs of cognitive impairment,” h/her insight and judgement are “good/intact,” there are “no indications today of audio hallucinations or visual hallucinations or delusions, no indication of risk to h/herself or others,” and “is a good historian.” An interview was conducted with Resident #1 on 8/6/25 at 9:30 AM. The resident stated “A couple of nights ago a [resident] came into my room and hit me 7 times with my walking stick [Resident picked up a “grabber/reaching tool” on an end table next to a television and held it up]. I was hit on the back [left] side of my head and my shoulder. "I have no idea what has happened since. They may have talked to me about it afterwards, but I don’t remember. What upsets me the most is they don’t tell me what is going on, what the consequences are. I’m the [person] they beat on. I have a right to know. I want them to call the police. I want them to arrest [h/her]. The police did not talk to me. I have had no communication from the management. Do I feel safe here? The next time somebody walks into my room I will be ready to defend myself.” Review of Progress Notes for Resident #1 dated 3 days prior on 8/3/25 record “Resident is complaining that another resident came into [h/her] room. Nurse did not witness any physical aggression no bruises or skin issues noted, will continue to monitor both residents closely.” Further review reveals no mention of the identity of the other resident, and no documentation of any “monitoring” of either resident. Review of Progress Notes dated the next day, 8/4/25 record Resident #1 being interviewed by the facility’s Social Worker [SW]. Per the SW’s note- “Writer followed	F0609		

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F0609 SS = D	Continued from page 2 up on events from this weekend. Resident has requested a Velcro stop sign. This will help prevent unwanted guests and wandering, several residents who are mobile are nearby." An interview was conducted with the Social Worker [SW] on 8/6/25 at 10:58 AM. The SW stated that s/he had a conversation with Resident #1 on 8/4/25 where the resident reported another resident wandered into h/her room and "struck [h/her] 7 or 8 times." Resident #1 wanted "police called." The SW stated s/he was unaware of any physician or family notification, and unaware of any report of the incident to the required state agency[s] or law enforcement. The SW stated s/he did not report the allegation of abuse to the facility's Administrator or any state agency or law enforcement. An interview was conducted with the facility's Director of Nursing [DON] on 8/6/25 at 11:30 AM. The DON stated that after hearing of the initial observations of staff regarding Resident #1 and after conducting an interview with the alleged perpetrator the DON deemed the abuse "unlikely" to have happened. The DON confirmed that any allegation of abuse was required to be reported, including to the State Survey Agency, but was not.	F0609	Resident was interviewed and confirmed feeling safe at facility. Res to res incident reported to all appropriate parties. Resident was offered and agreed to a stop sign to deter unwanted visitors. Care plan of resident was reviewed and updated.	8/31/2025
F0610 SS = D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.	F0610	All residents have the potential to be affected by the stated deficiency; no similar findings and/or negative affects have been identified by this alleged deficient practice. staff were educated on the findings and requirements of F610: Investigation of Alleged Violations. Specifically, this education focused on investigating all allegations of abuse and substantiate according to policy and regulation. DON or designee will maintain record of abuse reportables ensuring every allegation is investigated/reported timely so that solutions are inacted and sustained. Abuse Prevention Meetings will be held within 72hr of alleged incidents to ensure ongoing and sustained compliance with this alleged deficient practice. Any adverse findings will be immediately addressed will be reported to QAPI Committee further review and consideration.	

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F0610 SS = D	Continued from page 3 This REQUIREMENT is NOT MET as evidenced by: Based on interview and record review, response to allegations of abuse, neglect, exploitation, or mistreatment, the facility failed to have evidence that all alleged violations are thoroughly investigated regarding 1 resident [Resident #1] of 3 sampled residents. Findings include: Per review of Physician Assessment Notes for Resident #1, dated 7/17/25 and 7/24/25, Resident #1 “has a primary medical history of dementia, depression and insomnia,” “does not evidence any signs of cognitive impairment,” h/her insight and judgement are “good/intact,” there are “no indications today of audio hallucinations or visual hallucinations or delusions, no indication of risk to h/herself or others,” and “is a good historian.” An interview was conducted with Resident #1 on 8/6/25 at 9:30 AM. The resident stated “A couple of nights ago a [resident] came into my room and hit me 7 times with my walking stick [Resident picked up a “grabber/reaching tool” on an end table next to a television and held it up]. I was hit on the back [left] side of my head and my shoulder. "I have no idea what has happened since. They may have talked to me about it afterwards, but I don’t remember. What upsets me the most is they don’t tell me what is going on, what the consequences are. I’m the [person] they beat on. I have a right to know. I want them to call the police. I want them to arrest [h/her]. The police did not talk to me. I have had no communication from the management. Do I feel safe here? The next time somebody walks into my room I will be ready to defend myself.” Review of Progress Notes for Resident #1 dated 3 days prior on 8/3/25 record “Resident is complaining that another resident came into [h/her] room. Nurse did not witness any physical aggression no bruises or skin issues noted, will continue to monitor both residents closely.” Further review of Progress Notes reveals no mention of the identity of the other resident, and no documentation of any “monitoring” of either resident. Review of Progress Notes dated the next day, 8/4/25 record Resident #1 being interviewed by the facility’s Social Worker [SW]. Per the SW’s note, “Writer followed up on events from this weekend. Resident has requested a Velcro stop sign. This will help prevent unwanted	F0610	**Tag F 610 POC accepted on 9/17/25 by T. Dougherty/S. Stem**	

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F0610 SS = D	Continued from page 4 guests and wandering, several residents who are mobile are nearby." An interview was conducted with the Social Worker [SW] on 8/6/25 at 10:58 AM. The SW stated that s/he had a conversation with Resident #1 on 8/4/25 where the resident reported another resident wandered into h/her room and "struck [h/her] 7 or 8 times." Resident #1 wanted "police called." The SW stated s/he knew the identity of the resident who allegedly struck Resident #1, but that it was not documented anywhere. The SW confirmed there was no documentation in the second resident's record that any increased monitoring was conducted after the alleged incident, as was stated in the nurse's Progress Note of 8/3/25. The SW stated s/he was unaware of any formal investigation of the incident, and did not contribute any written material to an investigation. An interview was conducted with the facility's Director of Nursing [DON] on 8/6/25 at 11:30 AM. The DON stated that after hearing of the initial observations of staff regarding Resident #1 and after conducting an interview with the alleged perpetrator, the DON deemed the abuse "unlikely" to have happened. The DON confirmed that an investigation was required to determine if the allegation is substantiated or unsubstantiated. The DON confirmed there was no written record of the staff and resident interviews or evidence that the physical abuse allegations were "thoroughly investigated."	F0610		