

Division of Licensing and Protection  
103 South Main Street  
Waterbury, VT 05671-2306  
<http://www.dail.vermont.gov>  
Voice/TTY (802) 871-3317  
To Report Adult Abuse: (800) 564-1612  
Fax (802) 871-3318

January 6, 2015

Ms. Ursula Margazano, Administrator  
Woodridge Nursing Home  
P.O. Box 550  
Barre, VT 05641-0550

Dear Ms. Margazano:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **December 15, 2014**. Please post this document in a prominent place in your facility.

We may follow-up to verify that substantial compliance has been achieved and maintained. If we find that your facility has failed to achieve or maintain substantial compliance, remedies may be imposed.

Sincerely,



Pamela M. Cota, RN  
Licensing Chief

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

PRINTED: 12/19/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  475045	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  C 12/15/2014
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NAME OF PROVIDER OR SUPPLIER  WOODRIDGE NURSING HOME	STREET ADDRESS, CITY, STATE, ZIP CODE P.O. BOX 550 BARRE, VT 05641
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(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	F 000		
F 155 SS=D	<p>An unannounced onsite investigation of two facility self reports was conducted by the Division of Licensing &amp; Protection on 12/15/14. The following regulatory violations were identified: 483.10(b)(4) RIGHT TO REFUSE; FORMULATE ADVANCE DIRECTIVES</p> <p>The resident has the right to refuse treatment, to refuse to participate in experimental research, and to formulate an advance directive as specified in paragraph (8) of this section.</p> <p>The facility must comply with the requirements specified in subpart I of part 489 of this chapter related to maintaining written policies and procedures regarding advance directives. These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the individual's option, formulate an advance directive. This includes a written description of the facility's policies to implement advance directives and applicable State law.</p> <p>This REQUIREMENT is not met as evidenced by: Based on staff interview and medical record, policy and facility investigation review, the facility failed to ensure that the right to refuse treatment was respected for 1 of 3 residents in the survey sample (Resident #1). Findings include: Per record review on 12/15/14, Resident #1 had</p>	F 155	<p>The following constitutes the facility's response to the findings of the DLP and does not constitute an admission of guilt or agreement of the facts alleged or conclusions set forth on the summary statement of deficiencies.</p> <p>The facility maintains that it does afford for the residents' right to refuse to participation.</p> <p>Resident #1 suffered no negative outcome.</p> <p>All residents are potentially affected by this alleged deficient practice</p> <p>Resident Rights reviewed and re-education completed with LNA and nurse that were involved with the incident. Nursing staff re-educated re Resident Rights</p> <p style="text-align: right;">Unit Mng, DNS, SDC, Admin and/or designee</p>	12/22/2014  On-going  1/10/2015

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *[Signature]* TITLE: Administrator DATE: 1/2/2015

any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that the 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.

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F 155	<p>Continued From page 1</p> <p>diagnoses that included a prior stroke, cognitive impairments, anxiety, depression and behavioral problems. S/he had care plans in place for cognitive deficits related to the stroke and behavior problems which included paranoia. His/her behavioral care plan stated that if Resident #1 "is being verbally abusive, leave the room and reapproach as needed" and if Resident #1 "asks staff to leave [his/her] room, do so without question. Send other staff members in to assist [him/her]." Under Resident #1's care plan for alteration in cognition, the care plan states, Resident #1 "may refuse treatments/medications at times...respect refusals and update MD as needed."</p> <p>Per 12/15/14 review of the nursing progress notes, on 10/15/14 an LNA (Licensed Nursing Assistant) came from Resident #1's room, "very upset" and reported to a staff nurse that s/he ... "can't deal with [Resident #1] anymore, [s/he's] being mean and saying terrible things. I don't even want to go in there anymore." The note documents that the nurse entered Resident #1's room with the same LNA and Resident #1 told the staff nurse "I don't want [the LNA] in here, I don't like [him/her]." The nurse told the resident that s/he would be in there while the LNA provided care. The nurse, with the LNA still present in the room, asked Resident #1 what the LNA did and the resident stated, s/he's "...an idiot and I don't want [him/her]". The nurse then documented telling Resident #1, that s/he "needed a better reason than that" and [Resident #1] "...thought for a few seconds" and then stated "[S/he's] abusive." The nurse asked the resident to be "more specific." Resident #1 then alleged that the LNA had hit him/her in the face with a washcloth, hit him/her in the (left) arm and indicated that s/he had hit his penis. The note then documents that</p>	F 155	<p>Random competency quiz given to nursing staff weekly Xs 3 months to ensure understanding of Resident Rights. Outcome results reported in Department Review Meeting weekly and at QAPI Meeting with changes to process made as appropriate</p> <p>Unit Mng, DNS, SDC, Administrator and/or designee</p> <p><i>F155 pOC accepted 1/5/15 SDC/mng/APA/PMC</i></p>	1/15/2015 on-going
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F 155	<p>Continued From page 2</p> <p>Resident #1 was "lifted from the toilet with lift, LNA cleansed perirectal area without complaints or difficulty."</p> <p>During a telephone interview on 12/15/14 at approximately 1:30 PM, the staff nurse confirmed the above information from the nursing progress notes and confirmed that the LNA continued to provide care to Resident #1 after the resident stated that he did not want the LNA in the room and after the resident alleged abusive treatment from the LNA. (The nurse remained in the room while the care was provided).</p> <p>Per 12/15/14 review, the facility's Resident Bill of Rights, (Rev 9/27/13) states "You have the right to refuse care or treatment, to the extent permitted by law ...." On 12/15/14 at approximately 4 PM the facility DNS (Director of Nursing Service) confirmed that the resident's right to refuse treatment was not respected when the staff nurse did not remove the LNA from providing care for Resident #1 after the resident stated that s/he did not want the LNA in his/her room.</p> <p>(See F226, F241, F282)</p>	F 155		
F 226 SS=D	<p>483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES</p> <p>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.</p> <p>This REQUIREMENT is not met as evidenced by: Based on staff interview and medical record, facility policy and facility internal investigation</p>	F 226		

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F 226	Continued From page 3 review, the facility failed to operationalize their abuse/neglect/mistreatment policy by reassigning or suspending a staff member after allegations of abuse were made by 1 of 3 residents in the survey sample (Resident #1). Findings include: Per 12/15/14 review of the nursing progress notes, on 10/15/14 an LNA (Licensed Nursing Assistant) came from Resident #1's room, "very upset" and reported to a staff nurse that s/he ... "can't deal with [Resident #1] anymore, [s/he's] being mean and saying terrible things. I don't even want to go in there anymore." The note documents that the nurse entered Resident #1's room with the same LNA and Resident #1 told the staff nurse "I don't want [the LNA] in here. I don't like [him/her]." The nurse told the resident that s/he would be in there while the LNA provided care. The nurse, with the LNA still present in the room, asked Resident #1 what the LNA did and the resident stated, s/he's "...an idiot and I don't want [him/her]". The nurse then documented telling Resident #1, that s/he "needed a better reason than that" and [Resident #1] "...thought for a few seconds" and then stated "[S/he's] abusive." The nurse asked the resident to be "more specific." Resident #1 then alleged that the LNA had hit him/her in the face with a washcloth, hit him/her in the (left) arm and indicated that s/he had hit his penis. The note then documents that Resident #1 was "lifted from the toilet with lift, LNA cleansed perirectal area without complaints or difficulty." During a telephone interview on 12/15/14 at approximately 1:30 PM, the staff nurse confirmed the above information from the nursing progress notes and confirmed that the LNA was not removed from care and continued to provide care to Resident #1 after the resident made allegations of abuse (the nurse was present while the care	F 226	The facility maintains that it has developed and implemented written policy and procedures that prohibit mistreatment, neglect, and abuse of residents.  Resident #1 suffered no negative outcome.  All residents are potentially affected by this alleged deficient practice  Policy re: Abuse, Prohibition, Investigation & Reporting reviewed and re-education completed with LNA and nurse that were involved with the incident. Nursing staff re-educated re Abuse Prohibition, Prevention, Investigation & Reporting Policy  Unit Mng, DNS, SDC, Admin and/or designee	12/22/2014  On-going  1/10/2015

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F 226	Continued From page 4 was provided). During the interview, the nurse confirmed that s/he probably did not handle the situation correctly and that the LNA should not have continued to provide care for Resident #1, Per 12/15/14 review of the facility policy Abuse Prohibition, Prevention, Investigation & Reporting (effective date 8/7/14), section 7, under the heading Protection of Residents During Investigation [related to allegations of abuse] states "The alleged perpetrator shall be reassigned or suspended during the internal investigation pending the outcome of that investigation." On 12/15/14, the facility DNS (Director of Nursing Service) confirmed that the abuse policy was not implemented by the staff nurse when the LNA was not removed from providing care for Resident #1 after the allegation of abuse was made by the resident. (Refer F155, F241, F282)	F 226	Random competency quiz given to nursing staff weekly Xs 3 months to ensure understanding of Policy re: Abuse, Prohibition, Investigation & Reporting. Outcome results reported in Department Review Meeting weekly and at QAPI Meeting with changes to process made as appropriate  Unit Mng, DNS, SDC, Administrator and/or designee	1/15/2015 on-going
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY  The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.  This REQUIREMENT is not met as evidenced by: Based on staff interview, the facility failed to care for 1 of 3 residents in the survey sample in a manner and in an environment that maintains the resident's dignity and respect (Resident #1). Findings include: Per record review on 12/15/14, Resident #1 had diagnoses that included a prior stroke, cognitive impairments, anxiety, depression and behavioral	F 241	F226 PDC accepted 1/15/15 SDC/MAN/AMC	

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F 241	<p>Continued From page 5</p> <p>problems. S/he had care plans in place for cognitive deficits related to the stroke and behavior problems which included paranoia. Per 12/15/14 review of the nursing progress notes, on 10/15/14 an LNA (Licensed Nursing Assistant) came from Resident #1's room, "very upset" and reported to a staff nurse that s/he ... "can't deal with [Resident #1] anymore, [s/he's] being mean and saying terrible things. I don't even want to go in there anymore." The note documents that the nurse entered Resident #1's room with the same LNA and Resident #1 told the staff nurse "I don't want [the LNA] in here. I don't like [him/her]." The nurse told the resident that s/he would be in there while the LNA provided care. The nurse, with the LNA still present in the room, asked Resident #1 what the LNA did and the resident stated, s/he's "...an idiot and I don't want [him/her]". The nurse then documented telling Resident #1, that s/he "needed a better reason than that" and [Resident #1] "...thought for a few seconds" and then stated "[S/he's] abusive." The nurse asked the resident to be "more specific." Resident #1 then alleged that the LNA had hit him/her in the face with a washcloth, hit him/her in the (left) arm and indicated that s/he had hit his penis. The note than documents that Resident #1 was "lifted from the toilet with lift, LNA cleansed perirectal area without complaints or difficulty."</p> <p>During a telephone interview on 12/15/14 at approximately 1:30 PM, the staff nurse confirmed the above information from the nursing progress notes and confirmed that the LNA was not removed from care and continued to provide care to Resident #1 after the resident made allegations of abuse (the nurse was present while the care was provided) and stated that he did not want the LNA in his/her room.</p>	F 241	<p>The facility maintains that it does promotes care for residents in a manner that maintains or enhances each resident's dignity and respect in recognition of his/her Individuality</p> <p>Resident #1 suffered no negative outcome.</p> <p>All residents are potentially affected by this alleged deficient practice</p> <p>Resident Rights reviewed and re-education completed with LNA and nurse that were involved with the incident. Nursing staff re-educated re Resident Rights</p> <p style="text-align: right;">Unit Mng, DNS, SDC, Admin and/or designee</p>	<p>12/22/2014</p> <p>On-going</p> <p>1/10/2015</p>

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NAME OF PROVIDER OR SUPPLIER  WOODRIDGE NURSING HOME	STREET ADDRESS, CITY, STATE, ZIP CODE P.O. BOX 660 BARRE, VT 05641
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F 241	Continued From page 6 Per 12/15/14 review, the facility's Resident Bill of Rights, (Rev 9/27/13) states "You have the right to be treated with dignity and respect." On 12/15/14 at approximately 4 PM the facility DNS (Director of Nursing Service) confirmed that the Resident #1 continued to receive care from the LNA who the resident alleged was abusive and that a reasonable person would likely be uncomfortable with this situation. (Refer F155, F226, F282)	F 241	Random competency quiz given to nursing staff weekly Xs 3 months to ensure understanding of Resident Rights. Outcome results reported in Department Review Meeting weekly and at QAPI Meeting with changes to process made as appropriate	Unit
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN  The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.  This REQUIREMENT is not met as evidenced by: Based on medical record and facility investigation review and staff interview, the facility failed to assure that the plan of care was implemented for 1 of 3 residents reviewed. (Residents #1). Findings include: Per record review on 12/15/14, Resident #1 had diagnoses that included a prior stroke, cognitive impairments, anxiety, depression and behavioral problems. S/he had care plans in place for cognitive deficits related to the stroke and behavior problems which included paranoia. His/her behavioral care plan stated that if Resident #1 "is being verbally abusive, leave the room and reapproach as needed" and if Resident #1 "asks staff to leave [his/her] room, do so without question. Send other staff members in to assist [him/her]." Under Resident #1's care plan	F 282	Mng, DNS, SDC, Administrator and/or designee  F241 POC accepted 1/5/15 s Dennis APRN/jmc	1/15/2015 on-going

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NAME OF PROVIDER OR SUPPLIER  WOODRIDGE NURSING HOME		STREET ADDRESS, CITY, STATE, ZIP CODE P.O. BOX 560 BARRE, VT 05841		
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F 282	<p>Continued From page 7</p> <p>for alteration in cognition, the care plan states, Resident #1 "may refuse treatments/medications at times ...respect refusals and update MD as needed."</p> <p>Per 12/15/14 review of the nursing progress notes, on 10/15/14 an LNA (Licensed Nursing Assistant) came from Resident #1's room, "very upset" and reported to a staff nurse that s/he ... "can't deal with [Resident #1] anymore, [s/he's] being mean and saying terrible things. I don't even want to go in there anymore." The note documents that the nurse entered Resident #1's room with the same LNA and Resident #1 told the staff nurse "I don't want [the LNA] in here, I don't like [him/her]." The nurse told the resident that s/he would be in there while the LNA provided care. The nurse, with the LNA still present in the room, asked Resident #1 what the LNA did and the resident stated, s/he's "... an idiot and I don't want [him/her]". The nurse then documented telling Resident #1, that s/he "needed a better reason than that" and [Resident #1] "...thought for a few seconds" and then stated "[S/he's] abusive." The nurse asked the resident to be "more specific." Resident #1 then alleged that the LNA had hit him/her in the face with a washcloth, hit him/her in the (left) arm and indicated that s/he had hit his penis. The note than documents that Resident #1 was "lifted from the toilet with lift, LNA cleansed perirectal area without complaints or difficulty."</p> <p>During a telephone interview on 12/15/14 at approximately 1:30 PM, the staff nurse confirmed the above information from the nursing progress notes and confirmed that Resident #1's care plan was not implemented re respecting the resident's refusal for care provision. The nurse confirmed that the LNA continued to provide care to Resident #1 after the resident stated that he did</p>	F 282	<p>The facility maintains that services are provided by qualified persons</p> <p>Resident #1 suffered no negative outcome.</p> <p>All residents are potentially affected by this alleged deficient practice</p> <p>Re-education was provided to the nurse and LNA involved with incident regarding implementing the resident's choice to refuse and/or alter approach to care. Nursing staff re-educated re implementation of altered approaches to care.</p> <p style="text-align: right;">Unit Mng, DNS, SDC, Administrator and/or designee</p>	<p>12/22/2014</p> <p>On-going</p> <p>1/9/2015</p>

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F 282	Continued From page 8 not want the LNA in the room and alleged that the LNA had been abusive. (The nurse remained in the room while the care was provided). (See F226, F155, F241)	F 282	Random competency quiz given to nursing staff weekly Xs 3 months to ensure understanding of implementing Resident Rights. Outcome results reported in Department Review Meeting weekly and at QAPI Meeting with changes to process made as appropriate  Unit Mng, DNS, SDC, Administrator and/or designee on-going  <i>F282 POC accepted 1/15/15 SDennisAPP/PMC</i>	1/15/2015