

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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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 07/20/2026
NAME OF PROVIDER OR SUPPLIER Gill Odd Fellows Home of Vermont		STREET ADDRESS, CITY, STATE, ZIP CODE 8 Gill Terrace 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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. Based on interviews and record review, the facility failed to protect the resident's right to be free from physical abuse by a staff member for 1 of 3 sampled residents (Resident #1). Findings include: Per record review Resident #1 has diagnoses that include dementia and difficulty walking. S/he has care plan interventions that include extensive assist of 1-2 with rolling walker and as needed Hoyer lift. Per progress notes written on 7/9/2026 Resident #1 had vomited and was assisted to the toilet by Licensed Nursing Assistant (LNA) #1 and LNA #2 when Resident #1 became weak unable to stand. S/he sustained a skin tear measuring 3 cm X 2.7 cm x 0.1 cm. Review of the facility report submitted to the licensing agency on 7/9/2026 revealed that LNA #2 reported that during transfer, LNA #1 was forceful with Resident #1 which caused the resident to hit her/his head on the wall and face on the call light box and sustained a skin tear to the left elbow. Per review of LNA #2's witness statement provided to the facility, on 7/9/2026 just before 5:00 PM Resident #1 had vomited and was being brought to the tub room by LNA #1 for assistance. While standing with assistance from LNA #1 and LNA #2, the Resident's legs became weak, and s/he could not stay standing. Instead of assisting Resident #1 to sit back on the toilet to try again, LNA #1 pushed Resident #1 up against the wall trying to keep her/him up. LNA #2 witnessed the Resident's head bump into the wall and heard the Resident yelp. LNA #1 then forcibly sat the Resident back down onto the toilet and s/he yelled again. The Resident was then assisted to stand again; at this time, her/his face hit the call light box and s/he started to cry. LNA #1 sat the Resident down again and yelled something to the effect of I can't pick you up on your own. You are heavy, you need to help us, or you will end up on the floor. Understand? Resident #1 said yes. At this time LNA #3 came to assist and she and LNA #1 attempted to assist the Resident to stand. The Resident was being pushed up against the wall while LNA #1 attempted to pull up a brief, at this point Resident #1 was crying. LNA #2 noted that the Resident had sustained a skin tear. Per interview with the Director of Nursing on 7/15/2026 at 11:00 AM Resident #1 had sustained a skin tear and bruising on her/his right arm during transfer. During an interview with LNA #2 on 7/17/2026 at 10:10 AM she confirmed that LNA #1 had been forceful with Resident #1, the Resident had been injured, was crying, and scared as a result of the way LNA #1 had assisted her/him. Based on corrective actions completed on 7/14/2026, prior to the onsite, this citation is designated as past non-compliance with the compliance date of 7/14/2026. The following actions were completed by the facility: The facility reported the incident to the Licensing Agency, police, and the Office of Professional Regulation. LNA #1's employment was terminated. All residents were assessed for injury that may indicate possible abuse. Staff were educated on staff to resident abuse and recognizing potential concerns in coworker behaviors. The results of the audits are reported and evaluated during the quality assurance, performance improvement quarterly meetings.		

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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