



AGENCY OF HUMAN SERVICES  
DEPARTMENT OF DISABILITIES, AGING AND INDEPENDENT LIVING  
Division of Licensing and Protection  
103 South Main Street, Ladd Hall  
Waterbury, VT 05671-2306  
<http://www.dail.vermont.gov>  
Voice/TTY (802) 241-2345  
To Report Adult Abuse: (800) 564-1612  
Fax (802) 241-2358

July 27, 2011

Maureen Bertrand, Administrator  
Woodridge Nursing Home  
P.O. Box 550  
Barre, VT 05641

Provider #: 475045

Dear Mrs. Bertrand:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **June 22, 2011**.

Follow-up may occur to verify that substantial compliance has been achieved and maintained.

Sincerely,

Pamela M. Cota, RN  
Licensing Chief

PC:ne

Enclosure





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

PRINTED: 07/07/2011  
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  06/22/2011
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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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F 241	<p>Continued From page 1</p> <p>6/20/11 at 12:17 PM, an Licensed Nursing Assistant (LNA) in the dining room was interviewed and indicated that the reason that the residents were removed from the dining room into the circle was because their lunch trays had not arrived yet. It was observed at 12:17 PM that there were residents in the circle that had lunch trays in front of them and they were eating.</p> <p>During an interview on 6/20/11 at 12:41 PM, the Nurse Manager indicated that Residents #133, #39, #135 and #16 were to be participating in a specialized dining program starting 6/20/11, but through lack of communication with floor staff and dietary, the trays were never ordered for Residents #39, #135 and #16. It was observed that the lunch trays for residents #135, #39 and #16 were ordered by an LNA at 12:45 PM. The trays arrived and served to resident #135, #39 and #16 at 1:00 PM.</p> <p>On 6/20/11 at 12:55 PM the Director of Nursing Services was interviewed and indicated it was facility policy that residents at a table should be served their meals at the same time and that no resident should be at a table without a meal tray when other residents had received and were eating their meals.</p>	F 241		
F 253 SS=D	<p>483.15(h)(2) HOUSEKEEPING &amp; MAINTENANCE SERVICES</p> <p>The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.</p> <p>This REQUIREMENT is not met as evidenced by:</p>	F 253		

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F 253	<p>Continued From page 2</p> <p>Based on observations and confirmed through staff interview, the facility failed to assure that all resident areas were maintained in a sanitary and comfortable manner. Findings include:</p> <p>During the initial tour of the physical environment on the morning of 06/20/11, the following observations were made:</p> <p>a. On Maple Grove unit, in the shower room and the community bathroom which is used by the residents, end caps on the floor radiators were missing, exposing sharp edges. In addition, the shower room floor had several visible dried stains and dirt particles around the edges of the floor.</p> <p>b. There was crumbled paint and/or loss of sheet rock, exposing the wall next to the bed in room 229 and sheet rock dust was noted on the base cove directly below this area.</p> <p>Per observation with the Maintenance Director on 06/22/11 at 2:15 PM, the above missing shower and bathroom end caps and the dirty shower floor on Maple Grove unit, as well as the wall/ floor sheet rock dust in room 229 was confirmed.</p> <p>F 282 SS=D 483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</p> <p>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>This REQUIREMENT is not met as evidenced by: Based on staff interview, observation and</p>	F 253	<p>F-253</p> <p><u>Corrective Action:</u> All radiators end covers in patient care areas and patient bedrooms have been screwed in place to avoid displacement. The shower floor has been cleaned and any loose particles have been swept.</p> <p>Room #229 sheet- rock has been repaired and all dust has been removed.</p> <p><u>Other Residents:</u> All residents are at risk.</p> <p><u>Systemic Changes:</u> Each housekeeper is to audit their assigned rooms weekly and request necessary repairs in the maintenance log located at the nurses station. Logs will be reviewed twice a day by plant facility staff. (See attachments.) All staff have been educated in use of the Maintenance Request Logs.</p> <p><u>Monitoring:</u> Housekeeper Audits and Repair Requests will be reviewed by the Plant/ Facility/Buildings/Grounds Manager. He will report at the monthly QA/QI Committee the results of the audits monthly x's 3 then quarterly until 100% compliance has been achieved. This will be monitored by the Plant Facility Manger.</p> <p><u>Completion Date:</u> 8/8/11.</p> <p>F853 POC Accepted 7/21/11 P.Cummings RN / P.Mcota RN</p>

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F 282	<p>Continued From page 3</p> <p>medical record review, the facility failed to implement the care plan for 1 of 42 residents in the sample (Resident #62). The findings include:</p> <p>1. Based on record review, observation and confirmed through interview, Resident #62 did not receive treatment and services according to the written plan of care. Per record review on 06/21/11 at 4:30 PM, the following was noted:</p> <p>a) the resident care plan for skin integrity stated "gerri gloves on every day (qd) off in PM, assess and document status of skin based on risk category".</p> <p>b) the Braden Scale Assessment dated 04/08/11 and on 06/22/11 noted resident as "High Risk" for skin issues.</p> <p>c) per review of the Treatment Administration Record (TAR), nursing staff are to assess the resident's skin weekly.</p> <p>d) per review of the Licensed Nursing Assistant (LNA) Care Plan, directed staff to apply bi-lateral "gerri" [protective] sleeves to the residents arm every day/off at night.</p> <p>e) Per the Restorative Care Plan List developed on 5/11/10 to address mobility issues, "interventions -resident will have passive ROM [range of motion] to left hand B:I.D. [twice a day]"</p> <p>Per observation for two days of survey on 06/21/11 at 9:53 AM and on 06/22/11 at 9:00 AM and 12:00 PM, Resident #62 wore a protective 'sleeve' on the left arm only and no protective sleeve on the right arm. This was confirmed through interview with nursing and LNA staff on 06/22/11 at 11:45 AM. Per review of the TAR, the weekly skin checks were not documented as</p>	F 282	<p>F-282</p> <p><u>Corrective Action:</u> Care Plan for resident #62 has been implemented in reference to protective sleeves, skin assessments and ROM. No negative outcomes have resulted.</p> <p><u>Other Residents:</u> All residents are at risk.</p> <p><u>Systemic Changes:</u> All protective sleeves and skin assessments have been placed on the TAR indicating that the professional nurse is responsible for implementation and documentation of completion of the treatment. Education will be conducted regarding ROM. Care Plan revision will demonstrate the restorative treatment, the number or repetitions to the joint if the treatment includes ROM and how often the treatment is to be conducted. (See attached flow sheet.)</p> <p><u>Monitoring:</u> DNS or designee will perform monthly audits of restorative flow sheets and TAR's to ensure that all treatments and assessments are completed as indicated. The results will be reported monthly x's 3 and then quarterly at the monthly QA/QI committee meeting. Reporting will be continuous until 100% compliance is demonstrated through the audits.</p> <p><u>Completion Date:</u> 8/8/11</p> <p>F282 POC Accepted 7/26/11 [Signature]</p>	
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F 282	Continued From page 4 being assessed on 06/5/11, 06/12/11 & 06/19/11. Per review of documentation, the ADL (Activities of Daily Living) Data Report shows the resident received 1- 15 minutes of range of motion for 20 out of 31 days for the past 1 month period. There was no indication if this was PROM (Passive range of motion) nor the reason why it was not consistently performed. This was confirmed by the staff nurse and charge nurse at 12 noon on 06/22/11. Per interview on 06/21/11 at 9:20 AM 2 LNA staff stated - "sometimes we move the legs when we can and the wrist but it depends on [the resident's] mood". Per interview on 06/22/11 at 2:45 PM, the Unit Manager confirmed the treatment and services were not implemented as care planned.	F 282	
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES  The facility must ensure that the resident environment remains as free of accident hazards as is possible, and each resident receives adequate supervision and assistance devices to prevent accidents.  This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility failed to ensure each resident receives adequate supervision and/or assistance devices to prevent an avoidable accident for 1 of 10 Residents in the applicable sample. (Resident #234) Findings include:	F 323	<p>F-323 <u>Corrective Action:</u> As noted the admission fall assessment was completed, the resident did not have any negative outcomes as a result of the untimely assessment. Resident was discharged home on June 23, 2011.</p> <p><u>Other Residents:</u> All residents are at risk.</p> <p><u>Systemic Changes:</u> As per policy the Fall Risk Assessment will be completed within 24-48 hours of admission by the professional nurse. Should a resident be determined at risk for falls, an interim care plan will be initiated and falls protocol will be followed. Education will be conducted by the SDC to include protocol on the fall management policy.</p> <p><u>Monitoring:</u> DNS or designee will perform monthly audits on all fall assessments demonstrating completion as indicated. Audits will also be conducted on all falling star flow sheets for completion. The results will be reported monthly x's 3 and then quarterly at the monthly QA/QI committee meeting. Reporting will be continuous until 100% compliance is demonstrated through the audits.</p> <p><u>Completion Date:</u> 8/8/11</p>

F323 POC Accepted 7/2/11  
P. Cummings-RM / Pincota-RM

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F 323	<p>Continued From page 5</p> <p>Per record review, Resident #234 was admitted to the facility on 5/24/11 status post a fractured hip sustained from a fall at home. Nurse's notes indicated that on 5/26/11 at 1650 (4:50 PM) Resident #234 was "found on floor in room". Review of the facility Fall Risk Assessment and Fall Management policy indicates that a resident will "be assessed for fall risk on admission, and that specific interventions to manage falls and or reduce the resident's risk for falls will be identified on the Care Plan." The Unit Manager (UM) confirmed on 6/22/11 at 1:00 PM that the Fall Risk Assessment had not been done on admission, and that it was completed on 5/27/11. Review of the Fall Reduction Plan policy indicated that the UM in collaboration with staff identify residents considered "high risk for falls" including residents with one or more falls per month and all new admissions, and initiate the falling star program which observed the following per the falling star monitoring tool: chair/bed position, call light, shoes, alarm, bathroom, and room free of clutter, with every 30 minute checks over a 24 hour period for 30 days.</p> <p>In interview with the UM on 6/22/11, the UM reviewed Resident #234's monitoring tool and confirmed that the monitoring had only been completed on the night shift on 6/16/11, 6/17/11, and 6/19/11 and once on the day shift on 6/16/11. The UM also confirmed that the un-dated Licensed Nursing Assistant Care Plan was the facilities "interim care plan" for the period between admission and development of a comprehensive care plan, and that it did not address Resident #234's specific risks of falls, goals and resident specific interventions to manage falls and reduce the resident's potential</p>	F 323		
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F 323	Continued From page 6 for injury on admission.	F 323		

MAINTENANCE REPAIR  
PROGRAM

Policy/Procedure

Policy:

Woodridge Nursing Home will ensure proper working order of all equipment and for resident safety purposes and maintain dignity by reviewing patient care areas looking at damage to walls, fixtures, electric cording, etc.

Procedure:

1. If a safety/repair issue is identified on any piece of equipment, wall damage or any thing that is questionable the equipment will be removed immediately from use and labeled as "broken do not use". A maintenance request will be initiated.
2. Building Service employee will check maintenance repair logs on each unit and department daily, 7 days a week. Any repair issues related to safety must be addressed within 24 hours.
3. Once a repair has been completed the repair will be noted as completed in the log book and the original request will be kept on file by the Building Service Manager's office.

REQUISITION LOG BOOK  
FOR REPAIRS



## Dining Audit Tool

Date: \_\_\_\_\_ Meal: \_\_\_\_\_

Unit: \_\_\_\_\_ Staff Conducting the Audit: \_\_\_\_\_

Number of Staff assisting in feeding: \_\_\_\_\_

Quality Factor	Yes/No	Comments
Are residents prepared to eat?		
Is there a med care present in the dining area?		
Is the meal served within 30 minutes of delivery?		
Is the sound level comfortable?		
Are residents properly positioned?		
Are tables/over the bed tables at the appropriate height?		
Are residents in the same room or same table served at the same time?		
Are residents assisted with eating as indicated on their total care plan?		
Are residents complaining about: <ul style="list-style-type: none"> <li>• Food Temperature</li> <li>• Food Taste</li> <li>• Food Quality</li> <li>• Food Appearance</li> </ul>		
Are staff monitoring and encouraging intake of food and fluids?		
If food or fluids were refused, did staff determine the reason? If so were substitutes offered?		
Have substitute foods been offered timely? Did substitute food delivered timely?		
Are staff members sitting while assisting/feeding residents as necessary?		

Comments: