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

July 21, 2021

Mr. William Kowalewski, Administrator
Woodridge Nursing Home
142 Woodridge Drive
Barre, VT 05641-0550

Dear Mr. Kowalewski:

Enclosed is a copy of your acceptable plans of correction for the complaint investigation conducted on **June 24, 2021.** 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 06/24/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODRIDGE NURSING HOME	142 WOODRIDGE DRIVE 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 anonymous complaint was completed by the Division of Licensing and Protection from 6/22 through 6/24/21. The following regulatory deficiencies were identified:	F 000		
F 554 SS=E	Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7) §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and record review the facility failed to ensure that the interdisciplinary team has determined that 2 of 2 residents who self-administer medications have been identified as clinically appropriate to do so, for Resident #1 and #7. The findings include the following: 1. Per observation on 6/22/21 at approximately 10:30 AM, during a dressing change for Resident #1, two inhalers were resting at the bedside on top of the resident's, personal belongings. Per Physician orders identify the following: "Albuterol Sulfate HFA Aerosol Solution 2 puffs inhale orally every 4 hours as needed for SOB (shortness of breath)/wheezing start date of 1/11/21. Nicotrol Inhaler 1 puff inhale orally as needed for smoking cessation patient may have up to 2 new cartridges per day for use at the bedside with a start date of 1/8/21". Also, observed at the bedside as ordered by the physician were multiple bottles of "Calcium/Sodium/Magnesium/Green tea	F 554	1. A self-administration of medication assessment for Residents #1 was completed on June 23, 2021. Resident #1 was approved for medication self-administration. A self-medication assessment for Resident #7 will be conducted July 21, 2021. 2. One additional Residents has had a self-administration of medications assessment and is now approved to self-administer medications. 3. Upon admission, all Residents wishing to self-administer drugs will have a self-administration of medications assessment completed. When appropriate, self-administration of medications will be granted. Staff will be educated on the Woodridge Resident Self-Administration of Medications Assessment policy. 4. Self-administration assessments will be audited within twenty four hours of admission for all admissions for sixty days. Audit findings and evidence of medication self-administration education will be reported to the QAPI committee to ensure compliance. 5. Director of Nursing is the responsible party. Completion Date of July 30, 2021.	

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

William Kowalewski ADMINISTRATOR 7/20/21
Revised

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 554		F 554		
	Continued From page 1 supplement 800 mg give 2 tablets by mouth one time a day for supplement (KETO) patient own supply start date 1/23/21. Testovax 3 caps po daily OK to leave supplements in Resident's room for administration dated 5/18/21". Per interview with the Director of Nurses (DNS) on 6/23/21 at approximately 3 PM confirmation is made that there have not been any evaluations for Self-Administration of Medications since the resident was admitted on 1/8/21. Nor has the Interdisciplinary Team (IDT) determined that the resident is competent to self-administer medications. Per interview with the RN on 6/24/21 at approximately 11 AM confirmation is made that s/he does not check with the resident if he/she has taken medication as ordered but can identify if the capsule placed in the inhaler for administration has been used. 2. Per interview of Resident #7's medical record identifies a physician order as follows: "Calcium Carbonate Tablet 500 mg po as needed may keep at bedside with a start date of 6/5/21 and Sodium Chloride Solution 2 sprays in each nostril twice daily as needed may keep at the bedside with a start date of 6/4/21". Per interview with the Director of Nurses (DNS) on 6/23/21 at approximately 3 PM confirmation is made that there have not been any evaluations for Self-Administration of Medications since the resident was admitted on 8/26/19. Nor has the Interdisciplinary Team (IDT) determined that the resident is competent to self-administer medications.		**TAG F 554 POC approved 7/20/21 M. Bertrand/P.Cota**	

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F 554		F 554	
	Continued From page 2 Per interview with the RN (Registered Nurse) on 6/24/21 at approximately 11 AM confirmation is made that s/he does check with the resident to inquire whether meditations have been taken.		
F 658 SS=G	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and record review the facility failed to meet professional standards of practice regarding wound care for 5 of 9 applicable residents (Residents #1, #2, #4, #5, and #7). The findings include the following: 1. Per record review for Resident #1, the resident was admitted to the facility with chronic leg ulcers. Per observation on 6/22/21 at approximately 10:30 AM, the Licensed Practical Nurse (LPN) was to complete a dressing change to both legs. The LPN and the Registered Nurse (RN) nurse surveyor donned full PPE (gloves/gown/eye protection) and entered the resident's room. The resident's bed stored the necessary supplies required for the treatment. The room was observed as disorganized and cluttered with the breakfast tray present on the bedside table. The resident was recently found to have maggots in a wound. Personal belongings were identified on all surfaces to include the bed. The resident was sitting in a recliner next to the bed. A urinal was 3/4 full of urine that was resting on the window-sill next to the resident, along with bottles of	F 658	1. Residents #1, 2, 4, 5, & 7 have since received wound care and dressing changes according to the professional standards of practice for wound care. 2. All Residents have the potential to be affected by this deficient practice. No other Resident was identified as being affected by this deficient practice. 3. Education regarding wound care protocol including return demonstration meeting professional standards of practice will be provided to all licensed nurses. This education includes infection prevention precautions, wound care and dressing change standards of care. During orientation, new licensed nurse hires will be educated to the wound care standard of practice, including prevention precautions, wound care and dressing change standards of care. 4. Audits of all licensed staff providing wound care and dressing changes will be conducted as follows: daily for two weeks, then three times per week for two weeks and then once per week for another two weeks to ensure compliance with standards. Evidence of staff education and audits of wound care and dressing changes will be presented to the QAPI committee assure compliance. 5. Director of Nursing is the responsible party. Completion Date of July 30, 2021.

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F 658		F 658		
	Continued From page 3 over-the-counter supplements and inhalers. The following wound care was observed: -The resident's dressed feet with exposed toes were resting on the bare floor. The LPN asked the resident to raise his/her feet and covered the floor with a protective/disposable mat. -The LPN removed the old dressing on the left leg using scissors and placed the contaminated scissors on the bed. The old dressing was discarded in a disposable bag that was close to the nurse. -The LPN sanitized his/her hands and donned gloves, then began cleansing the wounds. The physician order states, "clean the wound gently wiping the wound beds to remove debris/dead tissue". The LPN saturated a stack of 2x2 gauze pads with the solution as ordered. The nurse proceeded to wipe down the wounds to the left leg using an up and down motion. After many sweeps of this action the top layer of 2x2's was discarded, and the cleansing motion continued utilizing clean gauze. S/He repeated the process until it was determined that the wound was cleaned to his/her satisfaction. The wound cleansing began at the knee and extended to the toes, including interior/posterior/lateral/medial surfaces. The area in between the resident's toes was not irrigated or cleaned. -The LPN then proceeded to apply Vaseline by massaging it onto the entire leg. The order identified that the "Vaseline is to be applied to the surrounding skin on the right and left legs including toes and feet". S/he placed his/her gloved fingers into the jar of Vaseline and removed the ointment and massaged the entire surface of the leg, from knees to tip of toes She massaged the Vaseline until the leg was completely covered. S/He then removed his/her			

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F 658		F 658		
	Continued From page 4 gloves performed hand hygiene, donned new gloves, and opened packages of dressing material that had been stored on the resident's bed. S/he opened boxes of supplies, adjusted dressings size by using the contaminated scissors and placed dressings on the Vaseline covered open wounds. -At the completion of the placement of the specific dressings the leg was wrapped with the materials as ordered. -The LPN then moved to the right leg and proceeded in the same manner. -The resident then rested his/her cleaned dressed feet onto the contaminated wet pad on the floor until both feet had been dressed. S/He then removed the contaminated pad, discarded it appropriately and placed the resident's feet directly on the bare floor. -The resident was observed throughout the day of 6/22/21 beginning on the 8:15 AM tour with his/her feet on the unprotected bare floor. -At one point during the dressing change the resident dropped his/her cell phone onto the floor and the LPN picked it up with his/her contaminated hands and handed the phone back to the resident and continued with the dressing change without changing gloves or sanitizing his/her hands. -Confirmation was made by the LPN on 6/22/21 at approximately 12:04 PM in the presence of the interim Staff Development Nurse that s/he did complete the dressing change per policy. -During observation of wound care by the wound care nurse on 6/24/21 at approximately 1:30 PM s/he confirms that the resident had been diagnosed with maggot infestation on 6/20/21. Per his/her assessment at this time the resident needs to have right foot irrigation to continue for 1			

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F 658		F 658		
	Continued From page 5 week. The Wound Care Nurse also confirms that the open wounds/lesions are not to be covered with Vaseline and if the nurse did apply the ointment to the entire leg including the wounds, then "that is a problem". The wounds were measured at this time and had not been measured since the specialist assessed the wounds on 6/10/21. The nurse also confirms that the wounds have worsened in some areas, documentation identifies the measurements s/he obtained and describes drainage and various other concerns. 2. Per record review, Resident #2 is identified on the facility Pressure Ulcer (PU) Log (push tool) with a stage 2 sacral PU measuring 2 centimeters (cm) x 0.75 cm. The resident's care plan and progress notes identify that s/he was admitted on 4/19/21 after a motor vehicle accident resulting in decreased mobility and unresolved anemia. An observation was conducted on 6/22/21 at approximately 3 PM in the presence of the Unit Manager (UM) and the Registered Nurse (RN) who conducted the wound treatment. The RN prepared the field for the dressing change, performed hand hygiene, donned gloves prior to beginning the dressing change, removed the old dressing and discarded the old dressing, discarded dirty gloves, and without sanitizing her hands, donned clean gloves and assessed the wound and applied a new dressing. The RN applied clean gloves, and without sanitizing her hands s/he measured and treated a new wound that was not previously present. Confirmation at the conclusion of the dressing change on 6/22/21 at 3 PM in the presence of the UM the RN did not wash/sanitize her hands in			

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F 658		F 658		
	Continued From page 6 between donning new clean gloves and accessing clean supplies. 3. Per observation on 6/23/21 at approximately 11:15 AM, while up in a wheelchair, Resident #5 was to have a dressing change prior to a Podiatry appointment. The RN proceeded with the dressing change by sanitizing his/her hands and donned gloves, removed the old dressing to the right great toe and proceeded to assess the wound. With the same gloves, the nurse continued to demonstrate the dryness of the skin on the toe and the foot. S/He passed his/her gloved thumb over the dry toe and the nail bed which is discolored. The RN then applied skin protectant and a protective dressing. The nurse removed his/her gloves and without sanitizing his/her hands, donned clean gloves and proceeds to remove the dressing on the left heel. The old dressing was discarded, and again, the RN brushed his/her fingers over the wound and the dry skin without sanitizing her hands or changing his/her gloves. S/He proceeds to apply the skin protectant and a protective dressing. S/He removes her gloves, and without sanitizing her hands dons new gloves, and applies the soft bootie. The nurse repositions Resident #5's feet in the wheelchair. At the conclusion of the treatment, the RN sanitizes his/her hands. The RN confirmed at 11:30 AM on 6/23/21 that s/he did not perform hand hygiene prior to the application of clean gloves and accessing clean supplies as identified on the Wound Care Policy listed below. 4. During observation of a dressing change on 6/23/2021 at approximately 2 PM for Resident #4,			

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F 658	Continued From page 7 the nurse failed to sanitize or wash hands between glove changes during the dressing change. 5. During observation of a dressing change on 6/24/2021 at approximately 11:30 AM for Resident # 7, the nurse failed to sanitize or wash their hands between glove changes during the dressing change. After the dressing, the nurse confirmed that she did not sanitize or wash hands between dressing changes. Per facility policy of Woodridge Wound Care states the following under section C: "Cleansing and Dressing of Skin Impairment(s) Wounds: 5. Perform hand hygiene and don gloves (PPE if required) prior to the beginning of dressing change. 6. Remove and discard old dressing. 7. Remove and discard dirty gloves. 8. Perform hand hygiene and don clean gloves prior to accessing clean supplies. 10. Perform wound treatment as ordered. 12. Discard wound supplies in trash receptacle. 13. Remove gloves and perform hand hygiene." Reference: Lippincott Manual of Nursing Practice (9th & 10th ed.). Wolters Kluwer Health/Lippincott Williams & Wilkins. See also F880 and F925.	F 658	**TAG F 658 POC approved 7/20/21 M. Bertrand/P.Cota**	
F 686 SS=G	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity	F 686		

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F 686	Continued From page 8 §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that(i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to ensure that necessary treatment and services are provided consistent with professional standards of practice to prevent pressure ulcers, for 1 of 7 applicable residents sampled, (Resident #1). The findings include the following: Per review of Resident #1's progress notes dated 6/20/21 the facility received report from RN (Registered Nurse) from the Medical Center Emergency Department (ED), that Resident #1, "also has an open area to right buttock near cleft center of right buttock measures 1 centimeter (cm) round, Mepilex dressing applied". The note was documented in the medical record by the LPN on duty at Woodridge. There is no further documentation in the medical record related to the pressure ulcer for the following four (4) days. On 6/24/21 at approximately 3 PM, the Wound Care Nurse (RN) evaluated, measured, treated,	F 686	1. Resident #1 wound was assessed and standard practice wound care provided per physician order by the wound care nurse on 06/24/21. 2. All current residents with newly identified pressure ulcers will be assessed to identify any risk that has not been previously addressed. If wound care intervention is required, the physician will be contacted and appropriate wound care will be provided. 3. Resident's wounds will be assessed upon admission, readmission, ED visit and weekly. If a wound care intervention is identified, the licensed nurse will implement the appropriate care per physician order. Staff will be educated on the skin care assessment policy, the rationale of the skin assessment tool, and the wound care policy. 4. Skin assessments will be audited weekly for six weeks. Results of the audits and evidence of the education will be presented to QAPI committee to ensure substantial compliance. 5. The Director of Nursing is responsible. Completion Date of July 30, 2021.	

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F 686	Continued From page 9 and applied a dressing to the now Stage 3 sacral pressure ulcer measuring 0.9 cm (centimeters) by 1 cm. This was confirmed by the wound care nurse. The facility confirms on 6/22/21 in approximately 11 AM, that the Unit Mangers utilize a Pressure Ulcer Quality Assurance form also known as a push tool, to manage/monitor the wounds on each unit. Resident #1 is not listed on the push tool identifying the new sacral wound. Per review of the Woodridge Wound Care Policy last reviewed on 7/28/20 identifies as follows: "A. Integumentary Assessment: #6 If an alteration in skin integrity is observed, the wound will be measured and documented in the Wound Progress Note. a.) The Medical Doctor/Nurse Practitioner must be notified of all existing or new pressure injuries. b.) Wound measurements will be obtained weekly thereafter to evaluate wound healing and response to implemented intervention. c.) A wound consult may be requested to assist with dressing recommendations."	F 686	**TAG F 686 POC approved 7/20/21 M. Bertrand/P.Cota**
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so.	F 842	1. The physician order documentation for resident #1 was updated and wound care provided by the wound care nurse on 06/24/2021 as per physician order. 2. All residents have the potential to be affected by this deficient practice. No other resident was identified to be affected by this deficient practice. 3. Discharge orders and progress notes on all residents returning from the ED will be reviewed daily in clinical huddle to ensure compliance with discharging physician orders. Licensed nurses will be educated to review all ED orders upon the resident's return to the SNF from the ED to assure compliance with following the physician's orders. 4. All discharge orders by the ED physician for residents returning to the SNF from the ED will be audited daily for two weeks, then three days week for two weeks and then once per week for two weeks to assure compliance. The results of the audits and evidence of the staff education will be presented to the QAPI committee.

			5. The Director of Nursing is the responsible person. Completion Date of July 30, 2021	

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F 842	Continued From page 10 §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented;(iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or	F 842	

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(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 842		F 842		
	Continued From page 11 (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and record review the facility failed to ensure that 1 of 9 sampled residents had documentation that includes sufficient and accurate information to provide necessary care to manage newly diagnosed infestation of maggots in chronic wounds for Resident #1. The findings include the following: Per review of the medical record, Resident #1 was sent to Emergency Department (ED) on 6/20/21 for an examination of the right foot. The nurse identified bugs between the toes on the resident's right foot. The resident returned to the facility on 6/20/21 at approximately 10:30 PM after being treated and diagnosed with right lower extremity infection/maggots. The ED discharge summary staff are directed as follows: "Special care for right lower extremity: On a daily basis the affected area MUST be irrigated initially with hydrogen peroxide followed by irrigation of Epsom Salts".			

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	475045	A. BUILDING _____ B. WING _____	C 06/24/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 842		F 842		
	Continued From page 12 On 6/21/21 at 10:30 AM signed physician orders direct staff to "Start daily right #5th toe irrigation with hydrogen peroxide. Then, irrigate with Epsom Salt/water 1:1". One hour later at 11:30 AM the physician orders are changed to "D/C Epsom salt/hydrogen peroxide irrigation. Urgent consult podiatry". The nursing staff are managing Resident #1's wound with orders that were followed prior to ED visit. Confirmation was made by the RN on 6/24/21 at 10:30 AM that the irrigation as described on the Discharge Summary from the hospital was not carried out after a discussion with the attending physician during his/her visit on 6/21/21. The discussion included the difficulty in managing the treatment, the size of the resident's feet and legs requiring an appropriately sized basin to fit the resident's extremities and the problem with dissolving the Epsom salts. Confirmation was made by the Registered Nurse (RN) at approximately 9 AM and the Attending physician on 6/24/21 at approximately10 AM that the discussion did take place on but made no conclusion as to what treatment should be ordered. The physician confirms that s/he identified the Epsom Salt/Hydrogen Peroxide as an "old treatment" and was not familiar with it. Therefore, referred the RN to consult with the wound care nurse for direction. Confirmation was made by the RN and the physician that there is no evidence in the medical record that the discussion took place. The resident did not receive any irrigation to the infested toes of the right foot until 6/24/21 at 1:30 PM when the wound care nurse carried out the		**TAG F 842 POC approved 7/20/21 M. Bertrand/P.Cota**	

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WOODRIDGE NURSING HOME	**142 WOODRIDGE DRIVE BARRE, VT 05641**

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F 842	Continued From page 13 treatment her/himself.	F 842	
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions	F 880	1. Residents #1, 2, 4, 5, & 7 have received professional standards of wound care and dressing changes. 2. All residents have the potential to be affected by this deficient practice. No other resident was identified as being affected by this deficient practice. 3. All licensed nurses will receive education on infection prevention and standards of practice for wound care and dressing changes. 4. Licensed nurses will be audited while providing wound care to assure compliance with the standards as follows: All licensed nurses will have three return observations. Then audits conducted on residents using the following schedule: daily audits for two weeks; then audits three days per week for two weeks; then audits once per week for two weeks. The results of the audits and evidence of the education will be presented to QAPI committee to ensure compliance. 5. Director of Nursing is the responsible person. Completion date is July 30, 2021.

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 06/24/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODRIDGE NURSING HOME	142 WOODRIDGE DRIVE BARRE, VT 05641

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F 880		F 880		
	Continued From page 14 to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and record review the facility failed to adhere to infection prevention and control program standards when providing wound care for 5 of 9 applicable residents (Residents #1, #2, #4, #5, and #7). The findings include the following: 1. Per record review for Resident #1, the resident		**TAG F 880 POC approved 7/20/21 M. Bertrand/P.Cota**	

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	475045	A. BUILDING _____ B. WING _____	C 06/24/2021

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WOODRIDGE NURSING HOME	**142 WOODRIDGE DRIVE BARRE, VT 05641**

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F 880		F 880		
	Continued From page 15 was admitted to the facility with chronic leg ulcers. Per observation on 6/22/21 at approximately 10:30 AM, the Licensed Practical Nurse (LPN) was to complete a dressing change to both legs. The LPN and the Registered Nurse (RN) nurse surveyor donned full PPE (gloves/gown/eye protection) and entered the resident's room. The the necessary supplies required for the treatment were on the resident's bed. The room was observed as disorganized and cluttered with the breakfast tray present on the bedside table. The resident was recently found to have maggots in a wound. Personal belongings were identified on all surfaces to include the bed. The resident was sitting in a recliner next to the bed. A urinal was 3/4 full of urine that was resting on the window-sill next to the resident, along with bottles of over-the-counter supplements and inhalers. The following wound care was observed: -The resident's dressed feet with exposed toes were resting on the bare floor. The LPN asked the resident to raise his/her feet and covered the floor with a protective/disposable mat. -The LPN removed the old dressing on the left leg using scissors and placed the contaminated scissors on the bed. The old dressing was discarded in a disposable bag that was close to the nurse. -The LPN sanitized his/her hands and donned gloves, then began cleansing the wounds. The physician order states, "clean the wound gently wiping the wound beds to remove debris/dead tissue". The LPN saturated a stack of 2x2 gauze pads with the solution as ordered. The nurse proceeded to wipe down the wounds to the left leg using an up and down motion. After many sweeps of this action the top layer of 2x2's was discarded, and the cleansing motion continued			

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	475045	A. BUILDING _____ B. WING _____	C 06/24/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODRIDGE NURSING HOME	142 WOODRIDGE DRIVE BARRE, VT 05641

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F 880		F 880		
	Continued From page 16 utilizing clean gauze. S/He repeated the process until it was determined that the wound was cleaned to his/her satisfaction. The wound cleansing began at the knee and extended to the toes, including interior/posterior/lateral/medial surfaces. The area in between the resident's toes was not irrigated or cleaned. -The LPN then proceeded to apply Vaseline by massaging it onto the entire leg. The order identified that the "Vaseline is to be applied to the surrounding skin on the right and left legs including toes and feet". S/he placed his/her gloved fingers into the jar of Vaseline and removed the ointment and massaged the entire surface of the leg, from knees to tip of toes She massaged the Vaseline until the leg was completely covered. S/He then removed his/her gloves performed hand hygiene, donned new gloves, and opened packages of dressing material that had been stored on the resident's bed. S/he opened boxes of supplies, adjusted dressings size by using the contaminated scissors and placed dressings on the Vaseline covered open wounds. -At the completion of the placement of the specific dressings the leg was wrapped with the materials as ordered. -The LPN then moved to the right leg and proceeded in the same manner. -The resident then rested his/her cleaned dressed feet onto the contaminated wet pad on the floor until both feet had been dressed. S/He then removed the contaminated pad, discarded it appropriately and placed the resident's feet directly on the bare floor. -The resident was observed throughout the day of 6/22/21 beginning on the 8:15 AM tour with his/her feet on the unprotected bare floor. -At one point during the dressing change the			

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	475045	A. BUILDING _____ B. WING _____	C 06/24/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODRIDGE NURSING HOME	142 WOODRIDGE DRIVE BARRE, VT 05641

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F 880		F 880		
	Continued From page 17 resident dropped his/her cell phone onto the floor and the LPN picked it up with his/her contaminated hands and handed the phone back to the resident and continued with the dressing change without changing gloves or sanitizing his/her hands. -Confirmation was made by the LPN on 6/22/21 at approximately 12:04 PM in the presence of the interim Staff Development Nurse that s/he did complete the dressing change per policy. -During observation of wound care by the wound care nurse on 6/24/21 at approximately 1:30 PM s/he confirms that the resident had been diagnosed with maggot infestation on 6/20/21. Per his/her assessment at this time the resident needs to have right foot irrigation to continue for 1 week. The Wound Care Nurse also confirms that the open wounds/lesions are not to be covered with Vaseline and if the nurse did apply the ointment to the entire leg including the wounds, then "that is a problem". The wounds were measured at this time and had not been measured since the specialist assessed the wounds on 6/10/21. The nurse also confirms that the wounds have worsened in some areas, documentation identifies the measurements s/he obtained and describes drainage and various other concerns. 2. Per record review, Resident #2 is identified on the facility Pressure Ulcer (PU) Log (push tool) with a stage 2 sacral PU measuring 2 centimeters (cm) x 0.75 cm. The resident's care plan and progress notes identify that s/he was admitted on 4/19/21 after a motor vehicle accident resulting in decreased mobility and unresolved anemia. An observation was conducted on 6/22/21 at			

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	475045	A. BUILDING _____ B. WING _____	C 06/24/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODRIDGE NURSING HOME	**142 WOODRIDGE DRIVE 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 880		F 880		
	Continued From page 18 approximately 3 PM in the presence of the Unit Manager (UM) and the Registered Nurse (RN) who conducted the wound treatment. The RN prepared the field for the dressing change, performed hand hygiene, donned gloves prior to beginning the dressing change, removed the old dressing and discarded the old dressing, discarded dirty gloves, and without sanitizing her hands, donned clean gloves and assessed the wound and applied a new dressing. The RN applied clean gloves, and without sanitizing her hands s/he measured and treated a new wound that was not previously present. Confirmation at the conclusion of the dressing change on 6/22/21 at 3 PM in the presence of the UM the RN did not wash/sanitize her hands in between donning new clean gloves and accessing clean supplies. 3. Per observation on 6/23/21 at approximately 11:15 AM, while up in a wheelchair, Resident #5 was to have a dressing change prior to a Podiatry appointment. The RN proceeded with the dressing change by sanitizing his/her hands and donned gloves, removed the old dressing to the right great toe and proceeded to assess the wound. With the same gloves, the nurse continued to demonstrate the dryness of the skin on the toe and the foot. S/He passed his/her gloved thumb over the dry toe and the nail bed which is discolored. The RN then applied skin protectant and a protective dressing. The nurse removed his/her gloves and without sanitizing his/her hands, donned clean gloves and proceeds to remove the dressing on the left heel. The old dressing was discarded, and again, the RN brushed his/her fingers over the wound and the dry skin without sanitizing her hands or changing			

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	475045	A. BUILDING _____ B. WING _____	C 06/24/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODRIDGE NURSING HOME	142 WOODRIDGE DRIVE 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 880		F 880		
	Continued From page 19 his/her gloves. S/He proceeds to apply the skin protectant and a protective dressing. S/He removes her gloves, and without sanitizing her hands dons new gloves, and applies the soft bootie. The nurse repositions Resident #5's feet in the wheelchair. At the conclusion of the treatment, the RN sanitizes his/her hands. The RN confirmed at 11:30 AM on 6/23/21 that s/he did not perform hand hygiene prior to the application of clean gloves and accessing clean supplies as identified on the Wound Care Policy listed below. 4. During observation of a dressing change on 6/23/2021 at approximately 2 PM for Resident #4, the nurse failed to sanitize or wash hands between glove changes during the dressing change. 5. During observation of a dressing change on 6/24/2021 at approximately 11:30 AM for Resident # 7, the nurse failed to sanitize or wash their hands between glove changes during the dressing change. After the dressing, the nurse confirmed that she did not sanitize or wash hands between dressing changes. Per facility policy of Woodridge Wound Care states the following under section C: "Cleansing and Dressing of Skin Impairment(s) Wounds: 5. Perform hand hygiene and don gloves (PPE if required) prior to the beginning of dressing change. 6. Remove and discard old dressing. 7. Remove and discard dirty gloves.			

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	475045	A. BUILDING _____ B. WING _____	C 06/24/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(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 880	Continued From page 20 8. Perform hand hygiene and don clean gloves prior to accessing clean supplies. 10. Perform wound treatment as ordered. 12. Discard wound supplies in trash receptacle. 13. Remove gloves and perform hand hygiene."	F 880	
F 925 SS=G	Maintains Effective Pest Control Program CFR(s): 483.90(i)(4) §483.90(i)(4) Maintain an effective pest control program so that the facility is free of pests and rodents. This REQUIREMENT is not met as evidenced by: Based on observation, administrative staff report reviews and staff interviews, the facility failed to maintain an effective pest control program ensuring that the facility is pest free, as evidenced by dead flies in overhead light fixtures on all three units, the dining room, and the dietary department. The facility also failed to ensure that 1 resident (Resident #9), with diagnosed maggots in his/her wound could not infest other residents. A second resident (#1) was diagnosed with infected maggots in his/her wounds 20 days later. The findings include the following: Per facility tour on 6/22/21 beginning at approximately 8:15 AM the surveyor observed evidence of dead flies in the plastic coverings of several overhead light fixtures in the following locations. Spruce Common Unit: Rm. #128- the light at the window area (facing the courtyard) fixture contains dead flies. Rm. #118- bathroom light found containing dead flies. Rm. #117- bathroom light found containing dead	F 925	1. a) All overhead light fixture lenses have been cleaned and cleared of any debris. b) The Woodridge Commercial Pest Management Maintenance agreement with the vendor has been revised to increase the frequency of monitoring and preventive services. c) Both Resident #1 and Resident #9 wounds are clear. 2. a) All other overhead light fixture lenses have been inspected and any evidence of debris has been removed and lens covers cleaned. b) The revised Woodridge Commercial Pest Management Maintenance vendor agreement applies to the entire building's interior and the exterior campus. c) All residents have the potential to be affected by this deficient practice. No other resident was similarly identified. 3. a) The contract with the pest control vendor has been revised as follows: i. Exterior pest control spraying will be increased to monthly for four months and then semi-annually. ii.Two Halo fly lights will be installed in the interior trash compactor room. Iii Twenty four Aura fly light traps will be installed throughout the facility and maintained monthly. iv. An air curtain will be purchased and installed at the rear loading dock double door. b) All overhead light fixture lenses will be inspected weekly for six weeks and then monthly thereafter for the presence of any evidence of debris. c) All window screens will be inspected weekly for six weeks and then monthly thereafter to confirm they are tightly in place. Additionally, immediately following window cleaning, all screens will be inspected to confirm proper reinstallation. 4. a) A random audit of light fixture lenses to confirm they are free of debris and a random audit of screen integrity and positioning will be conducted weekly for six weeks and then monthly subsequently.

			b) An overhead light fixture lens cleaning program will be launched effective August 1st 2021 requiring all overhead light lenses to be cleaned quarterly or more frequently as indicated. 5. a) Director of Support Services is the responsible person. Completion date of July 30, 2021 except number 3(a) and 3(b) above which is August 15, 2021.	

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 06/24/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODRIDGE NURSING HOME	142 WOODRIDGE DRIVE 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 925		F 925	
	Continued From page 21 flies. Rm. #131- dead flies in the fixture located by the window. Observation in the Main Dining room identifies some dead flies in the ceiling lights. Maple Grove Unit: Rms. #228, 226, 227 have dead flies in the light fixtures at the window. Rm. #227 dead flies in the bathroom also. Rm. #220 dead flies in the bathroom fixtures. Rms. #219, 212, 214 and 215 dead flies in the window fixtures. Evergreen Unit: Rm. #312-bathroom light fixture has dead flies. Tour of the Dietary Department identified the following and was confirmed by the manager Food Service Supervisor at approximately 10 AM: In the room where the cook stove, prep area and the serving line is located has 12 over head light fixtures. 6 of those 12 lights have visible dead flies. The light fixture above the prep area located by the walk-in freezer has the most dead flies. The clean dish room has 6 over head light fixtures and all 6 of them have visible dead flies. The dirty dish room has 5 over head light fixtures and 3 have visible dead flies present. Per interview with the Infection Preventionist on 6/22/21 at approximately 3:12 PM confirmation was made that on 5/29/21 maggots were identified in the wound of Resident #9. An e-mail was sent to administration by the Infection		**TAG F 925 POC approved 7/20/21 M. Bertrand/P.Cota**

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 06/24/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODRIDGE NURSING HOME	**142 WOODRIDGE DRIVE BARRE, VT 05641**

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F 925	Continued From page 22 Preventionist stating the following: ["What we need to figure out is how the flies were able to get into the building and able to infest [his/her] wound. [S/He] has been with us for many months, so we know [s/he] got them at Woodridge. I think we need to loop in the Environmental Service Director from the hospital and the nursing home. They may need to do an assessment or even bring in a pest control company to ensure we are preventing flies from entering the building. We need to assess are windows open, screens properly installed, do we need bug lights, etc... We need to be sure that we are controlling the pests to prevent this from happening to [him/her] again or someone else."] The Infection Preventionist also confirmed that on 6/7/21 Environmental Rounds were conducted with the Environmental Service Director from the hospital and the nursing home. During that tour, the group identified ["flies in lights in basement halls from the Environmental Director's office, out to the hall. Also flies in lights in medication room and in light in kitchen areas. There is storage under the sink in the kitchen/Rehab suite that should be removed/relocated. Electric room floor was full of dead flies. Should be cleaned and swept periodically."] The report was written identifies locations on Evergreen Unit and Spruce Unit. Per discussion with the Environmental Service Director, s/he confirmed that the facility does have a contract for pest control. During the pandemic when outside agencies were not allowed into the facility, the service only evaluated the outside of the building. The facility requested the contract agency to complete a chemical cleaning on Room #318 (Evergreen Unit) after	F 925		

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	475045	A. BUILDING _____ B. WING _____	C 06/24/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODRIDGE NURSING HOME	142 WOODRIDGE DRIVE 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 925	Continued From page 23 Resident #9 was diagnosed with an infestation of maggots in his/her wounds. Routine visits by the contracted service restarted on 6/2/21 and is scheduled for monthly visits that consist of outside building inspection and inside review along with discussion with the Environmental Service Director to discuss problems/concerns. Room #128 was thoroughly cleaned by the housekeeping department after the second infestation was identified for another resident, but was not chemically treated as Room #318 had been.	F 925		

Woodridge Nursing Home

Directed Plan of Correction

July 16, 2021

F880 - Education plan - Summary:

TAG F 880 POC approved 7/20/21 M. Bertrand/ P.Cota

In accord with the requested Directed Plan of Correction dated July 6, 2021, an Education Plan has been developed specific to F Tag 880 regarding Woodridge's failure to adhere to infection prevention and control program standards when providing wound care.

Below is a summary of that Education program:

1. Phase 1:
    a. The Education and Infection Prevention Departments have uploaded Cornerstone education modules for staff to complete regarding the standard of care for both proper hand hygiene and proper PPE usage (for all staff) and the standard of care for wound care (for licensed nurses). Each module contains an exam that includes an attestation statement.
    b. Department Heads and Nursing Leadership have been trained via a "train the trainer" session to instruct the standards of care and practice of #1(a) above to staff.
    c. Department Heads and Nursing Leadership have also been trained in the use of and the application of return demonstration and audits of their staffs regarding #1(a) above.

2. Phase 2:
    a. The identified managers will train each staff member and observe a return demonstration (x3) of each staff member, as applicable, for proper hand hygiene, wound care and PPE.

3. Phase 3:
    a. Random audits for all staff as follows:
        i. All staff will be audited on proper hand hygiene and proper PPE donning & doffing.
        ii. All LPN/RN"s and Providers will be audited on proper standards of practice for wound care.

4. Phase 4:
    a. All new hires entering into Woodridge will be educated on proper hand hygiene, proper donning & doffing of PPE, and proper standards of practice of wound care as appropriate.
    b. Initial audits will be done prior to initiating their assignment.
    c. Once on their assignment, preceptor will audit new hire and send completed paperwork to the Staff Educator, the Clinical Nurse Coordinator, and the Director of Clinical Nursing Services.
    d. Annual staff skill validation will include proper hand hygiene, proper donning and doffing and standards of care practice in wound care.

Woodridge Nursing Home

Directed Plan of Correction

July 16, 2021

F880 – Root Cause Analysis - Summary:

In accord with the requested Directed Plan of Correction dated July 6, 2021, a Root Cause Analysis has been conducted specific to F Tag 880 regarding Woodridge's failure to adhere to infection prevention and control program standards when providing wound care for five of nine applicable residents.

Below is a summary of that Root Cause Analysis:

1) RCA Team Leader:
   a) Kathleen Craig, RN Manager

2) RCA Members
   a. Debbie Reynolds, RN: Director of Clinical Nursing Services
   b. Karen Dwire, RN: Clinical Nurse Coordinator
   c. Kaitlin Cochran, RN: Staff Nurse
   d. Katie Mills, RN: Staff Nurse
   e. Carole-Ann Lequin, RN: Staff Nurse
   f. Kayla Lozier, RN: Clinical Nurse Coordinator
   g. Katie Bittner, RN: Clinical Nurse Coordinator
   h. Melodie Kuban, LPN: Staff Nurse

3) Identified Factors:
   a) Infection prevention and control program standards were not consistently followed.
   b) Proper hand hygiene and PPE standards were not consistently followed.
   c) Proper wound care protocols were not consistently followed.
   d) Proper sequencing of wound dressing changes were not consistently followed.
   e) Staff did not follow the Infection prevention and control education previously received.
   f) Nursing staff were not consistently assessed in nursing practice related to wound care.
   g) Communication was not clear regarding a physician's order.
   h) Staff allowed a resident's preferences to override infection prevention and control standards.
   i) Continuous and annual skill assessments of proper hand hygiene, PPE donning and doffing and the practice of wound care according to the standards of wound care practice were inconsistent.

4) Over Arching Root Cause Identified:
   a. Failure to follow infection prevention and control standards in the delivery of wound care and wound care dressing changes, to include proper hand hygiene and proper PPE usage.

Woodridge Nursing Home

Directed Plan of Correction

July 16, 2021

F880 – Root Cause Analysis – Summary (continued) :

5) Actions Taken:
    a. Infection prevention and control education for all staff was launched with required return demonstration including hand hygiene and proper PPE usage.
    b. Wound care and dressing change standards of care education was launched with return demonstration for all licensed nurses.
    c. Skills assessment and validation of the adherence to infection prevention and control standards launched for new employees.
    d. Skills assessment and validation of adherence to infection prevention and control standards for current staff reinforced.
    e. Ongoing adherence to infection prevention and control standards audits conducted in accord with the DPOC Education plan.
    f. Adherence to the infection prevention and control audit timeline as contained in the Woodridge Plan of Correction

THE
University of Vermont
HEALTH NETWORK

Central Vermont Medical Center

Pamela M. Cota, RN
Licensing Chief
Division of Licensing and Protection
State of Vermont
HC 2 South, 280 State Drive
Waterbury, VT 05671-2060
July 19, 2021
UPDATED

Provider ID#: 475045

Dear Pamela Cota:

I write in response to your letter of July 6, 2021, regarding the complaint investigation at Woodridge Nursing Home held June 24, 2021. Attached is the Form CMS 2567 with the Woodridge Plan of Correction added in the appropriate column, a Summary of the DPOC required Education plan and a summary of the DPOC required Root Cause Analysis.

The filing of this Plan of Correction to the cited deficiencies does not constitute an admission that the deficiencies alleged did in fact exist. These Plans of Correction constitute Woodridge Nursing Home's written commitment of substantial compliance.

Woodridge Nursing Home continues to enjoy our partnership with your Division in the spirit of providing high quality of care and quality of life for the Residents we serve together.

Thank you for approving the extension for our reply to Tuesday, July 20, 2021.
If you have any additional questions or requests, please do not hesitate to contact me.

Sincerely,

William Kowalewski
Administrator