

## DEPARTMENT OF DISABILITIES, AGING AND INDEPENDENT LIVING

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

October 10, 2014

Ms. Ursula Margazano, Administrator  
Woodridge Nursing Home  
142 Woodridge Ave.  
Berlin, VT 05602

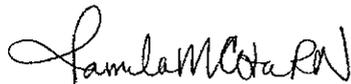
Provider ID #: 475045

Dear Ms. Margazano:

The Division of Licensing and Protection completed a survey at your facility on **September 24, 2014**. The purpose of the survey was to determine if your facility was in compliance with Federal participation requirements for nursing homes participating in the Medicare/Medicaid programs. This survey found that your facility was in substantial compliance with the participation requirements. Congratulations to you and your staff.

Please **sign the enclosed CMS 2567 and return** to this office by **October 20, 2014**.

Sincerely,



Pamela M. Cota, RN  
Licensing Chief

Enclosure

PC:kc

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

PRINTED: 10/10/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>475045</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>09/24/2014</b>
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NAME OF PROVIDER OR SUPPLIER  <b>WOODRIDGE NURSING HOME</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>P.O. BOX 550 BARRE, VT 05641</b>
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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
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F 000	<p><b>INITIAL COMMENTS</b></p> <p>An unannounced onsite recertification survey was conducted by the Division of Licensing &amp; Protection on 9/22/2014-9/24/2014. The facility was determined to be in substantial compliance with Federal regulations as a result of the survey.</p>	F 000		
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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.