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
[fax] 802-241-0343

AGENCY OF HUMAN SERVICES

April 9, 2026

Ms. Lindsey Ferland, Administrator
Gill Odd Fellows Home of Vermont
8 Gill Terrace
Ludlow, VT 05149

Provider ID #: 475052

Dear Ms. Ferland:

Enclosed is a copy of your acceptable plans of correction for the recertification survey conducted on **February 25, 2026.** 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 02/25/2026

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
E0000	Initial Comments The Division of Licensing and Protection conducted an unannounced, onsite emergency preparedness review on 2/25/26 during the annual recertification survey. There were no regulatory violations identified.	E0000		
F0000	INITIAL COMMENTS The Division of Licensing and Protection conducted an unannounced, onsite recertification survey from 2/23/26 through 2/25/26 to determine compliance with 42 CFR Part 483 requirements for Long Term Care Facilities. The following regulatory deficiencies were identified:	F0000		
F0552 SS = A	Right to be Informed/Make Treatment Decisions CFR(s): 483.10(c)(1)(4)(5) §483.10(c) Planning and Implementing Care. The resident has the right to be informed of, and participate in, his or her treatment, including: §483.10(c)(1) The right to be fully informed in language that he or she can understand of his or her total health status, including but not limited to, his or her medical condition. §483.10(c)(4) The right to be informed, in advance, of the care to be furnished and the type of care giver or professional that will furnish care. §483.10(c)(5) The right to be informed in advance, by the physician or other practitioner or professional, of the risks and benefits of proposed care, of treatment and treatment alternatives or treatment options and to choose the alternative or option he or she prefers. This REQUIREMENT is NOT MET as evidenced by: Based on interview and record review, the facility failed to ensure that 1 of 5 residents in the sample (Resident #1) was informed in advance, of the risks and	F0552		

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 02/25/2026

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
F0552 SS = A	Continued from page 1 benefits, treatment alternatives or treatment options, and to choose the alternative or option s/he prefers related to a change in medication. Findings include: Per a record review, Resident #1 has diagnoses that include other primary thrombophilia (indicating high risk of blood clots), ataxia (a neurological condition characterized by a loss of full control of bodily movements, resulting in uncoordinated, clumsy actions, particularly affecting gait, speech, and eye movements) following unspecified cerebrovascular episode, and hemiplegia and hemiparesis following cerebral infarction affecting right nondominant side. Per an MDS (Minimum Data Set, a standardize clinical assessment tool) dated 1/20/26, Resident #1 has a score of 3 out of 15 on their BIMS (Brief Interview for Mental Status, a test to check if thought processes are intact) indicating severe cognitive impairment. Resident #1's spouse is his/her primary decision maker. Per an interview with Resident #1 and his/her spouse on 2/24/26 at 10:21 am, Resident #1's spouse stated that Resident #1 had a recent medication change from Coumadin to Eliquis (both are anticoagulants or blood thinners that prevent blood clots and strokes.) Resident #1's spouse stated she was not notified prior to this change. S/he stated that they found out about the change when s/he inquired about the status of his latest INR test (International Normalized Ratio test, which measures how long it takes for blood to clot, typically to monitor patients on blood thinners like Coumadin). S/he was told that testing was no longer necessary since Resident #1 had been switched to Eliquis. Resident #1's spouse indicated s/he would have liked to know about the change ahead of time. S/he also stated that s/he was not sure if the change was okay due to the Resident's clotting disorder, or if the new medication was going to cost more. Per record review of physician's orders, the change from Coumadin to Eliquis was made on 2/3/26. Per an interview with the DON (Director of Nursing) on 2/24/26 at 4:00 pm,the DON confirmed that she was unable to provide documentation that Resident #1's spouse consented to the change from Coumadin to Eliquis prior to it being changed.	F0552	F0552 Staff failed to ensure resident's wife had a Solid understand of the medication change And that frequent follow up labs would no Longer be necessary, causing confusion. All residents have medication orders which Are subject to change. This has the potential To effect each resident in the building. Nursing staff have been educated that for any Change to medications or treatment, they are To notify the resident or responsible party of The change, obtain consent, and document The exchange in the medical record. This will be audited by the DON or her designee On a weekly basis and reported at QAPI for the Next 6 months. **Tag F0552 POC accepted on 4/9/26 by S. Freeman/S. Stem**	In compliance by 3/31/26
F0585 SS = E	Grievances CFR(s): 483.10(j)(1)-(4) §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity	F0585		

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 02/25/2026

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
F0585 SS = E	Continued from page 2 that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay. §483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph. §483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident. §483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include: (i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system; (ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations;	F0585	F0585 The facility failed to provide a system that enables residents to file an anonymous grievance. This has the potential to affect all residents Residing in the facility. Before surveyors left the building to close out Survey, grievance forms were made available And posted outside of the social services Office for anyone to take and complete at Anytime of day or night. We also placed a Small lock box near the door so that Grievances may be placed anonymously. In addition to the box in the front lobby. Grievances will continue to be a topic At each QAPI meeting, indefinitely. **Tag F0585 POC accepted on 4/9/26 by S. Freeman/S. Stem**	In compliance by 3/31/26

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 02/25/2026

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
F0585 SS = E	Continued from page 3 (iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated; (iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law; (v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued; (vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. This REQUIREMENT is NOT MET as evidenced by: Based on observations and interviews the facility failed to provide a system that enables residents to file an anonymous grievance. Findings include: Per observation on 2/25/26 at approximately 9:20 AM a grievance procedure was posted outside the dining room in the lobby. The grievance posting did not contain information regarding how to file an anonymous grievance. The posting stated if a resident has a concern or complaint to speak with the grievance officer/ Social Service Director or the Director of Nursing and lists their phone numbers. There were no blank grievance forms or a drop box to submit grievance forms observed.	F0585		

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 02/25/2026

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
F0585 SS = E	Continued from page 4 Per interview on 2/25/26 at 10:06 AM the Social Worker confirmed that the residents file grievances with either the Social Worker or the Director of Nursing. The Social Worker stated he did not know how a resident would file a grievance anonymously as they would have to ask a staff member for the form and submit the form back to a staff member. The Social Worker stated that blank grievance forms are located in the social work office and residents do not have access to blank forms independently. He stated there is not a drop box for grievances and that residents physically submit the form(s) to the Social Worker, the Director of Nursing, or another staff member. Per review of the facility's admission agreement there is a section titled: "Resident Rights & Grievance Procedure" that states that grievances may be filed anonymously by placing them in the mailbox near the front door of lobby. There are no grievance forms available to residents without requesting them from a staff member.	F0585		
F0657 SS = D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as	F0657	F0657 The facility failed to revise a plan of care to reflect an identified concern of a decline in mobility for 1 of 13 sampled residents (Resident #27). 80% of the facilities resident's use a wheelchair for Locomotion, this deficiency has the potential to Affect those residents. This resident's care plan was updated to reflect The need for leg rests on 2/25/26. The Rehab Director, or designee will be performing care plan audits for mobility on a monthly ongoing basis to look for accuracy, consistency and safety. This will be reported at QAPI for the next 6 months, and longer if there is a determined need. **Tag F0657 POC accepted on 4/9/26 by S. Freeman/S. Stem**	In compliance by 3/31/26

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 02/25/2026

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
F0657 SS = D	Continued from page 5 requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and record review, the facility failed to revise a plan of care to reflect an identified concern of a decline in mobility for 1 of 13 sampled residents (Resident #27). Findings include: Per a record review, Resident #27 has a diagnosis of progressive multiple sclerosis (MS). Per observation on 2/24/25 at 9:45 am, Resident #27 was noted to be dragging his/her right foot while attempting to self-propel his/her wheelchair, inhibiting his/her movement. There was no leg rests installed on his/her wheelchair. Per a record review, Resident #27's care plan intervention for wheelchair mobility (last revised on 1/12/25) did not address the use of wheelchair leg rests when in his/her wheelchair to improve his/her ability to self-propel. Per an interview with LNA #1 on 2/24/26 at 3:35 pm, she was aware that sometimes Resident #27 did have a problem self-propelling in his/her wheelchair "because [his/her] feet get tangled up." She stated she had reported it to a nurse. Per an interview on 2/24/26 at 3:45 pm with an OTR (Occupational Therapist, responsible for evaluating and addressing the level of assistance needed with activities of daily living such as ambulation and mobility), she stated she was aware of Resident #27's feet dragging and inhibiting his/her self-propulsion. She stated she had provided leg rests for his/her wheelchair and educated staff to utilize the leg rests on his/her wheelchair. The OTR stated that if Resident #27 has leg rests in place for his/her feet, that he/she has the upper body strength to self-propel by using his/her hands to roll the wheels on his/her chair. She was unable to confirm whether this had been addressed in his/her care plan. Per observation on 2/25/26 at 9:11 am, Resident #27 was lying in bed. The wheelchair was noted to have leg rests attached. However, further review of the Resident's care plan revealed that it still had not been revised to include the use of leg rest on the wheelchair.	F0657		
F0759 SS = D	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors.	F0759		

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 02/25/2026

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
F0759 SS = D	Continued from page 6 The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is NOT MET as evidenced by: Based on observation, record review, and interview the facility failed to ensure medication error rates were less than 5% or greater. There were 31 medication administration opportunities, 29 were observed to be given and 2 were omitted, resulting in errors for 2 of 6 sampled residents (Resident #14 and Resident #16). The total error rate for all observations was calculated at 6.45%. Findings include: During a medication administration observation on 02/24/2026 at 9:50 AM, the Registered Nurse (RN) administered medications to Resident #16 and stated, “That’s all for [Resident #16].” Per record review of the Medication Administration Record (MAR) it was noted that one prescribed medication (docusate sodium, stool softener) was documented as administered by the RN but was not observed to be given. During a medication administration observation on 2/25/2026 at 9:40 AM, the RN administered medications to Resident #14 and confirmed that all medications for Resident #14 were given. Per record review of the (MAR) it was noted that one prescribed medication (Miralax Powder [laxative solution]) was documented as administered but was not observed to be given. Per interview with the Director of Nursing (DON) on 2/25/2026 at 12:20 PM she produced a time stamp report which showed the docusate sodium was administered to Resident #16 at the same time as his/her other prescribed medications, and the Miralax was documented as administered to Resident #14 at the same time as his/her other prescribed medications. Per surveyor observation these medications were not given.	F0759	F0759 The facility failed to ensure medication error rates were less than 5% or greater. All residents have the potential to be affected by alleged deficient practice. Nurses have been re-educated on guidelines and policies on medication administration with emphasis on ensuring that all medications are available and administered as ordered by the physician. The DON/ADON/Designee will conduct medication administration observation to ensure compliance. Any identified concern will be addressed immediately. Additional staff training will be done if patterns or trends are identified. Any trainings, education, or audits will be reported at QAPI for the next 6 months. **Tag F0759 POC accepted on 4/9/26 by S. Freeman/S. Stem**	In compliance by 3/31/26
F0761 SS = D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals	F0761		

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 02/25/2026

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
F0761 SS = D	Continued from page 7 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. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) 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. §483.45(h)(2) 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 1976 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. This REQUIREMENT is NOT MET as evidenced by: Based on observation and interviews the facility failed to ensure all drugs and biologicals were stored in locked compartments for 1 of 2 medication carts. Findings include: Per observation on 2/23/26 at 11:44 AM, a medication cart in the long hallway between room 117-119 was unlocked. There was not a nurse or a staff member present within sight of the medication cart. Residents were observed self-propelling in this hallway towards the dining room. At 11:56 AM, an RN (Registered Nurse) was observed walking from the nurse's station around the corner towards the medication cart. Per interview with this RN on 2/23/26 at 11:57 AM he confirmed the medication cart contained over the counter medications, syringes, topical medications, injectables, prescribed resident specific medications and narcotics in a separate locked compartment. The RN confirmed the cart was left unlocked while unattended and that it should have been locked. Per interview on 2/24/26 at approximately 2:30 PM, the DON (Director of Nursing) confirmed that the medication cart should be locked when unattended by the nurse on duty.	F0761	F0761 The facility failed to ensure all drugs and biologicals were stored in locked compartments for 1 of 2 medication carts. This deficient practice has the potential to affect all residents in the facility. The nurse was educated regarding the dangers Of leaving the medication cart unlocked when not Present. All nursing staff assigned an inservice As a reminder on 2/24/26. Management to do walking rounds 5-7 days per week and will correct Immediately and spot education to staff if found to be unlocked. Results to be reported at QAPI for 6 months. **Tag F0761 POC accepted on 4/9/26 by S. Freeman/S. Stem**	In compliance by 3/31/26

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 02/25/2026

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
F0761 SS=D SS = F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is NOT MET as evidenced by: Based on observation and interviews, the facility failed to store, prepare, distribute and serve food in accordance with professional standards of food service safety. Findings include: Per observation during the initial tour of the kitchen on 2/23/26 at 10:13 AM a 5-ounce box of cornbread muffin mix with an expiration date of 11/5/25, and a 5-ounce bag of tortilla strips with a date opened on 1/7/26 with no expiration date on the packaging, were identified in the dry storage area. In the freezer, there was a bag of 24 frozen fish sticks in a bag open to air, with no date on the package, as well as one bag containing 3 frozen pie crusts that was opened without an expiration/opened date. Per interview with Cook # 1 on 2/23/26 at 10:40 AM, they confirmed these items did not have dates, were open to air, and/or expired. Per observation on 2/23/26 at approximately 12:03 PM Cook # 2 was observed in the kitchen without a hair	F0761 F0812	F0812 The facility failed to store, prepare, and serve food in accordance with professional stanards of food service safety. This has the potential to affect all residents, staff, and visitors eating at the facility. Dietary meeting held on 3/18/26 to review storage, expiration and labeling of foods. Staff educated and acknowledged understanding of the requirement of hat or hairnet while in the kitchen. Dietitian, Food Services Manager, or designee will conduct weekly audit looking for proper storage and labeling. Dietary staff will hold each other accountable by reminding those on the shift to adhere to hat or hairnet requirement. This will be ongoing and reports will be submitted to administrator on a monthly basis as well as reviewed at QAPI for the next 6 months. **Tag F0812 POC accepted on 4/9/26 by S. Freeman/S. Stem**	In compliance by 3/31/26

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 02/25/2026

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
F0812 SS = F	Continued from page 9 restraint while cooking, assembling, and plating food. Per interview on 2/23/26 at approximately 12:15 PM Cook # 2 stated staff in the kitchen do not need a hair restraint if their hair is of a certain length. He was unsure of what the specific, permitted length of hair a staff member was allowed to be working in the kitchen without a hair restraint. Per interview with the Dietary Manager 2/24/26 at 9:45 AM, she confirmed staff whose hair is "short enough" do not need to wear a hat or a hair net while preparing or assembling food, or while in the kitchen where these tasks are performed. She stated there is not a specific length that the facility adheres to in order to determine that someone's hair is "short enough" to not wear a hair restraint while working in the kitchen. She stated that as long as hair is short enough to not fall into the food, it is acceptable. Per review of a facility policy titled “Food Safety” the policy states under the Facility Employees Part 3, “Dietary staff must wear hair restraints (e.g., hairnet, hat, and/or beard restraint) to prevent hair from contacting food.”	F0812		
F0880 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;	F0880	F880 The facility failed to follow standard infection control practices during medication administration by not practicing appropriate hand hygiene during preparation and administration of medications and the presence of a staff member’s personal drink on 1 of 2 medication carts. This deficient practive has the potential to affect all residents residing in the facility. Staff received education regarding infection control relating to medication administration as well as keeping the carts free of food and drink. Nurse Educator to perform medication administration in-services through SNF clinic with LPN, RN, and LMNA staff. Infection control rounds to take placeup to 6 times per week to ensure carts are clean, free from food or drink. If audits reveal negative results, correction will be made on the spot. Results to be reported at QAPI for 6 months. **Tag F0880 POC accepted on 4/9/26 by S. Freeman/S. Stem**	In compliance by 3/31/26

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 02/25/2026

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
F0880 SS = E	Continued from page 10 §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 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:	F0880		

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 02/25/2026

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
F0880 SS = E	Continued from page 11 Based on observation, interview, and record review, the facility failed to follow standard infection control practices during medication administration by not practicing appropriate hand hygiene during preparation and administration of medications and the presence of a staff member's personal drink on 1 of 2 medication carts. This is a repeat deficiency for this facility, with violations cited during the previous three re-certification surveys dated 1/11/23, 1/24/24, and 3/19/25. Findings include: During a medication administration observation on 2/24/2026 at 9:20 AM, a Registered Nurse (RN) put on gloves and poured medications into individual 30 cc (1oz) cups. He accessed the nurse's station refrigerator twice to obtain pudding to use for crushed medication administration. The RN did not remove his gloves or perform hand hygiene before continuing to prepare medications for administration. The RN crushed the pills and mixed them with the pudding. Without taking his gloves off and performing hand hygiene the RN carried the cups with his gloved fingers inside the medication cups and administered the medications to Resident #41. Proper hand hygiene before, during and after glove use reduces the risk of contamination and spreading germs to residents (per CDC) Per facility "Handwashing/Hand Hygiene Policy" review it states to "reduce/prevent transmission of organisms from nursing staff to resident…wash hands before and after resident contact (i.e., meds, treatments, cares)." During a medication administration observation on 2/25/2026 at 9:30 AM, a large cup with a lid and straw was sitting on the medication cart. When asked, the nurse stated the drink was hers and that she thought it was ok because the cup had a lid on it. Per interview with the Director of Nursing (DON) on 2/25/2026 at 12:20 PM, she confirmed that not performing proper hand hygiene before or during medication preparation and placing fingers (gloved or ungloved) inside the medication cup before administering increases the risk of contamination. The DON stated that "staff drinks are not allowed to be on the medication cart because it is an infection control issue, regardless of whether there is a lid on the cup or not."	F0880		

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 02/25/2026

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
F0880 SS = E	Continued from page 12 Work cited:Clinical Safety: Hand Hygiene for Healthcare Workers | Clean Hands | CDC	F0880		