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	09/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Woodridge Nursing Home	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)
F 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. (continued on next page)

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Actual harm Residents Affected - Few	Based on observations, interviews, and record review, the facility failed to protect the resident's right to be free from physical abuse by another resident, as a result, 1 of 3 sampled residents (Resident #1) suffered physical harm. Findings include:Per record review, Resident #1's diagnoses include frontotemporal neurocognitive disorder. Per review of Minimum Date Set (MDS; a standardized tool used to evaluate residents' needs and improve care planning) dated 8/4/25, Resident #1 has a BIMS (Brief Interview for Mental Status) of 11, suggesting moderate cognitive impairment. Per record review, Resident #2's diagnoses include unspecified symptoms and signs involving cognitive function and awareness, major depressive disorder, unspecified dementia, and restlessness and agitation. A review of the medical record reveals a BIMS of 14, suggesting Resident #2 is cognitively intact. A review of Resident #2's Care Plan dated 6/27/25 reveals Disturbed thought process related to degenerative brain changes as evidenced by confusion, memory loss, and disorientation. with agitation and anxiety. The interventions include observing for mood changes or agitation, identifying triggers for escalation, and minimizing them.Record review reveals that Resident #2 has a history of behaviors. Per a progress note dated 5/10/25, it states that Resident #2 was observed physically pushing a Licensed Nursing Assistant (LNA) backward into the door when she attempted to redirect him/her away from an exit. Later that same day, Resident #2 was observed trying to open a door when an LNA attempted to redirect him/her. Resident #2 shoved the LNA and kicked him in the leg. A progress note dated 8/22/25 states that nursing staff observed Resident #2 pushing a resident with both hands on their shoulders.Per review of a facility incident report dated 9/22/25, Resident #1 was assaulted by his/her roommate, Resident #2, on 9/21/25, and sustained bruising and swelling to the right eye, right cheek, and lip, and an abrasion to the lower lip. Per a progress note dated 9/21/25, a Licensed Nursing Assistant (LNA) reported answering an emergency call light, finding Resident #1 with visible abrasions, blood on the neck and right side of the face, ear, forehead, and lip. The resident indicated that his/her roommate had punched him/her. Review of a progress note dated 9/21/25 states that Resident#1 was observed to have several facial scratches and bruising on his/her face and reported general discomfort. A progress note dated 9/21/25 indicates that Resident #1 rated his/her pain as 4/10, with emphasis on the face where s/he was hit. A progress note dated 9/21/25 reveals Resident #1 to have Right eye, right cheek, right ear, and right lip bruising, mild, abrasion to lower lip. Bruising on the top rear portion of [his/her] head and left wrist.On 9/23/25 at 12:52 PM, per an interview with Resident #1, s/he stated s/he was assaulted by Resident #2. S/he indicated that s/he asked his/her roommate to turn off the TV as it was getting late. Then Resident #2 called him/her some names, swore at him/her and then proceeded to punch him/her in the face at least three times. S/he stated s/he managed to lock him/herself in the bathroom and use the emergency light for help. Per observation, Resident #2 had evident bruising and swelling of the right eye, and an abrasion to the lower lip, and said both his/her back and neck are sore from the assault. S/he stated s/he is using ice on the face and Tylenol for pain. S/he stated the assault scared him/her as it was unexpected.Per interview on 9/23/2025 at 4:12 PM with the Director of Nursing and the Administrator, it was confirmed that Resident #1 was not protected from physical abuse and had sustained injuries because of an assault by his/her roommate.