

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 07/24/2025
NAME OF PROVIDER OR SUPPLIER Woodridge Nursing Home		STREET ADDRESS, CITY, STATE, ZIP CODE 142 Woodridge Drive Barre, VT 05641	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>Based on observation, interview and record review, the facility failed to protect the resident's right to be free from sexual abuse by a resident for 1 of 7 sampled residents (Resident #2). Findings include: Per record review of Resident #2's care plan dated 5/29/2025, Resident #2 is a quadriplegic, has cerebral palsy and decreased range of motion. Resident #2's care plan also mentions that the Resident requires a mechanical lift with assistance from two staff members to move. Resident #2's Brief Interview for Mental Status (a score assessing memory and cognitive function) is 14 out of 15 indicating that Resident #2 is cognitively intact. Resident #2 was observed on 7/23/2025 at 12:50 PM having difficulty repositioning himself in bed raising concern that Resident #2 wouldn't have been able to move away from Resident #1 who is able to mobilize in wheelchair independently per his/her care plan dated 6/25/2025. Per record review, an administration note dated 7/8/2025 states resident exhibiting concerning behavior several times this evening where staff observed [him/her] sitting in his/her wheelchair on [his/her] roommate's side of the room (next to roommate's bed) [Resident #2] and appearing to masturbate. Resident became angry with staff when [s/he] was taken out of roommate's space, and also angry when staff would not allow [him/her] to go back to that side of the room. A Social Workers progress note dated 7/9/2025 reports that Resident #2's roommate (Resident #1) was observed rummaging through [Resident #2's] personal belongings and then [s/he] was found sitting beside [Resident #2's] bed masturbating. SS [Social Services] was told that [Resident #2] was not feeling comfortable remaining in the room with [his/her] roommate. Resident #2 stated he/she felt very uncomfortable and scared. Per interview with Resident #2 on 7/23/2025 at 12:50 PM, they reported the incident made him/her uncomfortable when Resident #1 was next to his/her bed. Per record review, the facility abuse policy titled Prevention of Abuse reviewed on 11/18/2024 states that instances of abuse of residents, irrespective of any mental or physical condition, cause physical harm, pain or mental anguish. It includes verbal abuse, sexual abuse, physical abuse and mental abuse. Per interview with the Director of Nursing (DON) and the Administrator on 7/23/2025 at 12:30 PM, the DON and the Administrator confirmed that Resident #1 was found next to their roommate, Resident #2, masturbating.</p>

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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Develop and implement policies and procedures to prevent abuse, neglect, and theft.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to implement national background checks on two out of five employees sampled. Findings include: Per record review of five employees' personnel files, RN [Registered Nurse] #1 and LPN [Licensed Practical Nurse] #1 did not have national background checks in their employment file. RN#1 was hired in 8/13/12 and LPN#1 was hired on 8/25/14. RN#1 has worked at the facility for almost thirteen years without a background check. LPN#1 has worked at the facility for approximately 10 years without a national background check. Per record review of the facility's Prevention of Abuse policy [last reviewed 11/18/24] states, A. Before new employees are permitted to work with residents, [The facility]'s human resources shall conduct a comprehensive hiring process which will include in-depth interviewing practices and careful examination of references. B. [The facility] shall comply with CORI Law. C. [The facility]'s Human Resources will contact The [NAME] office of Professional Regulation Nurse and Nurse Aide registry, and any out-of-state nurse and nurse need registries as appropriate prior to hiring employees to determine if there is any sanction, findings or adjudicated finding of patient abuse, neglect, mistreatment or misappropriation of patient property against the prospective employee. D. The appropriate boards of licensure and or certification will be contacted regarding any past or pending abuse findings. The abuse policy does not discuss national background checks for all employees. Per review of licensing agency communications, a memo was sent out to nursing facilities on October 5, 2022, that states, 1. Prior to employing an individual and at least annually thereafter, a Facility must query the following entities regarding the prospective / current employee: .Agency providing a national criminal background check . To check whether the individual is barred from employment based on prior convictions in any state .2. Under [NAME] and federal laws and regulations, a Facility must decline to employ a prospective or current employee with: . Criminal convictions for the abuse/exploitation/neglect of a vulnerable adult or child in any state . In addition to the prohibitions mentioned above, [NAME] laws prohibit long-term care facilities from employing individuals with criminal convictions relating to bodily injury, theft or misuse of funds or property, and/or crimes inimical to the public welfare. A follow up memo was sent out to facilities on 5/1/2023 that further discusses initial national background checks and rechecks for staff: [NAME] [Department of Aging and Independent Living] has determined that re-checks are not necessary if a staff member has not worked or lived in another state since the initial national check was completed. Per interview with the DON [Director of Nursing] on 7/23/25 at 2:45 PM, it was confirmed that the facility did not have national background checks on file and would be contacting the main hospital for the records. A phone interview was conducted with the DON on 7/24/25 at 1:43 PM. The DON confirmed the facility did not perform national background checks on these two nursing staff members during their hiring, stating They are from [NAME], so we didn't do any national background checks. She stated that she was unaware of the memo sent out from CMS [Center for Medicare and Medicaid Services].</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to identify, investigate, and report to the State Survey Agency an incident of sexual abuse for 1 of 7 residents (Resident #2). Findings include:Per record review, the facility abuse policy titled Prevention of Abuse reviewed on 11/18/2024 states, [facility] will report any alleged patient abuse sexual abuse, mistreatment, neglect, or misappropriation of resident property to [NAME], APS, and the [NAME] Police Department whenever the facility has reasonable cause to believe that a resident experience abuse, mistreatment, neglect, or misappropriation of property.Per record review, a Social Workers progress note revealed that Resident #2 experienced forced observation of masturbation causing Resident #2 to feel very uncomfortable and scared A Social Workers progress note dated 7/9/2025 revealed that Resident #2's roommate (Resident #1) was observed rummaging through [Resident #2's] personal belongings and then he was found sitting beside [Resident #2's] bed masturbating. SS [Social Services] was told that [Resident #2] was not feeling comfortable remaining in the room with [his/her] roommate.Per interview with the Director of Nursing (DON) and Administrator on 7/23/2025 at 12:30PM, the DON and the Administrator confirmed that they were aware that Resident #1 was found next to their roommate, Resident #2, masturbating. The DON and Administrator also confirmed the facility did not identify the incident as sexual abuse and therefore it was not investigated or reported to the State Licensing Agency.</p>		