| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 475052 | A. Building<br>B. Wing | 08/06/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Gill Odd Fellows Home of Vermont | 8 Gill Terrace<br>Ludlow, VT 05149 |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
|---|---|
| F 0609<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.<br><br>Based on interview and record review, the facility 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 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. |

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.

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
|---|---|---|

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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
|---|---|
| F 0610<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Respond appropriately to all alleged violations.<br><br>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 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. |