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

August 11, 2026

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

Provider ID #: 475052

RE: Complaint Survey Findings - Past Non-Compliance

Dear Ms. Ferland:

On **July 20, 2026**, the Division of Licensing and Protection, completed a complaint investigation at Gill Odd Fellows Home of Vermont. As a result of that survey, the Division determined that at a point in time prior to the date of our visit you were not in substantial compliance with the federal regulations applicable to long-term care facilities.

Statement of Deficiencies Form CMS 2567

Enclosed is a statement of deficiency generated as a result of the survey. All references to regulatory requirements in the enclosure and in this letter are found in Title 42, Code of Federal Regulations. As the cited deficiency was corrected at the time of our visit, no plan of correction is required. Please **sign page 1 and return a signed copy of the 2567 to this office.**

Informal Dispute Resolution (IDR) Opportunity

In accordance with 42 CFR §488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. To be given such an opportunity, you are required to send your written request, along with the specific deficiencies being disputed, including an explanation of why you are disputing those deficiencies, to Pamela Cota, RN, at the Division of Licensing and Protection. Contact information is listed below. Please include if you would prefer a virtual meeting or prefer to submit information in writing for review. This request must be sent during the same ten days you have for submitting your plan of correction. You must still submit a plan of correction for all deficiencies, including those you are disputing, by the due date. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action. Please note that the following are not allowable disputes in the IDR process: scope and severity of deficiencies, unless they are immediate jeopardy level or constitute substandard quality of care; remedies imposed by CMS; survey process or inconsistency issues; or concerns about the IDR process.

A facility cannot use the IDR process to claim past noncompliance.

Email (preferred): Pamela.Cota@vermont.gov
Mailing address: Division of Licensing and Protection, attn Pamela Cota
HC 2 South, 280 State Drive
Waterbury, VT 05671-2060

Phone: (802) 241-0480

Sincerely,



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 07/20/2026

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
F0000	INITIAL COMMENTS The Division of Licensing and Protection conducted an unannounced, onsite investigation of one facility reported incident including report #3077317, on 7/15/2026 with offsite interviews through 7/20/2026 to determine compliance with 42 CFR Part 483 requirements for Long Term Care Facilities. The following regulatory deficiency was identified:	F0000		
F0600 SS = D	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is NOT MET as evidenced by: 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	F0600	"Past Noncompliance - no plan of correction required"	

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

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F0600 SS = D	Continued from page 1 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 yelped 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.	F0600		

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F0600 SS = D	Continued from page 2 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.	F0600		