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

June 5, 2019

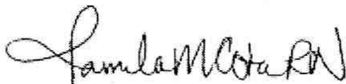
Mr. Allen Yearick, Administrator
Woodridge Nursing Home
P.O. Box 550
Barre, VT 05641-0550

Dear Mr. Yearick:

Enclosed is a copy of your acceptable plans of correction for the Federal portion of the Recertification survey and complaint investigation conducted on **May 15, 2019**. 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 05/15/2019

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
E 000	Initial Comments An unannounced emergency preparedness review was conducted on 5/13/19 - 5/15/2019 in conjunction with a recertification survey. There were no deficiencies identified in the emergency preparedness program.	E 000	**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 the2567 Statement of Deficiencies.**	
F 000	INITIAL COMMENTS An unannounced recertification survey and complaint investigation was conducted by the Division of Licensing & Protection on 5/13/19 - 5/15/2019. The findings for both the investigation and the recertification survey are as follows:	F 000	**This Plan of Correction is prepared solely as a matter of compliancewith Federal and State Agency's and Law.**	
F 623 SS=C	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the	F 623	**1.Each of the 4 residents (#'s 12, 17, 35 and 98) who were transferred to the hospital for acute conditions were treated and released back to Woodridge and 3 still remain in the facility. Resident #12 is deceased. However, these residents or resident representative had not received a written notice of transfer with complete information or content on the facility Notice of Transfer/Discharge form nor was the Ombudsman office notified per CFR(s) 48315(c)(3)-(6)(8).**	**06-20-19**

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [signature] TITLE: Administrator (X6) DATE: 6/3/19

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 623	Continued From page 1 resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and	F 623	**The facility immediately corrected the form to provide the appropriate information and the SSD met with or contacted each of the 3 residents or family to provide explanation of the form and it was entered into the medical record. A spreadsheet was created to document each facility-initiated transfer/discharge, including bed-holds, and this will be provided to the Ombudsman's Office monthly.** **2. Although other residents could have the potential to be affected by this deficiency, the new revised form has been implemented into use to notify residents or resident representatives and the ombudsman office. A spreadsheet was created to document each facility-initiated transfer/discharge, including bed-holds.** **3. The Care Management department staff, Business Office staff, Nursing and leadership were educated on the new Notice of**	

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F 623	Continued From page 2 telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to notify the resident and/or the resident's representative in writing, of a transfer/discharge for 4 applicable residents in a sample of 29, (Residents #12, 17, 35 and 98). The facility also failed to notify a representative of the Office of the	F 623	**Transfer/Discharge form and the policy and form will be presented at the next QA&A Committee meeting.** **4. The SSD or designee will conduct 100% audits of facility-initiated resident transfers/discharges to ensure compliance with using the new Transfer or Discharge form for the first month beginning June 1, 2019 and then random audits for the next two months. Documentation of these audits will be presented and reviewed accordingly at the monthly QA&A Committee meetings.** F623 PoC accepted 6/4/19 mBertrand RN/PMU	

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F 623	Continued From page 3	F 623		

State Long-Term Care Ombudsman as required. The findings include the following:

1. Per review of medical records, Resident #12, had been transferred to the hospital on 4/20/19 due to a Cerebral Vascular Accident (CVA). The resident returned to the facility on 4/23/19.. There is no evidence located in the medical record identifying that the family and /or representative was provided with a notification of transfer.

Per interview with the Social Service employees on 5/15/19 at approximately 8 AM, confirmation was made that s/he is unable to locate any documents related to transfer/discharge for Resident #12 that took place on 4/20/19. S/he also confirms that the office of the Long-Term Care Ombudsman was not notified of the transfer as required.

2. Per review of medical records, Resident #35 had been transferred to the hospital on 4/10/19, due to abdominal pain and a low-grade temperature. The resident returned to the facility on 4/15/19. There is no evidence located in the medical record identifying that the family and/or the representative was provided with a notification of transfer.

Per interview with the Social Service employees on 5/14/19 at 4:20 PM and again on 5/15/19 at approximately 8:00 AM, confirmation was made that s/he is unable to locate any documents related to transfer/discharge for Resident #35, that took place on 4/14/19. S/he also confirms that the office of the Long-Term Care Ombudsman was not notified of the transfer as required.

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F 623	Continued From page 4 3. Per record review and resident interview on 5/13/19, Resident #17 was hospitalized on 4/26/19. During interview on 5/13/19 at 7:58 AM, the administrator confirmed that the facility could not show evidence of issuing a properly formatted transfer notice at the time of or reasonably after the transfer. Neither did the facility provide evidence of ombudsman notification of the transfer to hospital. 4. Per record review, Resident #98 was transferred to the hospital with mental status changes on 4/8/19. There was no evidence that the resident or their legal representative was provided with a written notice of transfer, or that the office of the Long-Term Care Ombudsman was notified of the hospital transfer. Per interview on 5/15/19 at 9:15 AM, the Social Services representative confirmed they had not met this requirement.	F 623		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and	F 656	**1. The Care Plan for resident #225 was immediately corrected to reflect addressing the bacterial infection/precaution. This resident is no longer in the facility.** **2. Other residents have the potential to be affected by not having a comprehensive, person-centered Care plan, however the MDS Manager confirmed that all facility residents have Care Plans in place, including residents also identified with bacterial or other infections or precautions.**	**06-20-19**

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F 656	Continued From page 5 (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility failed to develop a plan of care for 1 of 29 applicable residents (Resident # 225). Findings include: Resident # 225 was admitted to the facility on 4/29/19 and currently has a bacterial infection requiring contact precautions. There is no evidence in the clinical record that a care plan has been developed to address Resident #225's needs related to the infection. On 5/15/19 at 11:16 AM, two unit nurses stated that there	F 656	**3. The MDS Manager and DNS held an educational meeting on May 23, 2019 with leadership to discuss all aspects of resident Care Plans, Care plan content, timely completion and accurate documentation. On May 29, 2019 Committee meeting reviewed and discussed the need for a Care Plan improvement project and identified IDT members to be involved with the ongoing focus on quality and completeness of Care Plans. The clinical portion of the Morning meeting will now identify at least weekly those residents with infections/precautions.** **4. Audits of resident Care Plans and infections or precautions will be conducted by the MDS Manager, or designee along with the DNS, and the Quality Improvement Consultant and Infection Preventionist on a monthly basis, and presented to the QA&A Committee meetings for three months.**	

F656 POC accepted 6/4/19 MBertrandRN/PMC

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

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F 656	Continued From page 6 should be a plan of care to address the infection and that there currently was not one.	F 656		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure that respiratory equipment was properly maintained for 3 applicable residents, (Residents #37, 45 and 107). The findings include the following: 1. Per observation on 5/13/19 at 10:00 AM, the filter on the oxygen concentrator in Resident #37's room was caked with dust; 2. Per observation on 5/13/19 at 10:10 AM, Resident #45 was found to have nebulizer equipment with the tubing, mask and medication chamber attached, stored on the top of the nebulizer that was resting on the bedside table, unprotected; 3. Per observation on 5/13/19 at 10:10 AM, Resident #107 was found to have nebulizer equipment, to include mouthpiece, and medication chamber attached and left unprotected on the windowsill with the mouthpiece resting against the window.	F 695	**1.a The Director of Support Services immediately changed the filter and cleaned the outside of the Oxygen Concentrator with Oxivir wipes per facility policy in the room for resident #37. The Vendor, Oxygen Solutions representative was contacted by the Administrator verifying their policy that their clerk checks and cleans the units on a weekly basis and provides the report to the Director of Hospital Services.** **b. Residents #45 and #107 immediately had both their nebulizers equipment properly bagged and dated per facility policy per the DNS.** **2. Other residents with Oxygen Concentrators in their rooms or who are on nebulizer treatments have the potential to be affected by this deficiency. The Director of Support Services inspected and cleaned the Oxygen concentrators for the other 5 units in use.**	**06-20-19**

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F 695	Continued From page 7 Confirmation was made by the Director of Nurses (DNS) on 5/13/19 at 10:30 AM, that the above identified items were stored improperly and not protected from contamination. The DNS also confirmed that facility policy was not followed.	F 695	**3.a The Oxygen Solutions Vendor representative will instruct all clerks performing checks on Oxygen Concentrators during their weekly visits to complete documentation and provide this to the Director of Support Services, or designee, on a weekly basis. The Director of Support Services has educated the EVS staff on May 20, 2019 to include Oxivir wipes cleaning of oxygen concentrators when they are cleaning rooms and reporting any concentrator issues to the Director of Support Services.** **b The Clinical Nurse Coordinators and Administrative Assistants on each Nursing Unit were educated again on following facility policy for nebulizers with weekly cleaning and properly bagging and labeling equipment when not in use.** **4.a The Director of Support Services, or designee will conduct a review of the weekly checks and**	

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F 695	Continued From page 7 Confirmation was made by the Director of Nurses (DNS) on 5/13/19 at 10:30 AM, that the above identified items were stored improperly and not protected from contamination. The DNS also confirmed that facility policy was not followed.	F 695	documentation performed by the Vendor to ensure the proper condition of Oxygen Concentrators in use. The Director, or designee will also inspect the Oxygen concentrators to ensure this matches the weekly documentation sheets and continue these audits for one month and then conduct random audits monthly for the next two months for accuracy and report these to the QA&A Committee meetings. b. Audits will be conducted by the Clinical Nurse Coordinators or their designee, on a monthly basis for compliance to the Nebulizer policy weekly for the first month and then monthly for the next two months. These audits will be reported to the monthly QA&A Committee meetings. F695 POC accepted 6/4/19 MBertrandRN/pmc	

Repeat

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HC 2 South, 280 State Drive
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Survey and Certification Voice/TTY (802) 241-0480
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To Report Adult Abuse: (800) 564-1612

June 5, 2019

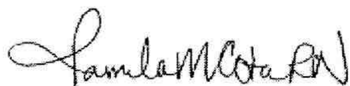
Mr. Allen Yearick, Administrator
Woodridge Nursing Home
P.O. Box 550
Barre, VT 05641-0550

Dear Mr. Yearick:

Enclosed is a copy of your acceptable plans of correction for the State portion of the Recertification survey conducted on **May 15, 2019.** 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

Division of Licensing and Protection

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S 000	Initial comments During the course of a recertification survey, completed by the Division of Licensing and Protection from 5/13/19-5/15/19, the following violation of the State of Vermont Licensing and Operating Rules for Nursing Homes was identified.	S 000		
S320 SS=F	7.13 (d)(1) QUALITY OF CARE - STAFFING LEVELS 7.13 (d)(1) The facility shall maintain staffing levels adequate to meet resident needs. 1. At a minimum, nursing homes must provide: i. no fewer than three (3) hours of direct care per resident per day, on a weekly average, including nursing care, personal care and restorative nursing care, but not including administration or supervision of staff; and ii. of the three hours of direct care, no fewer than two (2) hours per resident per day must be assigned to provide standard LNA care (such as personal care, assistance with ambulation, feeding, etc.) performed by LNAs or equivalent staff and not including meal preparation, physical therapy or the activities program. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to maintain staffing levels which provided two hours of direct care per resident per day by Licensed Nursing Assistants (LNA). Findings are as follows: Per record review of the daily nursing hours	S320	**1.The DNS in January 2019 identified staff inconsistences due to the large number of LNA call outs and FMLA's along with very few applicants to fill open LNA positions. This continued into February, however in March, the state LNA hr minimum of no fewer than (2) hours per resident per day of direct care was not met on several days as observed by the DNS. The Administrator, DNS and QIC immediately began discussions with HR and the CVMC Chief Nursing Officer (CNO) and HR VP regarding staffing and the**	**07-19-19**

Division of Licensing and Protection

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [signature] TITLE: Administrator (X6) DATE: 6-3-19

S320 POC accepted 6/4/19 MBertrand RN/PMC

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S320	Continued From page 1 provided to residents, the hours of direct care per resident per day by LNA staff fell below the required 2 hours per day minimum for multiple weeks in the months of March and April 2019. In the month of March, the weekly average of hours per resident per day were 1.8, 1.97, 1.85, and 1.81. The weekly averages in April totaled 1.79, 1.70, 1.81, and 1.87. Per interview on 5/15/19 at 10:40 AM, the Director of Nursing confirmed that the facility was not able to fill all of the LNA positions at the facility, and that the daily/weekly minimum staffing levels were not met for LNA direct care services.	S320	**need for a plan to correct; recognizing both the hospital and Woodridge were experiencing the nursing shortages growing in the region and State.** **2. Although residents have the potential to be affected by this staffing deficiency, no residents were harmed. Resident care and needs were ensured by re-assigning LNA's to direct care roles from Life Enrichment, Unit Assistants, Transportation and Scheduling as well as from Nursing, managers and the facility Leadership team and Census was held limiting admissions.** **3. The DNS initiated an attendance incentive program in February 2019 and reinforced the attendance policy to nursing staff. Resident care was ensured by re-assigning LNA's to direct care roles from Life**	

Division of Licensing and Protection

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	475045	A. BUILDING: ____ B. WING ____	05/15/2019

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