VERMONT

AGENCY OF HUMAN SERVICES

DEPARTMENT OF DISABILITIES, AGING AND INDEPENDENT LIVING

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

April 27, 2018

Mr. Allen Yearick, Administrator
Woodridge Nursing Home
P.O. Box 550
Barre, VT 05641-0550

Dear Mr. Yearick:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **March 28, 2018.** 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	475045	A. BUILDING ______ B. WING ______	C 03/28/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODRIDGE NURSING HOME	P.O. BOX 550 BARRE, VT 05641

(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 An unannounced onsite complaint investigation of multiple self reports and 2 anonymous complaints was conducted by the Division of Licensing and Protection on 3/27 through 3/28/18. The findings include the following:	F 000	**F000** **Responses in this Plan of Correction to the cited deficiencies do not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the 2567 Statement of Deficiencies. This Plan of Correction is prepared solely as a matter of compliance with Federal and State Agency's and Law.**	
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the	F 550	**F550 SS=D** **1. The nurse involved with Resident #2 was interviewed by the DON and immediately relieved of her duties then terminated and reported to the Board of Nursing. The 3 staff members involved in the catheterization were educated on Resident Rights, specifically on right of refusal/self-determination, dignity and respect. Resident #3 is no longer in the facility.** **2. Other Residents could have the potential to be affected by this deficiency, however no one else was identified at risk.** **3. Education on Resident Rights will be provided by the NHA, DON or designee, and SSD for all licensed staff; specifically it is a part of all new employee orientation, monthly All Staff meetings and will occur through inservices with staff through e-learn and scheduled sessions.**	**04-24-18**

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Allen Yearick NHA
TITLE: Administrator
(X6) DATE: 4/20/18

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.

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F 550 Continued From page 1

resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility.

§483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart.

This REQUIREMENT is not met as evidenced by:

Based on medical record review and staff interview the staff failed to protect and promote the rights of 2 of 9 sampled residents. The facility failed to treat Resident #2 and #3 with respect and dignity in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing the resident's individuality. The findings include the following:

1. Per record review for Resident #3 was admitted to the facility with diagnoses to include, but not limited to Benign Prostatic Hyperplasia with lower urinary tract symptoms. Per Licensing and Protection intake information, internal investigation and progress notes submitted by Administration, identify that on 11/9/17 at approximately 6:36 AM, Resident #3 was unable to void. Nurses progress notes identify the resident was resistive to care during bladder scanning. Bladder scanned at 6 AM identifies 502 cc's of urine in Resident #3's bladder.

Administration interviewed the primary nurse who catheterized the resident, who stated, "catheterization was necessary for the resident had more than 400 cc's of urine in the bladder". Administration also asked the primary nurse if the

F 550

The SSD will review Resident Rights and specific to the right to refuse at the monthly Resident Council meeting. Resident Rights were reviewed and discussed by the Resident Council VP at their March and April 2018 meetings. The SSD will conduct Resident roundtables on Resident Rights. Additionally, Resident Rights will be reviewed with the Resident/POA/Representative at their quarterly Care Plan meetings. A copy of Resident Rights is provided to all admissions and posters are prominently displayed within the facility.

4. The SSD and the DON or designee will report the documented Staff and any Resident educational inservices on Resident Rights and/or minutes to the monthly QAPI committee meeting for 3 months.

F550 POC accepted 4/26/18 MBertrand RN/PMC

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F 550	Continued From page 2	F 550		

resident had said no to the procedure. The nurse responded, "The resident says no to everything. It is not unusual for [him/her] to say no. The resident was uncomfortable, and I was doing what the doctor ordered said to do." Written statement by the incoming nurse identifies that when the primary nurse was questioned as to why continue with the procedure when the resident asked to stop, the primary nurse responded "Not when their bladder is full and I wasn't about to get hit".

Both the Medical Director and the Advanced Practice Registered Nurse confirmed during the interview on 3/28/18, that the primary nurse had alternatives to the treatment. Neither providers were notified of the resident's refusal of the treatment, until LNA #3 shared information that was communicated during the morning huddle meeting.

2. Per record review, Resident #2 was admitted to the facility with diagnoses to include, but not limited to Dementia, Parkinson's Disease and Chronic Obstructive Pulmonary Disease.

Per Licensing and Protection intake information and internal investigation submitted by Administration, on 1/31/18 at approximately 7:15 AM Resident #2 was being administered medication by the Licensed Practical Nurse (LPN). Two (2) Licensed Nurses Aides were present and witnessed the resident spitting out the medication the nurse had placed in his/her mouth. The LPN then replaced the same medications back in the resident's mouth, pinch his/her nose shut and said "I'm going to do you like my kids". The LPN was interviewed by Administration who confirmed that the nurse

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F 550	Continued From page 3 admitted the event. The LPN was relieved of her services immediately.	F 550		
F 578 SS=D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) 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 resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State Law.	F 578	**F 578 SS=D** **1. The nurse involved with Resident #2 was interviewed by the DON and immediately relieved of her duties and then terminated and reported to the Board of Nursing. The 3 staff members involved in the catheterization were inserviced on resident right of refusal/self determination and treatment with dignity and respect. Resident #3 is no longer in the facility.** **2. Other Residents could have the potential to be affected by this deficiency, however no one else was identified at risk.** **3. Education on Resident Rights will be provided by the NHA, DON or designee, and SSD for all licensed staff; specifically it is a part of all new employee orientation, will be presented monthly at All Staff meetings and will occur through inservices with staff through e-learn and scheduled sessions.**	**04-24-18**

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F 578 Continued From page 4

(v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time.
This REQUIREMENT is not met as evidenced by:
Based on record review and staff interviews the facility failed to respect the right to refuse treatment for 2 of 9 sampled residents, related to catheterization and medication administration (Resident #2 and #3). The findings include the following:

1. Per record review for Resident #3 was admitted to the facility with diagnoses to include, but not limited to Benign Prosthetic Hyperplasia with lower urinary tract symptoms. Per Licensing and Protection intake information, internal investigation and progress notes submitted by Administration, identify that on 11/9/17 at approximately 6:36 AM, Resident #3 was unable to void. Nurses progress notes identify the resident was resistive to care during bladder scanning. Bladder scanned at 6 AM identifies 502 cc's of urine in Resident #3's bladder.

Administration interviewed the primary nurse who catheterized the resident, who stated, "catheterization was necessary for the resident had more than 400 cc's of urine in the bladder". Administration also asked the primary nurse if the resident had said no to the procedure. The nurse responded, "The resident says no to everything. It is not unusual for [him/her] to say no. The resident was uncomfortable, and I was doing what the doctor ordered said to do." Written statement by the incoming nurse identifies that

F 578

The SSD will review Resident Rights and specific to the right to refuse at the monthly Resident Council meeting. Resident Rights were reviewed and discussed by the Resident Council VP at their March and April 2018 meetings. The SSD will conduct Resident roundtables on Resident Rights Additionally, Resident Rights will be reviewed with the Resident/POA/Representative at their quarterly Care Plan meetings. A copy of Resident Rights is provided to all admissions and posters are prominently displayed within the facility.
4. The SSD and the DON or designee will report the documented Staff and any Resident educational inservices on Resident Rights and/or minutes to the monthly QAPI committee meeting for 3 months.

F578 POC accepted 4/26/18 MBertrand RN/PNM

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F 578 Continued From page 5 F 578

when the primary nurse was questioned as to why continue with the procedure when the resident asked to stop, the primary nurse responded "Not when their bladder is full and I wasn't about to get hit".

Both the Medical Director and the Advanced Practice Registered Nurse confirmed during the interview on 3/28/18, that the primary nurse had alternatives to the treatment. Neither providers were notified of the resident's refusal of the treatment, until LNA #3 shared information that was communicated during the morning huddle meeting.

2. Per record review, identifies Resident #2 was admitted to the facility with diagnosis to include, but not limited to Dementia, Parkinson's Disease and Chronic Obstructive Pulmonary Disease.

Per Licensing and Protection intake information and internal investigation submitted by Administration, documents that on 1/31/18 at approximately 7:15 AM Resident #2 was being administered medication by the Licensed Practical Nurse (LPN). Two (2) Licensed Nurses Aides were present and witnessed the resident spitting out the medication the nurse had placed in his/her mouth. The LPN then replaced the same medications back in the resident's mouth, pinch his/her nose shut and said "I'm going to do you like my kids". The LPN was interviewed by Administration who confirmed that the nurse admitted the event. The LPN was relieved of her services immediately.

F 609 SS=D Reporting of Alleged Violations F 609
CFR(s): 483.12(c)(1)(4)

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F 609 Continued From page 6

§483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must:

§483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures.

§483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.
This REQUIREMENT is not met as evidenced by:
Based on staff interview and record review the facility failed to report alleged neglect for Resident #6 and a resident-to-resident altercation, for 2 of 9 sampled residents (#3 and #5), to the Division of Licensing and Protection (State Agency) within the required time frame. Findings Include:

1. Per record review, Resident #3 has a history of

F 609

F609 SS=D

04-24-18

1. Residents #3, #5 and #6 are no longer in the facility. The DON and NHA are no longer employed in the facility. The State Survey Agency was notified on Resident #3 and #5 altercation 2 days past the required 5 day reporting timeline. Resident #6 was not reported within the 5 required timeline and also the family of Resident #6 was not notified on the drug diversion. The employee involved in the diversion was terminated.
2. The 5 files maintained by the NHA on reportable events were reviewed and none were found to be untimely in the required State Agency(s) reporting requirements.
3. All allegations of abuse, neglect, exploitation or misappropriation, including injuries of unknown origin are reported immediately to the NHA, DON and SSD (Grievance Official) to determine the proper reporting to State Agencies per the facility Policy and Procedure and within 24hours. Those allegations reported where Resident bodily injury occurs and/or due to a crime will be reported within 2 hours. Self-reporting to State Agencies when it occurs, is reviewed by the NHA or designee at daily Morning meetings, including meeting the 5 day summary report made by the NHA including any final letter received from DLP closing the investigation.

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F 609 Continued From page 7

Paranoid Schizophrenia, along with Hallucinations. Per Licensing and Protection intake information, the facility internal investigation and progress notes from the evening of 10/30/17, Resident #5 was woken by his/her room-mate (Resident #3). Resident #3 was combative, hollering and attempting to attack Resident #5. Resident #5 reported that there was no physical contact between the two. However, he/she was nervous and shaking, indicating possible mental anguish as a result of the interaction (indicating potential verbal and/or mental abuse).

The resident-to-resident altercation occurred during the overnight hours between 10/30/17 and 10/31/17. Notification to the State Survey and Certification Agency was not made until 11/6/17, seven (7) days after the occurrence. During an interview on 3/27/18 with the Director of Nursing (DON) and the Facility Administrator, confirmation was made that the State Agency was not notified as required.

2. Per record review, on 6/6/17 and 6/22/17 Resident #6 was found to have a missing Fentanyl Patch (a narcotic analgesic) that had previously been placed topically on his/her body. A thorough search of the resident's body and belongings failed to locate either of the missing patches. A facility investigation was conducted, and it was determined that an employee had removed the patches. That employee was subsequently terminated. The facility failed to notify the State Survey and Certification Agency and the resident's legal guardian and/or representative of the situation. During an interview on 3/28/18 the Director of Nursing (DON) and the Facility Administrator confirmed

F 609

4. The NHA or designee, will audit all reportable allegations that may be reported weekly for 4 weeks, then monthly for 4 months and report this to the monthly QAPI committee meetings for discussion and at that time, determine the need to continue reporting.

F609 PoC accepted 4/26/18 MBertrandRN/pm

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F 609	Continued From page 8 that there is no evidence that the above entities were notified as required.	F 609		
F 659 SS=D	Qualified Persons CFR(s): 483.21(b)(3)(ii) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (ii) 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 observation, record review and confirmed by staff interview the facility failed provide services as outlined in the written comprehensive care plan for 2 of 9 sampled residents (Resident #1 and #3). The findings include the following: 1. Per record review for Resident #1, who was admitted to the facility with diagnoses to include, but not limited to Dementia and Cognitive Communication Deficit. Per Licensing and Protection intake information, internal investigation and progress notes submitted by Administration identify that on 3/10/18 at approximately 9:30 PM, Resident #1 was woken by roommate's bed alarm sounding. On entering the room, Licensed Nurse Aides (LNA) were approached by Resident #1, asking what was going on. "I want to be educated about this". LNA's informed the resident "we can't tell you anything, it's none of your business" and encouraged the resident to return to bed. The resident became upset/agitated and started to swing and hit at Employee #1. The employee	F 659	**F659 SS=D** **1 The LNA's that were involved with the self-reported incident with Resident #1 were educated on the importance of following the Care Plan and possible approaches in dealing with Residents with behavioral issues. Resident #3 is no longer in the facility.** **2 All Dementia or Cognitive Deficit Residents whose comprehensive Care Plan identifies behavioral problems have the potential to be affected by this alleged deficient practice** **The SSD and MDS will identify Residents with Dementia and/or Cognitive deficit disorder with behavioral problems for Care Plan review and comparison.** **3 The DON or designee will have the Nurse Educator as well as the Director of Activities, who is certified to provide Dementia and behavioral training, conduct scheduled, specifically designed modules and lunch-n-learns each month. This, as well as Staff education on the importance of following the Care Plan for behavioral issue, will be documented.**	**04-24-18**

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F 659 Continued From page 9

then gently placed her hands on the resident's wrists in an attempt to calm her and to prevent herself from being hit. The resident was directed back to bed.

Resident #1's comprehensive care plan identifies behavioral problems, refusal of care, has poor safety awareness, dementia with anxiety and paranoia. Initiative for the management of these concerns are identified to ensure resident safety, make sure call light is in reach and step away when the resident is agitated or refusing care.

Interviews with both LNA's on 3/28/18 at approximately 7 AM, confirm that the incident occurred as stated above. The LNA staff were able to demonstrate the manner in which the resident was touched. The intent of calming the resident, not intended to be restraining. Resident #1 was sitting on the edge of his/her low bed with soft mats on the floor (to protect from an injury if a fall occurs), but staff were concerned s/he could fall as a result of her agitation. Therefore, did not leave the room until s/he was back in bed. Both LNA's confirm the conversation that took place with Resident #1, during the incident and the manner in which they handled the situation most likely added to Resident #1's agitation. Care plan review with both LNA's confirmed that they did not follow the plan of care as directed.

2. Per record review for Resident #3, was admitted to the facility with diagnosis to include, but not limited to Paranoid Schizophrenia, Parkinson's Disease, Hallucinations and Benign Prosthetic Hyperplasia with lower urinary tract symptoms.

Per Licensing and Protection intake information,

F 659

The DON or designee, will audit the comparison of Dementia Residents with behaviors and compliance to the Residents Care Plans.

4 The DON or designee will audit the behavioral/Care Plans for accuracy of interventions weekly for 4 weeks and then monthly for 3 months. The results will be reported to the monthly QAPI Committee for review.

F659 POC accepted 4/26/18 MBertrand RN/PMM

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F 659	Continued From page 10	F 659		

internal investigation and progress notes submitted by Administration, identify that on 11/9/17 at approximately 6:36 AM, Resident #3 was unable to void. Nurses progress notes identify the resident was resistive to care and bladder scan. Bladder scanned at 6 AM identifies 502 cc's of urine in Resident #3's bladder.

Internal investigation documents identify that Administration interviewed the nurse who catheterized the resident and stated, "catheterization was necessary for s/he had more than 400 cc's of urine in the bladder". S/He also asked if the resident had said "No" to the procedure. The primary nurse responded that Resident #3 had said "No to the catheterization". The nurse responded, "The resident says no to everything. It is not unusual for him/her to say no. The resident was uncomfortable, and I was doing what the doctor ordered said to do."

Resident #3's comprehensive care plan identifies mood problems, delirium, cognitive impairment and refuses care and medications at times. Approaches to manage mood problems are identified to monitor behaviors, approach in a calm manner, minimize potential for disruptive behaviors and notify MD as needed. The indwelling Foley catheter had been discontinued and the plan was to monitor post void residual urine in his/her bladder every 6 hours to ensures adequate emptying of the bladder and avoid discomfort. Goal was to be remain free from catheter related trauma with the approach to minimize agitation/anxiety/fear/discomfort and maintain the highest level of dignity. Approach in a calm professional manner.

Both the Medical Director and the Advanced

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	475045	A. BUILDING ______ B. WING ______	C 03/28/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODRIDGE NURSING HOME	P.O. BOX 550 BARRE, VT 05641

(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 659	Continued From page 11 Practice Registered Nurse confirmed during the interview on 3/28/18, that the nurse had alternatives to the treatment as identified on the interdisciplinary care plan. Review of Resident #3's care plan with the Director of Nurses on 3/29/18 at approximately 10:15 AM, confirm that the interventions were not followed as directed on the care plan.	F 659		