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

January 10, 2019

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 **December 19, 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 12/19/2018

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, on-site investigation of 3 self reports and 1 complaint was conducted by the Division of Licensing and Protection on 12/19/2018. The following regulatory issues were identified:	F 000	**Complaint Survey F Tags** **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 557 SS=E	Respect, Dignity/Right to have Prsnl Property CFR(s): 483.10(e)(2) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(2) The right to retain and use personal possessions, including furnishings, and clothing, as space permits, unless to do so would infringe upon the rights or health and safety of other residents. This REQUIREMENT is not met as evidenced by: Based on medical record review, staff and resident interviews and observations, the facility failed to assure that 4 of 5 residents reviewed were treated with respect and dignity. (Resident # 1, 2, 3, and #4). The findings are detailed below: 1. Per medical record review, Resident # 1 was the victim of a verbally abusive event in November 2018 with a staff LNA (Licensed Nursing Assistant) that was witnessed by staff and another resident's family. Resident # 1 was told by an LNA that s/he was the "nastiest person I have ever met in my life." Resident # 1 remembered this episode the day after it happened and recalled being upset by the event when interviewed by facility staff a day later. This is confirmed by the facility internal investigation and during interview with unit staff on 12/19/2018.	F 557	**F557 SS=E** **1 The LNA involved with the verbally abusive reportable event with Resident #1 was terminated following the completed, substantiated investigation and was reported to the Board of Nursing. Resident #1 remains in the facility. He has had no further verbally abusive event(s) as validated by an SSD Interview and recorded in his record.**	**02-11-19**

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [signature] TITLE: Administrator (X6) DATE: 1/8/19

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 557	Continued From page 1 2. Per medical record review, Resident # 2 was the victim of a verbally and physically abusive event perpetrated by a traveling staff LPN (Licensed Practical Nurse) in October 2018. Resident # 2 was observed by staff being pushed down, back into his/her wheelchair, being "yelled at to stay put." Assessments and care planning are in place for this resident on how to redirect him/her when the need arises. That this event occurred is confirmed during interview with facility staff and further confirmed in the facility internal investigation. 3. Per record review, Resident #3 is alert and oriented, and was admitted to the rehab unit needing assistance from staff to go to the bathroom. On 12/9/18, the resident stated that they waited a "long time" for response to the call bell, and when the Licensed Nursing Assistant (LNA #1) came to the room they responded to the toileting request with the statement "I will see, it is really busy today". When LNA #1 did return to assist Resident #3, the resident reported that the aide slammed down the commode, acting angry and impatient, and did not speak at all to the resident. Resident #3 requested that LNA #1 not be assigned to their care anymore. Per interview on 12/19/18, Resident #3 stated that this LNA did not treat him/her with respect, and made them feel like they were an inconvenience, and that they were angry that the resident needed assistance. 4. Per record review, Resident #4 is alert and oriented, and admitted to the facility for rehab after surgery. The resident is dependent on staff for toileting and hygiene assistance. Resident #4 reported to the nurse that one of the Licensed	F 557	**The Traveler LPN involved in the verbally and physically abusive reportable event with Resident #2 following suspension and investigation was terminated with the Traveler Agency. Resident #2 remains within the facility. He has had no further reported physical or verbally abusive interaction with staff. The SSD interviewed his private caregiver of record and validated that he has no awareness of any verbal or physical abuse and recorded such in the resident's record..** **The LNA involved with the disrespectful attitude and lengthy response time that was a reportable event with Resident #3 was terminated after a completed, substantiated investigation and reported to the Board of Nursing. Resident #3 remains in the facility. He has had no further issues with staff attitudes and lack of respect shown to him as evidenced and validated by the SSD interview and documented in his record.** **The LNA involved in the rude, impatient and rough and disrespectful incident with Resident #4 was terminated following a complete, substantiated investigation and reported to the Board of Nursing. This was the same LNA that was identified with the reportable incident of Resident #3 above. Resident #4 remains in the facility and has had no further rough or disrespectful care or service as**	

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F 557	Continued From page 2 Nursing Assistants (LNA) had been rough during care on 12/9/18. The resident stated that the LNA #1 was impatient with the resident when they called for assistance after an incontinence episode, saying "I just did you", and then proceeding to abruptly rip off a brief which was painful to the groin area. Also during the mechanical lift transfer, the resident stated that the transfer pad was pressing on their surgical wound and was very painful. The resident asked the LNA to stop as it was painful, however the LNA ignored the request and continued with the transfer. The resident reported the concern to therapy, the nurse, and their family and requested to not have care provided by LNA #1 again. Per interview on 12/19/18, Resident #4 stated that they were not treated with dignity and respect by the LNA who was rude and rough with them, and that someone like that does not belong working with old people who need help. See also F0600.	F 557	**documented from an interview with the SSD. 2 Other Residents have the potential to be affected by any acts or approaches by staff that are verbally or physically abusive or may not treat residents with dignity and respect, however not by any of the staff referenced in this citation since they were terminated. The facility closely follows its Abuse policy as well as observes Residents rights particularly with dignity and respect to ensure all staff are aware that violations will not be tolerated. The facility strictly follows the mandated reporter notifications and procedures required by CMS and VT Agencies. 3 Education on Resident Rights with emphasis on Dignity and Respect as well as re-education of the Abuse Policy will be provided by the Grievance Official or designee at monthly All Staff meetings, change of shift huddles, roundtable or coffee clutch discussions which may also include residents and scheduled inservices. Additionally, this same presentation/education will occur at the next monthly Resident Council meeting. 4 All Staff documentation and attendance records will be provided by the Grievance Official, NHA or DON at the next monthly QA&A Committee meeting and continue for 3 months.**	
F 600 SS=E	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or	F 600		

F-557 POC accepted 1/10/19 G. Coleman RN/S. Berry, RN

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F 600	Continued From page 3 involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on medical record review, staff and resident interviews and observations, the facility failed to assure that 4 of 5 residents reviewed were free from verbal or physical abuse. (Resident # 1, # 2, # 3 and # 4). The findings are detailed below: 1. Per medical record review, Resident # 1 was the victim of a verbally abusive event in November 2018 with a staff LNA (Licensed Nursing Assistant) that was witnessed by staff and another resident's family. Resident # 1 was told by an LNA that s/he was the "nastiest person I have ever met in my life." Resident # 1 remembered this episode the day after it happened and recalled being upset by the event when interviewed by facility staff a day later. This is confirmed by the facility internal investigation and during interview with unit staff on 12/19/2018. 2. Per medical record review, Resident # 2 was the victim of a verbally and physically abusive event perpetrated by a traveling staff LPN (Licensed Practical Nurse) in October 2018. Resident # 2 was observed by staff being pushed down, back into his/her wheelchair, being "yelled at to stay put." Assessments and care planning are in place for this resident on how to redirect him/ her when the need arises. That this event occurred is confirmed during interview with facility staff and further confirmed in the facility internal investigation on 12/19/18. 3. Per record review, Resident #3 is alert and oriented, and was admitted to the rehab unit needing assistance from staff to go to the	F 600	**F600 SS=E** **1The LNA involved with the verbally abusive reportable event with Resident #1 was terminated following the completed, substantiated investigation and was reported to the Board of Nursing. Resident #1 remains in the facility. He has had no further verbally abusive event(s) as validated by an SSD interview and recorded in his record.** **The Traveler LPN involved in the verbally and physically abusive reportable event with Resident #2 following suspension and investigation was terminated with the Traveler Agency. Resident #2 remains within the facility. He has had no further physical or verbally abusive interaction with staff. The SSD interviewed his private caregiver of record and validated that he has no awareness of any verbal or physical abuse and recorded such in the resident's record.** **The LNA involved with the disrespectful attitude and lengthy response time that was a reportable event with Resident #3 was terminated after a completed, substantiated investigation and reported to the Board of Nursing. Resident #3 remains in the facility. He has had no further issues with staff attitudes and lack of respect shown to him as evidenced and validated by the SSD interview and documented in his record.**	**02-11-19**

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F 600	Continued From page 4 bathroom. On 12/9/18, the resident stated that they waited a "long time" for response to the call bell, and when the Licensed Nursing Assistant (LNA #1) came to the room they responded to the toileting request with the statement "I will see, it is really busy today". When LNA #1 did return to assist Resident #3, the resident reported that the aide slammed down the commode, acting angry and impatient, and did not speak at all to the resident. Resident #3 requested that LNA #1 not be assigned to their care anymore. 4. Per record review, Resident #4 is alert and oriented, and admitted to the facility for rehab after surgery. The resident is dependent on staff for toileting and hygiene assistance. Resident #4 reported to the nurse that one of the Licensed Nursing Assistants (LNA) had been rough during care on 12/9/18. The resident stated that the LNA #1 was impatient with the resident when they called for assistance after an incontinence episode, saying "I just did you", and then proceeding to abruptly rip off a brief which was painful to the groin area. Also during the mechanical lift transfer, the resident stated that the transfer pad was pressing on their surgical wound and was very painful. The resident asked the LNA to stop as it was painful, however the LNA ignored the request and continued with the transfer. The resident reported the concern to therapy, the nurse, and their family and requested to not have care provided by LNA #1 again. Per review of LNA #1's personnel file, there was evidence of past concerns with the LNA and an impatient manner when caring for residents. Per interview on 12/19/18, the DNS stated that there were concerns on the long term care unit where LNA #1 had worked, however the residents were	F 600	**The LNA involved in the rude, impatient and rough and disrespectful incident with Resident #4 was terminated following a complete, substantiated investigation and reported to the Board of Nursing. This was the same LNA that was identified with the reportable incident of Resident #3 above. Resident #4 remains in the facility and has had no further rough or disrespectful care or service as documented from an interview with the SSD.** **2 Other Residents have the potential to be affected by any acts or approaches by staff that are verbally or physically abusive or may not be treating residents with dignity and respect, however not by any of the staff referenced in this citation since they were terminated. The facility closely follows its Abuse policy as well as observes Residents rights particularly with dignity and respect to ensure all staff are aware that violations will not be tolerated. The facility strictly follows the mandated reporter notifications and procedures required by CMS and VT Agencies.** **3 Education on Resident Rights with emphasis on Dignity and Respect as well as re-education of the Abuse Policy will be provided by the Grievance Official or designee at monthly All Staff meetings, change of shift huddles,**	

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

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F 600	Continued From page 5 either cognitively unable to or were unwilling to say that they were not treated with respect by this LNA. There was enough concern that they transferred LNA #1 to the rehab unit where most residents are alert and oriented. Per interview on 12/19/18, the Social Services person confirmed that both complaints regarding LNA #1 were received the afternoon of 12/9/18. The LNA was sent home on 12/9/18, did not return to the facility, and later terminated after the facility investigation was completed.	F 600	**roundtable or coffee clutch discussions which may also include residents and scheduled inservices. Additionally, this same presentation/education will occur at the next monthly Resident Council meeting.** **4 All Staff documentation and attendance records will be provided by the Grievance Official, NHA or DON at the next monthly QA&A Committee meeting and continue for 3 months.** F-600 POC accepted 1/10/19 G. Coleman RN/S. Berry, RN	