Division of Licensing and Protection
HC 2 South, 280 State Drive
Waterbury, VT 05671-2060
http://www.dail.vermont.gov
Survey and Certification Voice/TTY (802) 241-0480
Survey and Certification Fax (802) 241-0343
Survey and Certification Reporting Line: (888) 700-5330
To Report Adult Abuse: (800) 564-1612

June 23, 2021

Mr. Ross Farnsworth, Administrator
St Johnsbury Health & Rehab
1248 Hospital Drive
Saint Johnsbury, VT 05819-9248

Dear Mr. Farnsworth:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **May 13, 2021**. 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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	475019	A. BUILDING ______ B. WING ______	C 05/13/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST JOHNSBURY HEALTH & REHAB	1248 HOSPITAL DRIVE SAINT JOHNSBURY, VT 05819

(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 complaint investigation was conducted by the Division of Licensing and Protection on 5/10 - 5/13/21 at St. Johnsbury Health and Rehabilitation Center. There were regulatory violations identified.	F 000	The filing of this plan of correction does not constitute an admission of the allegations set forth in the statements of deficiencies. St. Johnsbury Health and Rehabilitation Center has prepared and executed a plan of correction as evidence of the facilities' continued compliance with applicable federal and state laws.	
F 583 SS=E	Personal Privacy/Confidentiality of Records CFR(s): 483.10(h)(1)-(3)(i)(ii) §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records. §483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. §483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service. §483.10(h)(3) The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(i)(2) or other applicable federal or state laws. (ii) The facility must allow representatives of the	F 583		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [signature] | TITLE: Center Executive Director | (X6) DATE: 6/9/2021

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.

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

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F 583	Continued From page 1 Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law. This REQUIREMENT is not met as evidenced by: Based upon observation, interview, and record review, the facility failed to provide personal privacy and ensure exposed residents were shielded from public view for 3 residents [Res.#1, #2, & #3] of 7 sampled residents. 1. Per review of Res. #1's medical record, the resident's diagnoses include dementia, paranoia, and alcohol abuse. A Brief Interview of Mental Status [BIMS] was conducted on 4/22/21, with the resident's status assessed as 'Moderately Impaired'. Per Nurse Practitioner Notes dated 3/30/21, the resident "is inappropriately staying only in brief most days." Per observation on 5/10/21 at 9:40 AM, Res. #1 was observed sitting on the edge of the bed nearest the window in his/her room. The resident was wearing only briefs and facing the doorway to the hall. The door to the resident's room was open and resident's privacy curtain was pulled back exposing the resident to anyone in the unit's hallway. During the observation, a Licensed Nursing Assistant [LNA] entered the room, spoke with the resident, then exited the room. The LNA did not pull the privacy curtain to shield the resident from view or shut the door after exiting the room. Per observation on 5/11/21 at 9:43 AM, Res. #1 was again observed sitting on the edge of the bed nearest the window in his/her room. The resident was wearing underwear and no undershirt and facing the doorway to the hall. The door to the resident's room was open and resident's privacy curtain was pulled back	F 583	F583 Resident #1, #2, and #3 remain in Center. and continue to have privacy needs met. Residents that chose to not wear clothing have the potential to be affected by this alleged deficient practice. A Center-wide audit was completed on: 6/8/21 to identify other residents potentially at risk. All staff were educated on the Resident's Rights to privacy and confidentiality policy. Center Nurse Executive (CNE) or designee will do random audits weekly x 4 weeks, and monthly x 3 months to ensure resident's privacy is maintained. Findings will be reviewed at QAPI and recommendations will be made as needed **TAG F 583 POC Accepted 6/23/21** **T .Dougherty/S. Leavitt**	6/23/21

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F 583	Continued From page 2	F 583		

exposing the resident to anyone in the unit's hallway. The shade to the resident's room was raised.

2. Per observation on 5/10/21 at 9:54 AM, Res. #2 was observed lying in his bed nearest the window in his/her room. The privacy curtain around the resident's bed was partially pulled to shield the upper half of the resident's body from view. The resident was lying on his left side, facing the open doorway and hallway, and was naked. The shade to the resident's window was raised. Per interview with Res. #2, the resident preferred to be unclothed for temperature regulation. Per observation, the resident's unclothed lower body was visible from the doorway. Per review of the resident's Care Plan, after the privacy concern observation was made on 5/10/21, the facility identified the resident as "at risk for being resistive to care, refusing to cover up with sheet, keeping shade to window open. [Initiated 5/10/21]"

3. Per review of Res.#3's medical record, the resident's diagnoses include dementia and depression. A Brief Interview of Mental Status [BIMS] was conducted on 3/23/21, with the resident's status assessed as "Severe Impairment". An Assessment of Res. #3's 'Functional Abilities and Goals', dated 4/27/21 reveals the resident requires 'Substantial/maximal assistance' for upper body dressing, and is 'dependent' on staff for lower body dressing. Per observation on 5/12/21 at 9:47 AM, Res. #3 was observed sitting up in the bed closest to the doorway of his/her room with the head of the bed raised. The resident was observed with a single bed sheet covering himself from slightly below the waist, and the resident naked from the sheet

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F 583	Continued From page 3 upwards. The door to the resident's room was open and resident's privacy curtain was pulled back exposing the resident to anyone in the unit's hallway. A female resident was observed sitting in a wheelchair in the doorway of her room, located directly across from Res. #3's room. The female resident confirmed Res.#3 was visible from where she was sitting in the hallway, pointed to Res. #3, and stated it was 'disturbing'. 4. Per interview with the facility's Administrator [ADM] and Director of Nursing Services [DNS] on 5/12/21 at 1:46 PM, the ADM and DNS reported that the facility allowed 'window visits' for residents and families related to COVID visitation guidelines. The ADM and DNS reported that families and visitors could walk along the outside of the one-story facility and visit a resident from the outside while the resident remained on the inside of the facility. The DNS confirmed that with the shade to the room raised, a resident is visible from the outside. Per observation on 5/10/21, The shade to Res.#2's window was raised, and from outside the one-story facility looking into the resident's room, the resident was visible and naked. Per observation on 5/11/21, The shade to Res.#1's window was raised, and from outside the one-story facility looking into the resident's room, the resident was visible and wearing only briefs. Per review of the facility's Privacy Rights: Patient policy, "The patient has a right to personal privacy ...Personal privacy includes accommodations ...personal care, visits, and meetings of family ...".	F 583		
F 600 SS=E	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and	F 600		

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F 600	Continued From page 4 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 upon interview and record review, the facility failed to evaluate the effectiveness of interventions to ensure 3 residents [Res.# 5, #6, & #7] of 8 sampled residents were free from physical abuse. Findings include: Review of medical records for Res.#4 reveal the resident was admitted to the facility in 2019 with diagnoses that include Vascular Dementia with Behavioral Disturbance, Anxiety Disorder, Major Depressive Disorder, and Traumatic Brain Injury. Per review of Psychiatric Consultation Notes dated 4/15/21, Res.#4 "has documented altercations in February, March and April in which [s/he] attacked other residents". Per review of the facility's Incident Report, on 2/16/21 Res. #4 slapped Res. #7 in the face. Nursing Notes record Res.#4 "self-propelled her wheelchair off of her hallway and down to B1. She was attempting to propel down the hallway and another resident was sitting in the middle of	F 600	Resident #4 still resides at the facility and has no further abuse allegations. Residents #5, and #7 remain in Center and remain free from abuse, and resident #6 is no longer at the center. Residents involved with resident to resident abuse allegations have the potential to be affected by this alleged deficient practice. These residents will have their intervention effectiveness evaluated. Abuse incidents for the past 30 days have been reviewed to ensure the effectiveness of inventions have been evaluated. Facility staff have been re-educated on the Abuse policy and ensuring the interventions that have been implemented are effective in preventing abuse.	6/23/21

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F 600	Continued From page 5 the hallway in her wheelchair. [Res.#4] slapped the other patient in the face ... When asked why [s/he] slapped the other resident [s/he] stated 'she was in my way.' Director of Nursing Services, physician, state police notified." The facility investigation lists 'Care Plan updated to reflect activities of interest' with redirection as the method to prevent further resident to resident abuse by Res. #4. The redirection added to prevent further abuse is listed as 'resident enjoys pistachios, trying on sunglasses, and to offer digital slideshow picture frame'. Review of regulatory interpretive guidelines regarding Abuse note that "redirection alone is not a sufficiently protective response to a resident who will not be deterred from targeting other residents for abuse once he/she has been redirected". Per review of the facility's Incident Report, on 3/16/21 Res. #4 struck Res. #6 twice on the hand. Incident Notes dated 3/16/21 record "This writer was bringing another resident back to her room from the other unit and observed [Res. #4] sitting in her wheelchair facing the emergency exit and [Res.#6] was facing towards the nurses station standing near room B23. Before I could get close to them, I witnessed [Res.#4] hit [Res.#6] on her left hand twice. [Res.#6] just stood there and I was able to separate them, call for help and check [Res.#6's] hand ... Notified Director of Nursing, Vermont State Police, [both residents' doctor], and [Res.#6's] sponsor of above." Nursing Notes dated 3/18/21 reveal Res. #6 suffered a "bruise to her left hand approximately 1 centimeter by 1 centimeter in size and circular." The facility investigation again lists 'Care Plan updated to reflect activities of interest' with redirection again as the method to prevent further resident to resident abuse by	F 600	DNS/designee will randomly audit resident to resident allegations of abuse to ensure the interventions that were implemented have been effective. These audits will be conducted weekly x4, then monthly x2 or until substantial compliance has been achieved. Center Nurse Executive (CNE) or designee will do random audits weekly x 4 weeks, and monthly x 3 months to ensure resident's privacy is maintained. Findings will be reviewed at QAPI and recommendations will be made as needed **TAG F 600 POC Accepted 6/23/21 T .Dougherty/S. Leavitt**	

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F 600	Continued From page 6 Res.#4. The redirection added to prevent further abuse is listed as 'offer [Res.#4] to watch movie of interest when propelling about facility'. Review of Care Plan Notes dated the 3/26/21 reveal 'Activities states that at times they can give [Res.#4] a task to keep her somewhat focused but most times she is doing her own thing and doesn't really participate in any activities.' Per review of Behavior Monitoring Notes on 3/30/21, "resident has declined to stay in her room or on the unit this shift. Staff have redirected and redirected and redirected without success. Resident self-propels in her wheelchair and refuses to stay in her room. Staff offered activities, television, conversation, music, food, drinks all without success. The more staff attempt to redirect resident to her room the more agitated she becomes. ... Activities provided 1:1 without success." Per review of the facility's Incident Report for the same date, 3/30/21, Res. #4 slapped Res. #5 in the face. Review of Nurses Notes regarding the incident record '[Res.#5] states that he was in the hallway when another resident approached him. He said that when [s/he] approached him, he was not saying anything to [him/her] or making any gestures at [him/her]. At this time that is when resident stated that the other resident hit him in the face.' The facility investigation of the incident for the third time lists 'Care Plan updated to reflect activities of interest' and redirection again as the method to prevent further resident to resident abuse by Res.#4. After the assessment of the Behavior Monitoring notes on 3/30/21 that "Activities provided 1:1 without success", the single intervention added to prevent further resident to resident abuse by Res.#4, dated 4/6/21, is "Activities to provide 1:1 interaction when resident	F 600		

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F 600	Continued From page 7 is agitated". Per review of the facility's Incident Report on 4/21/21 Res. #4 again slapped the same resident, Res. #5, in the face. Behavior Notes the next day record '[Res.#5] states he does not know why he was slapped, but that it did hurt ...[Res.#5] states that he does not want [him/her] down by his room anymore.' A follow up note dated 4/23/21 reveals 'he does again state that he does not want that resident near him, his room, or hallway. This is not the first time this resident has slapped [him] he states.' The facility investigation for the fourth time out of 4 incidents lists 'Care Plan updated to reflect activities of interest' and redirection again as the method to prevent further resident to resident abuse by Res.#4. Despite the statement in the facility investigation, review of the Care Plan reveals no new activities of interest added. The single intervention added to prevent further resident to resident abuse is listed as 'implement a room change'. Review of Nursing Notes and Nurse Practitioner Notes throughout February to May 2021 record multiple times where simply moving Res.#4 to another location did not prevent further incidents. The first resident to resident abuse dated 2/16/21 is documented as Res.#4 "wandered off unit onto another unit where [s/he] got into an altercation with another resident on that unit and slapped [him/her]." Behavior Notes on 3/30/21 report "resident has declined to stay in her room or on the unit this shift. Staff have redirected and redirected and redirected without success. Resident self-propels in her wheelchair and refuses to stay in [his/her] room." Nurse Practitioner Notes dated 4/6/21 reveal Res.#4 "seems to wander facility despite closed units,	F 600		

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F 600	Continued From page 8 even efforts to disguise doors did not work." An interview was conducted with the Director of Nursing Services [DNS] on 5/13/21 at 1:20 PM. The DNS stated that a despite redirection alone repeated multiple times as an intervention to prevent further incidents of resident to resident abuse by Res.#4, and confirming that regulatory interpretive guidelines note that "redirection alone is not a sufficiently protective response to a resident who will not be deterred from targeting other residents for abuse once he/she has been redirected", adding a specific activity to redirect the resident after an abuse incident was a new and sufficient intervention. The DNS stated that the redirection was "successful for a period of time." The DNS confirmed that repeating the same intervention of adding specific activities to redirect Res.#4 after the 2/16/21 incident did not prevent 3 further resident to resident abuse incidents from occurring.	F 600		
F 657 SS=E	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of	F 657	Residents #5, #6, and #7 remain in Center. Other residents could be affected by the alleged deficient practice. A Center-wide audit was completed on: 6/8/21 to identify other residents potentially at risk. Education provided to all staff on Abuse policy and procedure. All licensed nursing staff have been educated to update care plans with interventions to prevent falls and potential injuries. Random audits will be completed on effectiveness of care plan interventions and care plan revisions following a resident to resident altercation, and residents exhibiting behaviors towards other residents	6/23/21

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F 657	Continued From page 9 the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based upon interview and record review, the facility failed to ensure the Care Plan was reviewed to evaluate the effectiveness of interventions to prevent resident to resident abuse by 1 resident [Res.#4] of 8 sampled residents, and that interventions were added to prevent falls and potential injury to 2 residents [Res.#7 & #8] of 8 sampled residents. Findings include: 1.) Review of medical records for Res.#4 reveal the resident was admitted to the facility on 9/4/2019 with diagnoses that include Vascular Dementia with Behavioral Disturbance, Anxiety Disorder, Major Depressive Disorder, and Traumatic Brain Injury. Per review of Psychiatric Consultation Notes dated 4/15/21, Res.#4 "has documented altercations in February, March and April in which she attacked other residents". Per review of the facility's Incident Report on 2/16/21 Res.#4 slapped Res. #7 in the face. The facility investigation lists 'Care Plan updated to reflect activities of interest' with redirection as	F 657	Random audits will be completed to ensure care plans Are updated with interventions to prevent falls and potential Injury following each fall Audits to be completed weekly x 4 weeks, and monthly X 3 months. Findings will be reviewed at QAPI and recommendations will be made as needed. **TAG F 657 POC Accepted 6/23/21** **T .Dougherty/S. Leavitt**	

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F 657	Continued From page 10 the method to prevent further resident to resident abuse by Res.#4. Review of regulatory interpretive guidelines regarding Abuse note that "redirection alone is not a sufficiently protective response to a resident who will not be deterred from targeting other residents for abuse once he/she has been redirected". After the resident to resident Abuse incident on 2/16/21, included in Res.#4's Care Plan is "The resident has potential to demonstrate physical behaviors [hitting staff and other residents] related to Dementia. The Care Plan Goal is listed as "the resident will not harm self or others through the review date" [no date listed]. Per review of the facility's Incident Report on 3/16/21 Res. #4 struck Res. #6 twice on the hand. The facility investigation again lists 'Care Plan updated to reflect activities of interest' with redirection again as the method to prevent further resident to resident abuse by Res.#4. Review of Care Plan Notes dated the 3/26/21 reveal 'Activities states that at times they can give [Res.#4] a task to keep her somewhat focused but most times she is doing her own thing and doesn't really participate in any activities.' Per record review, on 3/26/21, 10 days after the second incident of resident to resident abuse on 3/16/21, the resident's Care Plan regarding "The resident has potential to demonstrate physical behaviors [hitting staff and other residents] related to Dementia" is 'revised', along with the Goal- "the resident will not harm self or others through the review date"; the single revision being Res.#4's name being substituted for the words "the resident".	F 657		

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	475019	A. BUILDING ______ B. WING ______	C 05/13/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST JOHNSBURY HEALTH & REHAB	1248 HOSPITAL DRIVE SAINT JOHNSBURY, VT 05819

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F 657	Continued From page 11 4 days later, on 3/30/21, per review of Behavior Monitoring Notes "resident has declined to stay in [his/her] room or on the unit this shift. Staff have redirected and redirected and redirected without success. Resident self-propels in [his/her] wheelchair and refuses to stay in [his/her] room. Staff offered activities, television, conversation, music, food, drinks all without success. The more staff attempt to redirect resident to her room the more agitated [s/he] becomes. ... Activities provided 1:1 without success." Per review of the facility's Incident Report for the same date, 3/30/21, Res. #4 slapped Res. #5 in the face. The facility investigation of the incident for the third time lists 'Care Plan updated to reflect activities of interest' and redirection again as the method to prevent further resident to resident abuse by Res.#4. After the assessment of the Behavior Monitoring notes on 3/30/21 that "Activities provided 1:1 without success", the single intervention added to prevent further resident to resident abuse by Res.#4, dated 4/6/21, is "Activities to provide 1:1 interaction when resident is agitated". Per review of the facility's Incident Report on 4/21/21 Res. #4 again slapped the same resident, Res. #5, in the face. The facility investigation for the fourth time out of 4 incidents lists 'Care Plan updated to reflect activities of interest' and redirection again as the method to prevent further resident to resident abuse by Res.#4. Despite the statement in the facility investigation, review of the Care Plan reveals no new activities of interest added. The single intervention added to prevent further resident to resident abuse is listed as 'implement a room change'.	F 657		

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F 657	Continued From page 12	F 657		

Review of Nursing Notes and Nurse Practitioner Notes throughout February to May 2021 record multiple times where simply moving Res.#4 to another location did not prevent further incidents. The first resident to resident abuse dated 2/16/21 is documented as Res.#4 "wandered off unit onto another unit where [s/he] got into an altercation with another resident on that unit and slapped her." Behavior Notes on 3/30/21 report "resident has declined to stay in [his/her] room or on the unit this shift. Staff have redirected and redirected and redirected without success. Resident self-propels in [his/her] wheelchair and refuses to stay in [his/her] room." Nurse Practitioner Notes dated 4/6/21 reveal Res.#4 "seems to wander facility despite closed units, even efforts to disguise doors did not work."

An interview was conducted with the Director of Nursing Services [DNS] on 5/13/21 at 1:20 PM. The DNS stated that a despite redirection alone repeated multiple times as an intervention to prevent further incidents of resident to resident abuse by Res.#4, and confirming that regulatory interpretive guidelines note that "redirection alone is not a sufficiently protective response to a resident who will not be deterred from targeting other residents for abuse once he/she has been redirected", adding a specific activity to redirect the resident after an abuse incident was a new and sufficient intervention. The DNS stated that the redirection was "successful for a period of time." The DNS confirmed that repeating the same Care Plan intervention of adding specific activities to redirect Res.#4 after the 2/16/21 incident did not prevent 3 further resident to resident abuse incidents by Res.#4 from occurring.

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F 657	Continued From page 13	F 657		

2.) Per review of the facility's Falls Management policy, under 'Practice Standards' includes the steps 'Review and revise care plan regularly', and 'Update care plan to reflect new interventions'. Under the facility's Problem Management process, the 'Response to a patient fall' includes "Implement immediate interventions after the fall" and "Update care plan with new interventions as appropriate". An interview was conducted with the Director of Nursing Services [DNS] on 5/13/21 at 1:20 PM. The DNS confirmed the facility's Falls Management process includes reviewing a resident's Care Plan regarding fall prevention after each fall the resident suffers and stated new interventions to prevent future falls are added to the resident's Care Plan after each fall.

Per review of the facility's Incident Log for January 2021 through May 10, 2021, Res.#7 was involved in 35 separate fall incidents. Review of Res.#7's Care Plan reveal there were no new interventions added to prevent future falls after 13 of the 35 falls [37% of the falls].

Further review of the facility's Incident Log for December 29, 2020 through May 10, 2021 revealed Res.#8 was involved in 26 separate fall incidents. Review of Res.#8's Care Plan reveal there were no new interventions added to prevent future falls after 8 of the 26 falls [30% of the falls].

The facility supplied an Incidents by Incident Type log which listed the 35 falls by Res.#7 and 26 falls by Res.#8, and the DNS was offered an opportunity to demonstrate that interventions were added to the residents' Care Plans after each fall, as stated by the DNS and recorded in facility policy. The DNS was unable to produce

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F 657	Continued From page 14 any documentation that interventions were added to Res.#7's or Res.#8's Care Plans after each fall in order to prevent future falls.	F 657		