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

September 12, 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 investigation survey conducted on **August 14, 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

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

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 08/14/2019

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
F 000	INITIAL COMMENTS An unannounced onsite investigation of one facility-reported incident and one complaint was conducted by the Division of Licensing and Protection on 8/13- 8/14/19. The following federal regulatory deficiencies were identified. Findings include:	F 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. This Plan of Correction is prepared solely as a matter of compliance with Federal and State Agency's and Law.**	
F 622 SS=D	Transfer and Discharge Requirements CFR(s): 483.15(c)(1)(i)(ii)(2)(i)-(iii) §483.15(c) Transfer and discharge- §483.15(c)(1) Facility requirements- (i) The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless- (A) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility; (B) The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility; (C) The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident; (D) The health of individuals in the facility would otherwise be endangered; (E) The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. Nonpayment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid;	F 622	**F622 SS=D** **1. The Resident #1 identified and involved in the citation of deficiency is no longer in the facility.** **2. No other residents in the facility were affected by this deficiency although they could have the potential to be affected by this deficiency if not corrected by updating the facility Discharge/Transfer policy for compliance with CFR:483.15. No resident will be denied the right to return to the facility following hospitalization, or be otherwise involuntarily discharged, unless the requirements of CFR: 483.15, including proper documentation are followed.**	**09-13-19**

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [signature]
TITLE: NHA
(X6) DATE: 09-06-19

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.

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 08/14/2019

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
F 622	Continued From page 1 or (F) The facility ceases to operate. (ii) The facility may not transfer or discharge the resident while the appeal is pending, pursuant to § 431.230 of this chapter, when a resident exercises his or her right to appeal a transfer or discharge notice from the facility pursuant to § 431.220(a)(3) of this chapter, unless the failure to discharge or transfer would endanger the health or safety of the resident or other individuals in the facility. The facility must document the danger that failure to transfer or discharge would pose. §483.15(c)(2) Documentation. When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider. (i) Documentation in the resident's medical record must include: (A) The basis for the transfer per paragraph (c)(1)(i) of this section. (B) In the case of paragraph (c)(1)(i)(A) of this section, the specific resident need(s) that cannot be met, facility attempts to meet the resident needs, and the service available at the receiving facility to meet the need(s). (ii) The documentation required by paragraph (c)(2)(i) of this section must be made by- (A) The resident's physician when transfer or discharge is necessary under paragraph (c) (1)(A) or (B) of this section; and (B) A physician when transfer or discharge is necessary under paragraph (c)(1)(i)(C) or (D) of	F 622	**3. Educational in-services on involuntary discharge requirements per CFR: 483.15 will be provided to the Medical provider team, Care Management, and Nursing leadership. Additionally, the facility Transfer/Discharge policy has been updated to reflect the requirement for medical provider documentation. Resident records will be reviewed for compliance prior to a resident's involuntary discharge or transfer determination.** **4. Documentation of education will be provided to the next QA&A monthly committee meeting. The Committee will also review and approve the updated revision of the policy. The Administrator will be responsible for implementing the approved plan of correction or any further direction determined by the QA&A Committee.** F622 POC accepted 9/11/19 KCamposRN/PM	

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 08/14/2019

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

F 622 Continued From page 2 F 622

this section.
(iii) Information provided to the receiving provider must include a minimum of the following:
(A) Contact information of the practitioner responsible for the care of the resident.
(B) Resident representative information including contact information
(C) Advance Directive information
(D) All special instructions or precautions for ongoing care, as appropriate.
(E) Comprehensive care plan goals;
(F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care.
This REQUIREMENT is not met as evidenced by:
Based on record review and interviews, the facility failed to meet the regulatory requirements for an involuntary discharge of a resident regarding documentation of the specific resident need(s) that cannot be met, facility attempts to meet the resident needs, and the service available at the receiving facility to meet the need(s) for one resident sampled (Resident #1). Findings include:

Per record review, Resident #1 was admitted to the nursing home in December 2018, with diagnoses that included Congestive Heart Failure (CHF), Dementia with Behavioral Disturbance, Aphasia due to a stroke, and recurrent Urinary Tract Infections. The resident had behaviors since admission to the nursing home that included frequent yelling out that was difficult to redirect even after any anticipated needs were met. The resident was not able to communicate verbally to clearly state their needs. Resident #1

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 08/14/2019

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
F 622	Continued From page 3	F 622		

was transferred to an acute care hospital on 5/2/19 with exacerbation of CHF and Aspiration Pneumonia. Although the resident's CHF and Pneumonia were resolved by 5/6/19, the nursing home did not readmit the resident due to concerns about managing the behaviors, and asked for a Palliative Care consult. According to the notes by the Palliative Care MD, the family wanted the resident to return to the nursing home, and possibly with hospice.

According to the Discharge Explanation included with the 6/14/19 Notice of Transfer/Discharge sent to the legal representative, the nursing home refused to readmit the resident back to the facility, stating that the behaviors were disruptive to the unit where they had resided, that the resident's needs were not able to be met at the nursing home, and they did not have the staffing to provide one on one care for the resident. Per interview on 8/14/19 at 12:30 PM, the Administrator confirmed that he was the one who had written the Discharge Explanation of why they were refusing to readmit the resident. The facility did not issue a 30 day involuntary discharge notice prior to the May hospitalization despite the ongoing challenges caused by the disruptive behaviors.

In review of the medical record, there was no physician statement at the time of the 6/14/19 discharge notice documenting why the nursing home was not able to meet the resident's needs, or a recommendation for appropriate alternative placement. The resident was not accepted back to the facility, and had to remain at an acute care hospital for almost three months, although there was not a clinical need for them to remain there. The resident was issued an involuntary discharge

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 08/14/2019

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
F 622	Continued From page 4 notice on 6/14/19, and the family appealed the discharge on 6/27/19. The resident was not allowed to return to the nursing home before issuing a discharge notice, nor during the appeal process. Resident #1 was not discharged to another placement appropriate for them quickly, and ended up staying at the hospital until 7/24/19, when s/he was discharged to a residential care home.	F 622		
F 626 SS=G	Permitting Residents to Return to Facility CFR(s): 483.15(e)(1)(2) §483.15(e)(1) Permitting residents to return to facility. A facility must establish and follow a written policy on permitting residents to return to the facility after they are hospitalized or placed on therapeutic leave. The policy must provide for the following. (i) A resident, whose hospitalization or therapeutic leave exceeds the bed-hold period under the State plan, returns to the facility to their previous room if available or immediately upon the first availability of a bed in a semi-private room if the resident- (A) Requires the services provided by the facility; and (B) Is eligible for Medicare skilled nursing facility services or Medicaid nursing facility services. (ii) If the facility that determines that a resident who was transferred with an expectation of returning to the facility, cannot return to the facility, the facility must comply with the requirements of paragraph (c) as they apply to discharges. §483.15(e)(2) Readmission to a composite	F 626	**F626 SS=G** **1. The Resident #1 identified and involved in the citation of deficiency is no longer in the facility.** **2. No other residents in the facility were affected by this deficiency although they could have the potential to be affected by this deficiency if not corrected by updating the facility Discharge/Transfer policy for compliance with CFR:483.15. No resident will be denied the right to return to the facility following hospitalization, or be otherwise involuntarily discharged, unless the requirements of CFR: 483.15, including proper documentation are followed.**	**09-13-19**

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 08/14/2019

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
F 626	Continued From page 5 distinct part. When the facility to which a resident returns is a composite distinct part (as defined in § 483.5), the resident must be permitted to return to an available bed in the particular location of the composite distinct part in which he or she resided previously. If a bed is not available in that location at the time of return, the resident must be given the option to return to that location upon the first availability of a bed there. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to ensure that a resident was allowed to return to the facility following a hospitalization for 1 resident sampled (Resident #1). Findings include: Per record review, Resident #1 was admitted to the nursing home in December 2018, with diagnoses that included Congestive Heart Failure (CHF), Dementia with Behavioral Disturbance, Aphasia due to a stroke, and recurrent Urinary Tract Infections. The resident had behaviors since admission to the nursing home that included frequent yelling out that was difficult to redirect even after any anticipated needs were met. The resident was not able to communicate verbally to clearly state their needs. Resident #1 was transferred to an acute care hospital on 5/2/19 with exacerbation of CHF and Aspiration Pneumonia. Although the resident's CHF and Pneumonia were resolved by 5/6/19, the nursing home had concerns about managing the behaviors, and asked for a Palliative Care consult. The Palliative Care consult was conducted by the MD on 5/13/19, and documented that the consult intent was to identify goals of care, symptom management, and guide family in decision-making for the resident. This	F 626	**3. Educational in-services on involuntary discharge requirements per CFR: 483.15 will be provided to the Medical provider team, Care Management, and Nursing leadership. Additionally, the facility Transfer/Discharge policy has been updated to reflect the requirement for medical provider documentation. Resident records will be reviewed for compliance prior to a resident's involuntary discharge or transfer determination.** **4. Documentation of education will be provided to the next QA&A monthly committee meeting. The Committee will also review and approve the updated revision of the policy. The Administrator will be responsible for implementing the approved plan of correction or any further direction determined by the QA&A Committee** F626 POC accepted 9/11/19 KCampos RN/PM	

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 08/14/2019

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
F 626	Continued From page 6	F 626		

included multiple family members including the DPOA for health care for this resident.

According to the notes by the Palliative Care MD, the family wanted the resident to return to the nursing home, and possibly with hospice. A meeting was held by the Administration of the Nursing home, the MD of the resident, the Long Term care Ombudsman and the resident's family on 5/29/19 where a stipulation was made that the family would be required to sign a Memorandum of Agreement outlining the terms on which the nursing home would readmit the resident. The legal representative refused to sign the Memorandum as they felt it was taking away their right to be involved in decision making for the resident.

Per interview on 8/13/19 at 2:35 PM, the family legal representative for the resident stated that the resident had lost a lot of strength while in the hospital. They had been receiving Physical Therapy at the nursing home, and was able to ambulate with a walker from the unit to the dining room. By the time the resident left the hospital, they were not able to walk anymore. The family member stated that they were getting therapy again at the level 3 home, and they were hopeful that the resident would regain the ability to ambulate at the prior level of ability.

According to the Discharge Explanation included with the 6/14/19 Notice of Transfer/Discharge sent to the legal representative, the nursing home refused to readmit the resident back to the facility, stating that the behaviors were disruptive to the unit where they had resided, that the resident's needs were not able to be met at the nursing home, and they did not have the staffing to

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 08/14/2019

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
F 626	Continued From page 7	F 626		

provide one on one care for the resident. Per interview on 8/14/19 at 12:30 PM, the Administrator confirmed that he was the one who had written the Discharge Explanation of why they were refusing to readmit the resident. The facility did not issue a 30 day involuntary discharge notice prior to the May hospitalization despite the ongoing challenges caused by the disruptive behaviors.

In review of the medical record, there was no physician statement at the time of the 6/14/19 discharge notice documenting why the nursing home was not able to meet the resident's needs, or a recommendation for appropriate alternative placement. The resident was not accepted back to the facility, and had to remain at an acute care hospital for almost three months, although there was not a clinical need for them to remain there. The resident was issued an involuntary discharge notice on 6/14/19, and the family appealed the discharge on 6/27/19. The resident was not allowed to return to the nursing home before issuing a discharge notice, nor during the appeal process. Resident #1 was not discharged to another placement appropriate for them quickly, and ended up staying at the hospital until 7/24/19, when s/he was discharged to a residential care home.