VERMONT

AGENCY OF HUMAN SERVICES
DEPARTMENT OF DISABILITIES, AGING AND INDEPENDENT LIVING
Division of Licensing and Protection
103 South Main Street, Ladd Hall
Waterbury VT 05671-2306
http://www.dail.vermont.gov
Voice/TTY (802) 241-2345
To Report Adult Abuse: (800) 564-1612
Fax (802) 241-2358

June 18, 2010

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

Provider #: 475045

Dear Mrs. Bertrand:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **May 12, 2010**. Please post this document in a prominent place in your facility.

We will 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,

Suzanne E. Leavitt RN, MS

Suzanne Leavitt, RN, MS
Assistant Director

Enclosure

PRINTED: 06/14/2010
FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	475045		05/12/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODRIDGE NURSING HOME	P.O. BOX 550 BARRE, VT 05641

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An unannounced on-site annual recertification survey was completed by the Division of Licensing and Protection from 5/10/10 to 5/12/10.	F 000	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. There the nursing home requests that this plan of correction serves as its allegation of compliance with all requirements. Please note that 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 POC is being filed as evidence of the Homes continued compliance with all applicable laws.	
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based upon record review and staff interview, the facility failed to revise the plan of care for 1 of 17 residents in the applicable sample (Resident #112). Findings include: 1. Per record review on 5/12/10, the care plan for Resident #112 was not revised following the 5/10/10 physician order for a new diagnosis of	F 280	F-280 Corrective Action: Care Plan for resident #112 was updated on 5/12/10. Other Residents: All residents are at risk. Systemic Changes: Care plans are revised by the professional staff as the care of the resident changes. The process has been reviewed with the Unit Managers, Charge Nurses and all Team Leaders. Monitoring: DNS or designee will perform monthly audits of care plan revisions and report monthly x's 4 and then quarterly at the monthly QA/QI committee meeting. Reporting will be continuous until 100% compliance is demonstrated through the audits. Completion Date: June 21, 2010 RC updated 6-17-10	

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

Maureen Bertrand — Administrator — 6/17/10

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 280	Continued From page 1 mixed urinary incontinence. Per interview on 5/12/10 at 9:26 AM, the Unit Manager confirmed the care plan for Resident #112 was not revised to reflect the new diagnoses of mixed urinary incontinence. 2. Per record review on 5/12/10, Resident #112 was diagnosed with depression on 1/29/10 per physician order and started on Lexapro (antidepressant) 5 mg daily for 5 days and then 10 mg daily. Per review of the Medication Administration Record (MAR), Resident #112 received Lexapro 10 mg one tablet daily from 5/1/10 to 5/12/10. Per interview on 5/12/10 at 10:18 AM, the Unit Manager confirmed that the care plan did not reflect the diagnosis of depression.	F 280		
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview facility staff failed to follow physician's orders for 1 resident (Resident # 178) in the total sample. Findings Include: During a medication pass on 5/10/10 at 3:55 PM the medication nurse obtained Resident # 178's FSBS (finger stick blood sugar) and obtained results of 411. He/she then proceeded to administer the resident 11 units of Novolog Insulin coverage. Immediately after the med pass the medications were reconciled and this surveyor noted MD's	F 281	F-281 Corrective Action: As noted on this statement the nurse immediately administered the additional 2 Units of Novolog Insulin as per physician orders. The resident did not suffer any secondary complications related to a second administration of insulin. Other Residents: All residents are at risk. Systemic Changes: All nurses administering medications will have a minimum of an annual medication pass audit. This was completed on 5/27/10 with the nurse that was being reviewed by the surveyor. Education is being conducted for the review of the 5 R's of medication administration with all nurses administering medication.	

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F 281	Continued From page 2 orders (written 4/22/10) were to give 13 units of insulin coverage for a blood sugar over 400. At 4:40 PM the staff nurse confirmed that the physician's orders stated to 'give 13 units of Novolog coverage for BS over 400.' He/she immediately administered the additional 2 units of Novolog Insulin.	F 281	Monitoring: DNS or designee will report on the medication pass audits at the monthly QA/QI committee meeting. The report will occur x's 4, then quarterly continuously until all medication pass audits have been completed with all nurses administrating medications. This will be an ongoing process and will be included in each nurse's annual review.	
F 431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the	F 431	Completion Date: June 21, 2010 POC complete 6-17-10	

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F 431	Continued From page 3 quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to assure that medications were labeled and/or discarded properly for 6 of 40 residents in the sample (Residents #4, #14, #81, #90, #96, #223) and also 3 stock supply medications. Findings include: 1. Per observation on 5/10/10 at 4:00 PM during inspection of the medication storage room on the Evergreen unit, there were expired medications found in the stock supply cabinet. One bottle of liquid Ducosate Sodium had an expiration date of September 2009; one bottle of liquid Acetaminophen had an expiration date of November 2009, and one jar of Genfiber Psyllium powder was expired July 2009. Upon inspection of the medication cart on hall three at 4:15 PM, there was a bottle of liquid Ducosate Sodium opened and expired September 2009, and one bottle of Saline Eye Wash solution that expired June 2009. On 5/10/10 at 4:15 PM, the Unit Manager confirmed that these items were outdated and should have been discarded. 2. Per observation on 5/10/10 at 4:15 PM, accompanied by the Unit Manager, the medication cart on hall two of the Evergreen Unit contained four vials of prescribed Insulin that were unlabeled or outdated. Resident #14 had an opened Lantus Insulin with no date of when it was opened, and a vial of Novolog Aspart Insulin opened on 4/8/10, which is 4 days over the	F 431	F-431 Corrective Action: All outdated medications were immediately removed from the medication carts and the medication rooms. Medications replaced where appropriate. Other Residents: All residents are at risk. Systemic Changes: Education was conducted for all nurses on the attached policy. Delegation of monthly medication/cart audits was assigned will be conducted as per policy to ensure compliance. See attached audit form. Education also included the review of managing vials of medication and the process of dating and initialing by the nurse who makes the first withdrawal. Monitoring: DNS or designee will report on the medication room/cart audits at the monthly QA/QI committee meeting. The report will occur x's 4, then quarterly until all medication room/cart audits demonstrate 100% compliance of completing of the task and replacement of outdated or unused medications. Completion Date: June 21, 2010 6-17-10	

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F 431	Continued From page 4 recommended 28 day use window. Resident # 81 had an opened vial of Lantus Insulin dated as opened on 4/6/10, which is 6 days over the 28 day window. Resident # 90 had an opened bottle of Lantus Insulin with no date recorded as to when it was opened. At the time of these observations at 4:15 PM, the Unit manager confirmed that these Insulins were unlabeled or outdated. 3. Per observation on 5/10/10 at 4:30 PM, the medication cart on hall 2 of Spruce Common Unit contained an Insulin prescribed to Resident #96 that was unlabeled to reference the day it was opened, and Resident #4 had a bag with 5 vials of Promethazine 25 mg/ml. that all had an expiration date of November 2009. On 5/10/10 at 4:35 PM, the nurse administering medications from that cart confirmed that the Insulin was unlabeled and the Promethazine vials were expired. Per review of the med cart on hall 3, there was one vial of Promethazine 25 mg/ml. prescribed to Resident #223 that had an expiration date of November 2009. On 5/10 10 at 4:50 PM, the Unit Manager confirmed that these medications were outdated.	F 431		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility;	F 441	F-441 Corrective Action: Bleach wipes were delivered to each medication cart for the use of disinfecting glucometers on 5/10/10. Other Residents: All residents are at risk. Systemic Changes: Educations was conducted for all nurses on preventing the spread of infection. The education clarified the used of a bleach based solution to disinfect glucometers after use and the handling of equipment used on more than one resident.	

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F 441	Continued From page 5 (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) 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. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation and interview facility staff failed to sanitize the glucometer after obtaining a blood sugar for 1 resident in the total sample (Resident # 178) and to sanitize the glucometer before placing it on the medication cart. Findings include: Per observation on 5/10/10 at 3:55 PM during a medication pass, the staff nurse used an alcohol wipe to clean the glucometer after obtaining a residents blood sugar instead of a bleach based	F 441	Monitoring: DNS or designee will conduct medication pass audits that will identify disinfecting of gluometers after use and the proper management of equipment. The report of these audits will be made at the monthly QA/QI committee meeting. The report will occur x's 4, then quarterly until audits demonstrate 100% compliance in the prevention of the spread of infection. Completion Date: June 21, 2010 POC complete 6-17-10	

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F 441	Continued From page 6 solution or an EPA approved germicidal to prevent blood-borne pathogens. In addition, after checking the residents blood sugar, the nurse placed the glucometer on the residents bed side table and then placed it on the medication cart without sanitizing. At 4:40 PM the staff nurse confirmed that he/she had failed to sanitize the glucometer after placing it on a resident's bedside table and then on the medication cart and had used an alcohol based wipe to clean the glucometer. MMWR March 11, 2005: Alcohol is not an approved product for cleaning environmental areas potentially contaminated with blood borne pathogen. When cleaning a glucose meter, or any other object potentially contaminated with blood, you must use either an EPA approved germicidal disinfectant or a 1:10 bleach to water (minimal concentration).	F 441		