VERMONT

Department of Disabilities, Aging and Independent Living
Division of Licensing and Protection
280 State Drive/HC 2 South
Waterbury, VT 05671-2060
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AGENCY OF HUMAN SERVICES

October 28, 2025

Mr. Richard Kelly Barber, Administrator
Woodridge Nursing Home
142 Woodridge Drive
PO Box 550
Barre, VT 05641

Provider ID #: 475045

Dear Mr. Kelly Barber:

Enclosed is a copy of your acceptable plans of correction for the complaint investigation conducted on **September 23, 2025.** 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
Pamela M. Cota, RN, BS
Assistant Division Director
State Survey Agency Director

Enclosure

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 475045	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 09/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Woodridge Nursing Home	**142 Woodridge Drive PO Box 550, Barre, Vermont, 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
F0000	INITIAL COMMENTS The Division of Licensing and Protection conducted an unannounced, onsite complaint investigation of Complaint #2623080, and FRI # 2623031, #157982, 157977 on 9/23/25 to determine compliance with 42 CFR Part 483 requirements for Long Term Care Facilities. A deficiency was cited at the harm level as a result of this survey.	F0000		
F0600 SS = G	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is NOT MET as evidenced by: 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.	F0600	1. Resident #1 has physically recovered from the assault and continues to report that he feels safe at the facility. Social Services continues to visit a minimum of weekly to check in on his psychological and emotional status. 2. Resident #2 was transferred to an inpatient psychiatric unit and has been discharged from the SNF facility. 3. Staff education on the residents' right to be free from abuse was conducted on 9-30-2025 and 10 - 10- 2025 for all departments. This includes the responsibility for surveillance and supervision of residents' behaviors, moods, and triggers to anticipate escalation and allow for early intervention to deescalate the situation and prevent resident-to-resident verbal and physical abuse. Education includes the importance of reporting mood and behavior changes to the licensed nurse for further interventions and provider notification when indicated. 4. A weekly IDT Behavior Management meeting is held to review residents with behavioral health needs and to adjust their individualized care plans as needed to ensure the residents' goals, dignity, psychosocial well-being, and safety are maximized.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Wendy LaBate Admin	Admin	10/9/2025

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F0600 SS = G	Continued from page 1 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	F0600	5. A survey of 10 staff members with interview questions regarding abuse prevention will be coordinated by the Administrator weekly X 4 weeks and monthly thereafter X 3 months to ensure staff's full understanding of the abuse prevention policies and their related responsibilities. The results will be reviewed and addressed at the time of the survey and presented at the monthly QAPI meeting. Continued surveying will be determined by the QAPI Committee after the first 3 months. 6. Compliance date 10/14/25. **Tag F0600 POC accepted on 10/27/25 by D. Hoffman/S. Stem**	

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

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F0600 SS = G	Continued from page 2 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.	F0600		