



**AGENCY OF HUMAN SERVICES**  
**DEPARTMENT OF DISABILITIES, AGING AND INDEPENDENT LIVING**

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Division of Licensing and Protection  
HC 2 South, 280 State Drive  
Waterbury, VT 05671-2060  
<http://www.dail.vermont.gov>  
Survey and Certification Voice/TTY (802) 241-0480  
Survey and Certification Fax (802) 241-0343  
Survey and Certification Reporting Line: (888) 700-5330  
To Report Adult Abuse: (800) 564-1612

February 22, 2023

Ms. Theresa Southworth  
Gill Odd Fellows Home Of Vermont  
8 Gill Terrace  
Ludlow, VT 05149-1004

Provider ID #: 475052

Dear Ms. Southworth:

On **February 21, 2023**, we conducted a revisit to the survey of **January 11, 2023**, to verify that your facility had achieved compliance with the tags cited at that survey. Based on our revisit, we found that your facility has corrected those deficiencies.

If you have any questions concerning this letter please contact me at (802) 241-0480.

Sincerely,

A handwritten signature in cursive script that reads "Pamela Cota RN".

Pamela Cota, RN  
Licensing Chief

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/22/2023  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>475052</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>R</b> <b>02/21/2023</b>
NAME OF PROVIDER OR SUPPLIER  <b>GILL ODD FELLOWS HOME OF VERMONT</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>8 GILL TERRACE</b> <b>LUDLOW, VT 05149</b>		
(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	
{F 000}	INITIAL COMMENTS  The Division of Licensing and Protection conducted an unannounced, onsite revisit survey at the facility on the date indicated in the upper right hand corner of this form. The violation(s) previously identified have been corrected.	{F 000}			
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE			TITLE		(X6) DATE

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.