

Division of Licensing and Protection
103 South Main Street, Ladd Hall
Waterbury, VT 05671-2306
<http://www.dail.vermont.gov>
Voice/TTY (802) 871-3317
To Report Adult Abuse: (800) 564-1612
Fax (802) 871-3318

November 30, 2012

Mrs. Maureen Bertrand,
Woodridge Nursing Home
P.O. Box 550
Barre, VT 05641

Dear Mrs. Bertrand:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **October 31, 2012**. 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

PC:jl



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

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Division of
NOV 27 12
PRINTED: 11/19/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 475045	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ Licensing and Protection	(X3) DATE SURVEY COMPLETED C 10/31/2012
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NAME OF PROVIDER OR SUPPLIER WOODRIDGE NURSING HOME	STREET ADDRESS, CITY, STATE, ZIP CODE P.O. BOX 550 BARRE, VT 05641
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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
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F 000	<p>INITIAL COMMENTS</p> <p>An unannounced on-site complaint investigation was conducted on 10/31/12 by the Division of Licensing and Protection. The following are regulatory findings.</p> <p>F 225 SS=D 483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS</p> <p>The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.</p> <p>The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.</p> <p>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance.</p>	F 000	<p>Please note that Woodridge Nursing Home has achieved compliance with all the requirements of the completion date specified in the plan of correction on the deficiency statement. The nursing home requests that this plan of correction serves as its allegation of compliance with all requirements. Please note that the filing of this plan of correction does not constitute any admission as to any of the alleged violations set forth in this statement of deficiency. The plan of correction is being filed as evidence of the home's continued compliance with all applicable laws.</p> <p>F225 Resident #1 no longer resides in the facility and did not experience any negative outcomes as a result of the alleged deficient practice. Physician and family were notified of the bruising on 10/31/12. An investigation was completed by the Unit Manager on 10/31/12.</p> <p><u>Corrective Action:</u> All residents are at risk.</p> <p><u>Systemic Changes:</u> Staff have been reeducated regarding abuse, mistreatment, neglect, misappropriation of resident property and reporting of alleged violations. Staff have also been reeducated regarding reporting injuries of unknown source immediately to the Administrator or designee. Administrator or designee will report injuries of unknown source, allegations of abuse in accordance with the state law through established procedures.</p> <p><u>Monitoring:</u> Random audits will be done monthly for three months and reported to the Quality Assurance Committee. DNS to monitor.</p> <p><u>Completion date:</u> 11/30/12 Doc accepted 11/29/12 Susan J. Emmons RN</p>	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE Administrator / V.P. Support Services	(X8) DATE 11/26/12
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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 225	Continued From page 1 with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, staff failed to report injuries of unknown source immediately to the administrator of the facility and to other officials in accordance with State law through established procedures for 1 applicable resident. (Resident #1) Findings include: Per record review and confirmed by interview on 10/31/12, Resident #1 sustained bruising to both thighs and staff failed to report this to the administrator. The nursing progress note of 9/30/12 at 10:48 A.M. states "LNA [Licensed Nursing Assistant] noted 2 bruises to left inner thigh, 1 measuring 5 cm in diameter and the other approximately 1.5 cm in diameter, both deep purple in color, resident does not recall how [s/he] obtained them". In addition, there is no documentation that the physician nor family were notified. Per interview at 1:15 P.M. the Administrator stated that an incident report would be sent to Quality Assurance and the incident would be reviewed during morning meeting and then investigated by the Unit manager. The Administrator confirmed at that the bruises were not reported or investigated.	F 225			
F 282 SS-D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility	F 282			

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F 282	<p>Continued From page 2</p> <p>must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to assure that services were provided in accordance with the resident's plan of care for 1 applicable resident regarding documentation of skin checks and administration of medication. (Resident #1) Findings include:</p> <p>1. Per record review and staff interviews, Resident #1 was care planned to have weekly skin checks by the nurse which is to be documented in the nursing note, to receive medications for constipation, as well as for staff to monitor and document bowel movements.</p> <p>a. Per review of the nursing progress notes and MAR/TAR [medication/treatment administration record] documentation, there is no documentation that the skin check, due on 10/05/12 was completed. In addition, on 10/19/12 the MAR/TAR box was checked corresponding to the skin check, however, there is no corresponding nursing note as to the condition of the skin.</p> <p>b. Per review of the MAR/TAR, it indicates routine and PRN (as needed) standing order medications for bowel management; colace stool softener 10 milligrams (mg) t.i.d. (three times a day), MOM (milk of magnesia) 5 milliliters PRN daily, and Bisacodyl 10 mg suppository PRN. Per interview on 10/31/12 at 12:23 P.M. to review facility's bowel management protocol, the DNS</p>	F 282	<p>F282</p> <p>Resident #1 no longer resides in the facility and did not experience any negative outcomes as a result of the alleged deficient practice.</p> <p><u>Corrective Action:</u> All residents are at risk.</p> <p><u>Systemic Changes:</u> Staff have been reeducated on the weekly skin check protocol. Residents will receive weekly skin checks per protocol with a corresponding nurses note describing the condition of the skin. Staff have also been reeducated on the bowel protocol to include the monitoring of bowel movement frequency and the implementation of as needed bowel medication regime.</p> <p><u>Monitoring:</u> Random audits will be done monthly for three months and reported to the Quality Assurance Committee. DNS and Unit Manager to monitor.</p> <p><u>Completion date:</u> 11/30/12</p> <p><i>POC accepted 11/29/12 Sharon J. Emmons RN</i></p>

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F 282	Continued From page 3 (Director of Nursing Services) stated staff are to start with MOM after 3 days of no bowel movement, on the night shift, and if not working by the next day, then a suppository would be administered. S/he confirmed that although not indicated on the MAR/TAR, the expectation would be to start with MOM. The ADL Data Report shows the resident did not have a bowel movement for 5 days from 09/28/12 - 10/04/12, however no PRN constipation medication was given during that time. MOM was not given after the third day and only suppository was given. Per a nurse note on 10/07/12 at 10:39 P.M. "signs and symptoms constipation hard stool noted on insertion of suppository". Per the MAR/TAR, the stool softener colace 10 mg t.i.d. was not documented as not being given on 09/27/12 at noon, 09/29/12 at noon, or 10/08/12 at noon and 5:00 P.M. Per interview at 1:04 P.M. the DNS confirmed the facility failed to assure that services were provided in accordance with the resident's plan of care.	F 282			
F 327 SS=D	483.25(j) SUFFICIENT FLUID TO MAINTAIN HYDRATION The facility must provide each resident with sufficient fluid intake to maintain proper hydration and health. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility failed to ensure 1 applicable resident (Resident #1) received a therapeutic diet when there is a nutritional problem. Findings include:	F 327			

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F 327	Continued From page 4 1. Per review of the Dietary Assessment dated 10/04/12, Resident #1 was identified as having weight loss of 10-15 lbs. over the past year secondary to diminished appetite. Resident #1 was also identified as needing extensive cueing and/or total assist at times with meals, as having 'fair' intakes and likes strawberry flavored drinks. Per the interventions section, it states "will schedule strawberry ensure every A.M., staff offer it other times if intake of meal is poor". In addition, the estimated nutritional needs for fluids was 1940 milliliters (ml)/day. The care plan notes skin and constipation issues and directed staff to encourage fluids and to manage nutrition/hydration. Per review of the MAR/TAR (Medication/Treatment Administration Records) and the breakfast slips for this resident, they did not have Ensure listed. Additionally, the ADL Data Report shows the daily fluid intake from 09/27/12 - 10/26/12, ranging anywhere from 60 ml -1360 ml a day. Per interview on 10/31/12 at 2:35 P.M. the dietician stated that the expectation would be that the Ensure was sent up at breakfast and be noted on the breakfast slip with nursing documenting on the MAR/TAR. S/he also confirmed that the daily fluid intakes were not documented for all shifts and could not determine the total amount given per day.	F 327	F327 Resident #1 no longer resides in the facility and did not experience a weight loss while at the center, nor did they suffer any negative outcomes as a result of the alleged deficient practice. <u>Corrective Action:</u> All residents are at risk. <u>Systemic Changes:</u> Nurse managers have been educated on the protocol for assuring that residents at high risk for dehydration receive adequate monitoring. <u>Monitoring:</u> Random audits will be done monthly for three months and reported to the Quality Assurance Committee. DNS and Unit Manager to monitor. <u>Completion date:</u> 11/30/12 <i>POC accepted 11/28/12 Susan J. Emmons RN</i>	
F 498 SS=D	483.75(f) NURSE AIDE DEMONSTRATE COMPETENCY/CARE NEEDS The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident	F 498		

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F 498	Continued From page 5 assessments, and described in the plan of care. This REQUIREMENT is not met as evidenced by: The facility failed to ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care for 1 applicable resident (Resident #1) Findings include: 1. The LNA (licensed nursing staff) staff did not demonstrate skills and techniques necessary to care for the resident. Per an anonymous report to the Department of Licensing on 10/27/12, Resident #1 was reported to have bruising and abrasions to the thighs and perineum area. Per review of the care plan and assessment dated 09/27/12, Resident #1 needed extensive assistance with incontinence care and staff were directed to manage shearing and friction to the skin. Per interview on 10/31/12 at 12:23 P.M. the DNS stated the resident, although not resistive to care, [s/he] was not able to open the legs wide enough for peri-care and that staff would spread the legs for care keeping one hand on the leg. The resident was at times able to stand at the grab bar and staff would push through the thighs to clean the peri-area. The DNS also stated that per interview with the LNA on 10/29/12, confirmed that at one point the LNA did "push through the thighs while on commode seat during the shower". When asked if the LNA had a yearly evaluation of personal care skills the DNS stated the yearly evaluation is basic safety fire, abuse, hoier lift use, infection	F 498	F498 Resident #1 no longer resides in the facility. <u>Corrective Action:</u> All residents requiring assistance with peri care are at risk. <u>Systemic Changes:</u> LNA's have been reeducated on perineal care and have demonstrated competency. LNA skills fair to be conducted in March of 2013 to validate competencies. <u>Monitoring:</u> Random audits will be done monthly for three months and reported to the Quality Assurance Committee. DNS to monitor. <u>Completion date:</u> 11/30/12 <i>POC accepted 11/29/12 Susan J. Emmons, RN</i>		

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F 498	Continued From page 6 control and that actual care skills are not formally evaluated. Although the unit manger would do rounds there is no formal or documented method to ensure LNAs demonstrate proper technique during care. The DNS confirmed the LNA did not demonstrate skills and techniques necessary to care for the resident and the facility is planning to do skills competency for peri-care, Foley care, and feeding.	F 498		
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