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	02/25/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Gill Odd Fellows Home of Vermont	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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 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 [NAME] # 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 [NAME] # 2 was observed in the kitchen without a hair restraint while cooking, assembling, and plating food.Per interview on 2/23/26 at approximately 12:15 PM [NAME] # 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.

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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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. 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.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.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. 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. Work cited:Clinical Safety: Hand Hygiene for Healthcare Workers | Clean Hands | CDC

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. 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.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. 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.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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 [ROOM NUMBER]-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.