

Division of Licensing and Protection

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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

October 6, 2016

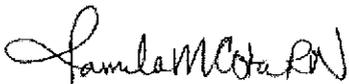
Mr. Richard Morley, Administrator
Woodridge Nursing Home
P.O. Box 550
Barre, VT 05641-0550

Dear Mr. Morley:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **August 22, 2016**. 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: 475045	(X2) MULTIPLE CONSTRUCTION A. BUILDING----- B. WING	(X3) DATE SURVEY COMPLETED C 08/22/2016
NAME OF PROVIDER OR SUPPLIER WOODRIDGE NURSING HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 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)

F 000 INITIAL COMMENTS

F 000-

An unannounced on-site investigation of two self reports was conducted by the Division of Licensing and Protection on 8/22/16. The following are regulatory findings as the result.

F 250 1483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE

F 250

The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.

Resident #1 was admitted on 06/24/16 with multiple diagnoses to include Depression, Anxiety and Cognitive deficits.

In response to the findings, "the facility must provide medically-related social services to attain or maintain the highest practicable physical, mental and psychosocial well-being of reach resident".

This REQUIREMENT is not met as evidenced by:

Since the day of the focus survey, Resident #1 has been seen by Social Services twice on August 22, 2016 and multiple times since then.

Based on staff interview and record review, the facility failed to provide medically-related social services to services to attain or maintain the highest practicable physical, mental, and/or psychosocial well-being for 1 of 4 residents in the sample (Resident #1). Findings include the following:

Since the focus survey, the facility screened for any additional residents who had a potential for self-harm; no residents were identified. Immediate steps were taken by DON, Social Services and Woodridge Leadership team to communicate any psychosocial concerns at the daily clinical care morning meeting. A system for communication to Social Services has been established via multiple means such as email, telephone call or pager.

Resident #1 was admitted on 06/24/16 with diagnoses to include Major Depression, Anxiety, and Cognitive deficits following a cerebral infarction. Per medical record review, a Nursing Note dated 08/13/2016 states that the evening LNA (licensed nursing assistant) reported to the nurse that Resident #1 began to discuss the events of 08/06/16, and stated "I had a hell of a week I was pinned down". The LNA also reported the resident was observed to be weepy and stated "I wish I was dead". The notes further stated that a message would be left for social services related to above statement. There is no

Employee involved was counseled on proper procedure for potential for self-harm on 8/23/2016. DON developed a suicide threat and precautions policy and procedure and implemented on 8/28/2016. Ongoing education regarding potential for self-harm and new policy and procedure has been put into effect as of 8/28/2016. Facility-wide education on new policy is ongoing and the goal is to have 85% completion of all full-time and part-time employees by 9/22/2016.

(continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE
Tuona Hunt TITLE
AVPLAIT (X5) DATE
9/15/2016

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.

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

PRINTED: 08/31/2016
FORM APPROVED
OMS NO 0938-0391

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F 250 Continued From page 1
evidence that social services was notified nor was an evaluation completed with Resident #1 regarding the above concerns.

Per interview on 08/22/16 at 12:10 P.M., Social Services (S.S.) stated that no message was received and was not aware of the resident's statements. The S.S. further stated staff are able to email, call or page social services or the nursing supervisor. Per interview with the ADNS [assistant director of nursing services] at 1:19 P.M. acknowledged the nurse can evaluate and address whether "the statement was just a frustrated comment or a real issue". The ADNS confirmed there was no evidence that the facility met the psychosocial well being regarding statements of Resident #1.

F 387 483.40(c)(1)-(2) FREQUENCY & TIMELINESS SS=D OF PHYSICIAN VISIT

The resident must be seen by a physician at least once every 30 days for the first 90 days after admission, and at least once every 60 days thereafter.

A physician visit is considered timely if it occurs not later than 10 days after the date the visit was required.

This REQUIREMENT is not met as evidenced by:

Based on record review and interview the physician failed to make a timely visit for 1 of 4 resident's in the sample (Resident #1) Findings include:

1. Resident #1 was admitted on 06/24/16 with

F 250
In addition, the DON or designee will perform 100% audits on those residents who trigger "YES" on Section D on the MDS or verbalizes potential self-harm. The data from these audits will be brought to the QAPI meetings for six months or until the committee determines resolution.

The Administrator is ultimately responsible to ensure that medically related social services are being maintained.

This deficiency has been corrected as of September 13, 2016.

F250 POC accepted 10/6/16 SEMMONS RN

F 387
Resident #1 was seen by her MD on 08/18/2016.

In response to the deficiency noted: "The resident must be seen by a physician at least once every 30 days for the first 90 days after admission, and at least every 60 days thereafter. A physician visit is considered timely if it occurs not later than 10 days after the date the visit was required".

All residents have the potential to be affected by the deficient practice. An internal audit of all current resident records was conducted by the business office staff at the DON's request to identify base-line compliance.

The Administrator and CMO have communicated the physician visit requirements to physicians during a Medical Management Committee meeting on August 11, 2016. (continued on next page)

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F 387 Continued From page 2
multiple chronic medical diagnoses. The initial physician visit was made on 08/18/16, greater than 30 days after admission.

F 387 The facility has implemented a system change. The Woodridge office staff will be responsible going forward for tracking MD visits on a bi-weekly basis. The office staff will directly communicate with the Practice Managers regarding the schedule for required physician visits. The providers identified will be contacted directly by their Practice Managers.

The findings will be communicated to the Administrator and reported out quarterly to the QAPI Committee.

Performance will be monitored by the chair of the Medical Management Committee. Ongoing monitoring will be evaluated based on performance.

This deficiency has been corrected as of September 13, 2016.

F387 POC accepted 10/16/16 Stammers/KH/AMC