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 Reporting Line (888) 700-5330
To Report Adult Abuse: (800) 564-1612

October 27, 2020

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

RE: Complaint Survey Findings - Past Non-Compliance

Dear Mr. Yearick:

On **October 13, 2020**, the Division of Licensing and Protection, completed a complaint investigation at Woodridge Nursing Home. As a result of that survey, the Division determined that at a point in time prior to the date of our visit you were not in substantial compliance with the federal regulations applicable to long term care facilities.

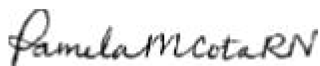
Statement of Deficiencies Form CMS 2567

Enclosed is a statement of deficiency generated as a result of the survey. All references to regulatory requirements in the enclosure and in this letter are found in Title 42, Code of Federal Regulations. As the cited deficiency was corrected at the time of our visit, **no plan of correction is required**. Please **sign page 1 and return a signed copy of the 2567 to this office.**

Informal Dispute Resolution

In accordance with §488.331, you have one opportunity to question cited deficiencies through an informal dispute process. To be given such an opportunity, you are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies to Suzanne Leavitt RN, MS, Assistant Division Director, Division of Licensing and Protection. **This written request must be received by this office by November 8, 2020.**

Sincerely,



Pamela M. Cota, RN
Licensing Chief
Enclosure

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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 10/13/2020

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 into a facility reported incident was conducted by the Division of Licensing and Protection on 10/13/2020. The following regulatory deficiency was identified, and is cited as past noncompliance due to the facility completing corrective actions prior to the onsite investigation.	F 000		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, inrterview, and record review, the facility failed to ensure that the environment was free of accident hazards for one applicable resident. Findings include: Per record review, Resident #1 was admitted to the facility in January 2020. The resident had diagnoses that included dementia with behavioral disturbances. Resident#1 had a pattern of exit-seeking behaviors, and made it clear that they wanmted to leave the facility. On 4/19/20, the resident attempted to exit the building through the window, and struggled with staff who attempted to stop the resident from exiting. The resident sustained a skin tear to the hand and possibly a bump to the head as they were going out of the window. Staff were able to stop the	F 689	Past noncompliance: no plan of correction required.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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 689	Continued From page 1 resident outside on the ground, but the resident refused to come back into the building. 911 was called, and the police and hospital security personnel were able to subdue the resident and transport them to the Emergency Dept. for evaluation. Per observation of the windows in resident rooms, they open sliding up and down, some with a second floor distance to the ground, some on ground level. Per interview on 10/13/2020, the Social Service Director stated that before this egress incident with Resident #1, none of the windows had a device attached to prevent them from opening all the way. The screens could be pushed out, and a resident would be able to climb out through the opening. The maintenance staff addressed the concern by attaching a metal stop on the window frame to only allow the windows to open partially and prevent any room for egress through that space. By 5/13/20, all windows in resident rooms had been fitted with a stop, with the exception of two rooms that already had screws in them to prevent opening, and the beauty parlor that was kept locked when not in use. This deficiency is being cited as past non-compliance due to the fact that the accident hazard has been addressed adequately. Steps taken: 1. The facilty first secured the windows in the room of Resident # 1. 2. Priority was given to the dementia unit and areas of the facility that had a higher risk of resident elopement. 3. All windows had a stop attached to them by 5/13/20.	F 689		

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F 689	Continued From page 2 4. Staff were made aware of the concern and asked to check the windows when in the resident rooms, and regular audits coducted to ensure that thewindows were secured throughout the facility.	F 689		