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
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November 1, 2022

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 survey conducted on **September 28, 2022.** 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

Pamela M. Cota, RN
Licensing Chief

YouTo Report Adult Abuse: (800) 564-1612

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 _____	09/28/2022

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
E 000	Initial Comments The Division of Licensing and Protection conducted an unannounced onsite Emergency Preparedness survey 9/28/2022. The facility was found to be in substantial compliance with Emergency Preparedness planning.	E 000		
F 000	INITIAL COMMENTS The Division of Licensing and Protection conducted an unannounced onsite recertification survey from 9/26 through 9/28/2022. The following regulatory violations were identified:	F 000		
F 697 SS=D	Pain Management CFR(s): 483.25(k) §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to ensure pain management was provided for 1 of 5 residents sampled. Findings include: Per record review, staff failed to ensure adequate pain control and administer pain medications per provider orders for resident #64. The resident stated he/she has constant pain in his/her arm from a fall he/she took. Per record review, resident #64 fell in July 2022 and sustained fractures of the right proximal humerus and pelvis. Review of the MAR	F 697	1) Resident #64 was reassessed for pain and appropriate interventions were implemented based on the reported pain. 2) All Residents have the potential to be affected by this practice. The interdisciplinary team reviewed the MDS Section J for all Residents identified as being at risk for pain. Pain assessments are complete and interventions currently in place were verified to be appropriate. 3) The "Pain Assessment and Management" policy was implemented to delineate pain assessment procedures and the associated interventions when a resident reports pain. Education regarding the "Pain Assessment and Management" policy, and specifically implementing interventions in accordance with	

provider order when a resident reports pain, was provided to all nursing staff as appropriate to their role through a combination of electronic communications, individual discussion, and unit-based huddles. Overview of the facility's "Pain Assessment and Management" policy has been incorporated into the New Nurse Orientation for all new nurses as applicable to their role.

4) The Director of Nursing or designee will complete pain assessment audits to assess implemented pain interventions in accordance with provider orders for all residents with a score of 4-10 on the pain scale. Audits will be completed weekly for four weeks, and then bi-weekly for 4 weeks, and then monthly for one month, for a total of 12 weeks of audits, assuring sustained compliance throughout. Frequency of audits will be re-evaluated by Leadership based on sustained compliance. Performance data will be presented to and reviewed by the Quality Assurance and Accountability (QAA- QAPI) Committee. The audit plan and results will be shared with the Resident Council.
5) All actions will be completed by 11/08/2022.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
William Tatum	Administrator	10/28/22

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 697		F 697		

Continued From page 1

(medication administration record) from September 1-September 27 shows the resident's pain level is recorded twice daily per order, once during the 7AM-7PM shift and again between 7PM and 7AM. During the 26 days reviewed, on 21 occasions Resident #64 reported his/her pain level as greater than 5, with 6 of those recorded pain levels rated as 10 (pain scale 1-10 with 10 being the worst pain imaginable). Resident #64's care plan includes the problem of pain, noting pain escalation 7/29/2022 following right proximal humerus and pelvic fracture with interventions to include provide pain medications as ordered and document effectiveness. Review of providers orders include the following scheduled pain medications: meloxicam tablet 7.5 MG (milligrams) , give 7.5 mg by mouth one time a day for pain, acetaminophen tablet, give 1000 mg by mouth three times a day for pain, diclofenac sodium gel 1 %, apply to right shoulder topically two times a day for pain. Additionally, the following pain medications were ordered to be provided as needed for pain not controlled by the scheduled medications: acetaminophen 500 mg every 12 hours as needed for mild pain/fever and tramadol HCl tablet 50 mg, give 50 mg by mouth every 6 hours as needed for moderate to severe pain. The MAR was reviewed and revealed that resident #64 did not receive any additional pain medication during the time between September 1-27.

On September 28, 2022 at 8:30 AM, a nurse practitioner providing care for resident #64 stated moderate to severe pain is considered between 5-7, severe 7-10. He/she confirmed he/she would expect a resident would receive additional

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F 697	Continued From page 2 medication based on the reported pain levels and that per the record it had not been provided as ordered for Resident #64.	F 697	**Tag F697 POC Accepted on 11/01/2022 by L.Lovell/ P.Cota**	

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 staff interview and record review the facility failed to maintain required minimum staffing levels to allow for 2.0 hours of direct care per resident per day (PPD) by Licensed Nursing Assistants (LNAs). Findings include: Per review of the daily nursing PPD hours, the average direct care PPD by LNA staff was below the required 2 hours per day minimum during the following weeks in June and July of 2022: 6/8 -6/14/22 PPD = 1.94 6/15 - 6/21/22 PPD = 1.75 6/22- 6/28/22 PPD = 1.97 6/29 - 7/5/22 PPD = 1.91 7/6 - 7/12/22 PPD = 1.85	S320	1) LNA staffing patterns have been reviewed to assure that the weekly average HPPD for LNAs is not allowed to fall below an HPPD of 2.00. All hours of all LNA staff performing care are being recorded in the daily LNA HPPD totals. Daily admission decisions are made while evaluating that same day's HPPD staffing totals and that day's discharges. 2) All Residents have the potential to be affected by the same deficient practice. This deficient practice has been eliminated by assuring that the daily LNA HPPD (calculated as a weekly average) not be allowed to be lower than 2.00. If and when necessary, Admissions will be frozen to accomplish that result. 3) Systemically, Woodridge will either (1) add LNA hours to each day's planned HPPD totals so as to achieve an LNA HPPD of 2.00 or higher OR (2) freeze admissions so as to prevent the LNA HPPD from falling below 2.00. All LNA hours accumulated in the course of providing Resident care from all sources will be incorporated into the LNA HPPD so as to prevent the LNA HPPD from dropping below 2.00 HPPD and prevent LNA HPPD hours from not being added to the HPPD totals. 4) The daily HPPD/Census data will be audited by the Administrator or designee daily, and frequency of audits will be re-evaluated by Leadership based on sustained performance. The results of the audits will be presented at the QAPI (QAA) meeting. 5) 11/08/22 completion date.	

Division of Licensing and Protection
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S320	Continued From page 1 During interview on 9/28/2022 at approximately 1:15PM the staff scheduler provided additional documentation of hours worked between June and July that had not been included in the initial daily nursing hours provided. The additional information was calculated with the scheduler and did reflect a higher PPD however, the PPD remained under the required 2.0 hours. The staff scheduler confirmed that the direct care PPD was less than the requirement even with the additional hours provided.	S320	**Tag S320 POC Accepted on 11/1/2022 by L.Lovell/P.Cota**	