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

April 29, 2021

Mr. William Kowalewski, Administrator
Woodridge Nursing Home
142 Woodridge Drive
Barre, VT 05641-0550

Dear Mr. Kowalewski:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **March 23, 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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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	(X3) DATE SURVEY COMPLETED
	475045	A. BUILDING ____ B. WING ____	C 03/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODRIDGE NURSING HOME	142 WOODRIDGE DRIVE 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 complaint investigation was conducted on 3/22-3/23/21 by the Division of Licensing and Protection. There were regulatory violations identified.	F 000		
F 600 SS=D	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 upon interview and record review, the facility failed to ensure that 1 resident [Res.#3] of 4 sampled residents was free from verbal, sexual, physical, or mental abuse. Findings include: Review of Res. #3's medical record revealed the resident is a 75-year-old with diagnoses that include vascular dementia, Post Traumatic Stress Disorder, depression, a history of alcohol use disorder, behavior disturbances including emotional lability, agitation and aggressive behavior.	F 600	Past noncompliance: no plan of correction required.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [signature]
TITLE: Administrator/VP
(X6) DATE: 4/19/21

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.

F 600	Continued From page 1 Per review of Res. #3's Care Plan revealed the resident was identified as having: - "a behavior problem related to history of behaviors due to Post Traumatic Stress Disorder, dementia, impaired cognition. Resident has had occasion to hit, kick, or punch staff who try to help assist with care. This behavior is not consistent- staff are to withdraw and reattempt, look for precipitating factors- need to use bathroom, hunger, thirst, pain." - "a diagnosis of major depression and Post Traumatic Disorder." - "impaired cognitive function/dementia or impaired thought processes related to dementia." - "at risk for a mood problem related to Post Traumatic Stress Disorder, and left sided stroke, dementia, and expressive dysphagia." - "at risk for wandering, elopement" Further review revealed none of the interventions in the Care Plan areas identified above had been revised until after the incident on 11/27/20. Review of Nurse Practitioner Notes dated 11/24/20, 3 days prior to the incident, reveal Res. #3's "behaviors have been worsening again. He is very intrusive towards other residents, goes into their rooms, wheels his wheelchair close up in their personal space, trying to grab at them, taking things off their trays. Per nursing, earlier today a female resident told them she was afraid of him and to keep him away from her, and there have been some near-altercations fortunately averted." On 11/27/20, Nurse Practitioner Notes record [Res. #3] "continues to be quite restless, always moving about hallways in his wheelchair, still with intrusive behaviors. No recent aggressive behavior but his behavior continues to frighten	F 600		

F 600

Continued From page 2 other residents particularly females (1 of whom is spending less and less time here on her unit, has stated she is afraid of him, seems to be avoiding him).
ADDENDUM:
Patient initially seen in the morning for visit. Then in afternoon, [Res. #3] wandered into another male resident's room (who is also wheelchair-dependent), wheeled himself right up to him and hit [Res. #4] in the face, left upper arm and left shoulders, resulting in small abrasion Right upper lip with associated mild swelling and discomfort. Staff heard the other resident yelling for help and came into the room to separate the two. Discussed with social services, nursing including Director of Nursing: Unfortunately, as patient currently poses a safety risk to other frail residents most of whom cannot defend themselves and some of whom cannot speak, it is unsafe to keep patient here, so will send to Emergency Department [ED] via 911 for aggressive behavior, unable to maintain safety in current care setting. [The note continues:] Several hours later, spoke with Doctor in ED...Because he was not aggressive in the ED, they did not need to give him any medications. [Res. #3] then returned to Woodridge late afternoon. We have been gradually making med changes to address his aggressive behavior, but incident today indicates this is an urgent situation."

Per interview, record review, and regulation review with the facility's Director of Nursing Services [DNS] and the Social Services Director [SSD] on 3/23/21 at 11:50 A.M., both the DNS and SSD confirmed that Res. #3 had physically abused Res. #4 on 11/27/20.

The DNS and SSD provided documentation of

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Continued From page 3

the facility's identification, investigation, and reporting of the incident. Neither resident has had any previous interactions with each other. Abuse Prevention interventions implemented post incident include:

1. Advance Practice Registered Nurse reviewed [Res. #3's] medication regimen and will increase his Depakote and will continue PRN [as needed] trazadone for agitation. [Res. #3] will continue to receive PRN morphine for pain due to likelihood that he has chronic pain.
2. [Res. #3] currently receives Deer Oaks Psychological services for previous mental health diagnoses of Post-traumatic Stress Disorder, Chronic and Major Depressive Disorder. Although he refused the trauma screen, [Res. #3] did acknowledge on interview, "I'm a Vietnam veteran. Vietnam memories haunt me". [Res. #3] has a trauma informed care plan in place.
3. [Res. #3] will be brought to the Sensory room on Maple Grove during times of agitation to allow for time in a calming environment. This will be scheduled by the Maple Grove Clinical Coordinator.
4. A mesh STOP sign was put outside [Res. #4's] door on 11/27/20 to deter any unwanted entry. 5. [Res. #3] was relocated to room 211-P following his return to Woodridge on 11/27/20 which is directly across from the nurse's station. 6. [Res. #4] is agreeable and has requested a room/unit transfer to Spruce Common Unit 129-P as he has a close friend that lives on that unit and he visits with daily. A room change will be made once the Spruce room is available.
7. Social Service Director has contacted VA Medical Center-White River Junction Community Care Coordinator to arrange additional support services for [Res. #3].

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8. A care conference meeting has been arranged with VA Geri-psychiatrist and Woodridge Nurse Practitioner, Director of Nursing and Social Service Director. This meeting was conducted on 12/3/2020.
9. A follow up care meeting was held with [Res. #3's] Power of Attorney and healthcare agent on 12/4/20.

Based upon the information garnered during the investigation, the facility will be cited for Past Noncompliance related to failure to prevent Resident to Resident physical abuse.

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F 607 SS=D Develop/Implement Abuse/Neglect Policies
CFR(s): 483.12(b)(1)-(3)

§483.12(b) The facility must develop and implement written policies and procedures that:

§483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property,

§483.12(b)(2) Establish policies and procedures to investigate any such allegations, and

§483.12(b)(3) Include training as required at paragraph §483.95,
This REQUIREMENT is not met as evidenced by:
Based upon interview and record review, the facility failed to provide oversight and monitoring to ensure staff implemented policies regarding identifying signs of potential abuse, such as injuries of unknown sources, and reported their knowledge related to any alleged violation, for one resident [Res. #2] of 4 sampled residents.
Findings include:

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1. Resident #2 was assessed to ensure and confirm the absence of identifying signs of potential abuse.
2. All Residents have the potential to be affected by staff failure to report bruises of unknown origin.
   No other Residents were found to have been affected by the deficient practice.
3. In-services with the staff on the facility's abuse policy have begun to ensure the deficient practice does not recur. In-services will continue for six weeks.
4. Documentation of all in-services will be submitted to the QAPI Committee.
   Audits of skin assessments on the implementation of policies regarding identifying and documenting signs of potential abuse will be conducted, five per week for six weeks. Results of the audits will presented to the QAPI committee.
5. Completed by May 28, 2021

F607 POC accepted 4/27/21
TDougherty RN/PMC

F 607

Continued From page 5

Per review of the facility's policy "Preventing, Reporting, and Investigating Resident Abuse, Neglect, and Exploitation", section H: Reporting Known or Suspected Incidents of Abuse or Other Mistreatment: "It is the duty of all employees to report any such incident to the Administrator, Director of Nursing Services/Designee or Supervisor immediately after learning of the occurrence."

According to the State Operations Manual for Long Term Care Facilities
(Rev. 11-22-17) , section §483.12 Freedom from Abuse, Neglect, and Exploitation, includes under the definition of Abuse-
"Examples of injuries that could indicate abuse include but are not limited to: Injuries that are non-accidental or unexplained; Bruises, including those found in unusual locations such as the head, neck,...and Facial injuries, including but not limited to...black eye(s), bruising, bleeding or swelling of the mouth or cheeks."

Review of Nursing Notes for Res. #2, dated 2/1/2021 at 11:52 A.M. reveal "Staff noticed extensive bruising to Left eye, minimal bruising noted to right eye, bruising and bump noted to top of left head."
Per review of Occupational Therapy [OT] Notes dated 2/1/2021 at 12:37 P.M.,
"OT noted bruise/discoloration around [Res. #2's] Left eye, nursing made aware. Per LNA [Licensed Nursing Assistant] patient had that bruise upon waking up this morning."

Review of the facility's investigation into the injury of unknown origin reveals the LNA caring for Res. #2 noticed the bruising at 6:37 A.M. that morning,

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Continued From page 6 and during breakfast at 8:00 A.M. the bruising was 'more obvious'. Further review of the facility's investigation and of Res. #2's medical record contains no documentation that the 'obvious' bruising was reported by the LNA to Nursing, Supervisors, or any other staff.

Additional review of Res. #2's medical record and Medication Administration Record for 2/1/2021 reveal the Registered Nurse [RN] assigned to Res. #2 documented as giving 7 medications to the resident during the 8:00 A.M. hour, including removing and applying a medication patch to the resident's skin, and taking Vital Signs [Blood pressure, temperature, heart rate, respiration rate] of Res. #2. There is no note of the "extensive bruising to Left eye, minimal bruising noted to Right eye, bruising and bump noted to top of Left head" that the RN later documented, and no documentation that the bruising first noted by the LNA at 6:37 A.M. was reported by the RN to Supervisors or any other staff.

A review of the facility's report to the State Agency dated 2/1/2021 records "At 10:00 this morning, Occupational Therapist noticed [Res. #2] had facial bruising under her glasses. This is new finding, and no fall was noted."

An interview was conducted with the Director of Nursing Services [DNS] and Social Services Director [SSD] on 3/23/21 at 11:50 A.M. The DNS and SSD reported staff are educated upon initial orientation and then annually regarding Abuse Prevention, Identification, and Reporting. The SSD also stated that on the back of staff's identification cards are printed instructions regarding Abuse policies and procedures. Both the DNS and SSD confirmed that Res. #2's

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Continued From page 7 condition on 2/1/2021 should have been assessed as possible abuse and should have been reported immediately by the LNA but was not, and again should have been identified by the resident's RN later in the A.M., and again was not reported immediately. Both the DNS and SSD stated that no in-services or re-education of staff regarding reporting allegations of Abuse had been conducted regarding the incident on 2/1/2021 involving Res. #2.

F 657 SS=G	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 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	F 657	1. Resident #1 expired on 01/03/2021 2. All residents have the potential to be affected by the same deficient practice. Review of the care plans of Residents who had a fall within the past 30 days has be done and care plans requiring updating will be corrected. 3. In-services on the writing, reviewing and revision of care plans has begun to assure this deficient practice does not recur. In-services will continue for six weeks, 4. Documentation of all in-services will be presented to the QAPI Committee. Audits of care plans for falls and injury prevention will be conducted, five per week for the next six weeks. Results of the audits will be presented to the QAPI Committee. 5. Completion date May 28, 2021 F657 PoC accepted 4/27/21 TDougherty RN/PMU

F 657		F 657	
	Continued From page 8 comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based upon interview and record review, the facility failed to review and revise the Care Plan of one resident [Res.#1] of 4 sampled residents regarding prevention of falls and injury. Findings include: Res. #1 was initially admitted to the facility in 2019 with diagnoses that include Alzheimer's disease, Anxiety Disorder, Chronic Pain Syndrome, Restlessness and Agitation, and Vascular Dementia with Behavioral Disturbance. A review of the facility's Fall Prevention Policy identifies the Prevention procedure as "Residents will be individually evaluated for the potential risk of falling so that reasonable and appropriate measures can be developed to address each resident's individual needs in an effort to mitigate the identified risk areas." A review of Res. #1's Care Plan reveals the resident was identified, upon admission, as 'at risk for falls related to Impaired Balance, Weakness, Neurological deficits, Stroke, and Confusion.' The Care Plan includes 6 different interventions to prevent falls, including 'Complete Fall Risk Assessment per facility protocol and revise Plan of Care as needed'. Per review of Nurse's Notes dated 9/11/20, Res. #1 'was found lying on her left side on the floor of dayroom yelling/crying out to staff, she had a laceration on her left forehead ... Pressure was applied to laceration to stop bleeding, tissue was re-approximated to wound. A clean dry dressing was applied. The Doctor was updated- he will be		

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Continued From page 9 here in the A.M. and apply stitches to the wound ...[Res. #1] was very upset, yelling, crying at staff
..."

After the fall, Res. #1 was assessed using the Morse Fall Risk Assessment Scale. The scale rates the resident as a High Risk if they score 45 or higher. Res. #1's score after the fall was 75. Per the facility's Fall Prevention Policy, the resident's "Fall Reduction Plan will include: Development of Individualized Care Plans that reflect current, resident-centered interventions including documentation that reflects reviewed and/or updates for each problem with the care plan that the new fall impacted."

Review of Res. #1's Care Plan after the fall on 9/11/20 reveals no documentation that a fall had occurred, and no new interventions added to prevent future falls.

A Nurse Practitioner Note dated 11/16/20 describes the resident as "a 96-year-old female with ... advanced dementia with a history of behavior disturbance, and history of recurrent falls." The note further states "Last night at around 8:30 P.M. [Res.#1] fell, unwitnessed, nurse heard the loud noise. Patient crying out with fall and immediately went to her room to assess, noted large hematoma Left eyebrow area with an overlying abrasion. Also had a small laceration to left thumb."

A Nurses Note also dated 11/16/20 reveals 'This writer was able to provide support to [Res. #1's daughter], explaining all safety measures that staff have in place and how mom last fall was May 2020, not as recent as she thought originally. [Res. #1's daughter] asked for options of an

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Continued From page 10 alarm and this writer explained that an alarm would not be indicated for mom.' Review of Res. #1's medical record lists the resident's last fall as occurring on 9/11/20, two months prior to this fall on 11/15/20, and not in May 2020.

After the fall, Res. #1 was again assessed using the Morse Fall Risk Assessment Scale. The scale rates the resident as a High Risk if they score 45 or higher. Res. #1's score after the fall on 11/15/20 was again 75.
Review of Res. #1's Care Plan after the fall on 11/15/20 reveals no new interventions added to prevent future falls.

Review of Nursing Notes dated 12/12/20 reveal 'At 07:30 A.M. [Res.#!] was found on the side of her bed sitting up. It appears that she was trying to get up and slid right out of bed.'
Nurses Notes dated 12/14/20 further reveal '[after Res. #1's] fall daughter very upset since resident has fallen, and that she has frequent falls. Resident is 97-year-old with advanced dementia, poor safety awareness ... she is also at a high fall risk if staff were to put her in bed in the afternoon, since she recently had a fall and was sitting on the side of her bed on her floor ...'

Review of the resident's medical record reveals no fall assessment completed after the fall on 12/12/20, no documentation noted on the resident's care plan, and no new interventions added to prevent future falls.
Nurse Practitioner Note dated 12/14/20 relates Res. #1 'has had gradual ongoing decline over the past 8 months with recurrent falls and progressive advanced vascular dementia ... Patient also sustained a mechanical fall on 12/14/2020.' Per review of Res. #1's Care Plan,

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Continued From page 11 there is a notation that on 12/14/20 the resident sustained a 'laceration to forehead, subdural hematoma'.

An interview was conducted with the Director of Nursing Services [DNS] on 3/23/21 at 11:50 A.M. The DNS confirmed that Res. #1 underwent multiple falls with injuries while at the facility. The DNS stated that Res. #1's Care Plan should have been reviewed and revised to include new interventions to prevent future falls after each fall Res. #1 experienced. The DNS confirmed that consecutive falls on 9/11/20, 11/15/20, and 12/12/20 revealed no new interventions noted or implemented to prevent injuries and/or the next fall from happening.

See also F689.

F 689 SS=G Free of Accident Hazards/Supervision/Devices
CFR(s): 483.25(d)(1)(2)

§483.25(d) Accidents.
The facility must ensure that -
§483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and

§483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents.
This REQUIREMENT is not met as evidenced by:
Based upon interview and record review, the facility failed to provide an environment that is free of accident hazards as is possible for one resident [Res.#1] of 4 sampled residents assessed as fall risks, regarding implementing interventions to reduce hazard(s) and risk(s); and monitoring for effectiveness and modifying

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1. Resident #1 expired on 01/03/2021
2. All Residents have the potential to be affected by the same deficient practice. Review of the care plans of Residents who had a fall within the last 30 days has been done and care plans requiring updating will be corrected.
3. In-Services on maintaining an environment that is as free of accident hazards as is possible and assessing Residents for fall risks and implementing interventions to reduce hazards and risks and monitoring the effectiveness and modifying the interventions when necessary has begun and will continue for six weeks.
4. Documentation of all in-services will be submitted to the QAPI committee at a future meeting.
   Audits of Resident fall risk assessments and Resident fall risk interventions will be conducted, five per week for six weeks. Results of the audits will be presented at a future QAPI committee meeting.
5. Completion on April 30,2021

F689 POC accepted 4/27/21
TDougherty RN/[illegible]

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	Continued From page 12 interventions when necessary. Findings include: Res. #1 was initially admitted to the facility on 9/23/19 with diagnoses that include Alzheimer's disease, Anxiety Disorder, Chronic Pain Syndrome, Restlessness and Agitation, and Vascular Dementia with Behavioral Disturbance. A review of the facility's Fall Prevention Policy identifies the Prevention procedure as "Residents will be individually evaluated for the potential risk of falling so that reasonable and appropriate measures can be developed to address each resident's individual needs in an effort to mitigate the identified risk areas." A review of Res. #1's Care Plan reveals the resident was identified, upon admission, as 'at risk for falls related to Impaired Balance, Weakness, Neurological deficits, Stroke, and Confusion.' The Care Plan includes 6 different interventions to prevent falls, including 'Complete Fall Risk Assessment per facility protocol and revise Plan of Care as needed'. Per review of Nurse's Notes dated 9/11/20, Res. #1 'was found lying on her left side on the floor of dayroom yelling/crying out to staff, she had a laceration on her left forehead ... Pressure was applied to laceration to stop bleeding, tissue was re-approximated to wound. A clean dry dressing was applied. The Doctor was updated- he will be here in the A.M. and apply stitches to the wound ...[Res. #1] was very upset, yelling, crying at staff ...' After the fall, Res. #1 was assessed using the Morse Fall Risk Assessment Scale. The scale rates the resident as a High Risk if they score 45 or higher. Res. #1's score after the fall was 75. Per the facility's Fall Prevention Policy, the		

F 689		F 689	
	Continued From page 13 resident's "Fall Reduction Plan will include: Development of Individualized Care Plans that reflect current, resident-centered interventions including documentation that reflects reviewed and/or updates for each problem with the care plan that the new fall impacted." Review of Res. #1's Care Plan after the fall on 9/11/20 reveals no documentation that a fall had occurred, and no new interventions added to prevent future falls. A Nurse Practitioner Note dated 11/16/20 describes the resident as "a 96-year-old female with ... advanced dementia with a history of behavior disturbance, and history of recurrent falls." The note further states "Last night at around 8:30 P.M. [Res.#1] fell, unwitnessed, nurse heard the loud noise. Patient crying out with fall and immediately went to her room to assess, noted large hematoma Left eyebrow area with an overlying abrasion. Also had a small laceration to left thumb." A Nurses Note also dated 11/16/20 reveals 'This writer was able to provide support to [Res. #1's daughter], explaining all safety measures that staff have in place and how mom last fall was May 2020, not as recent as she thought originally.' Review of Res. #1's medical record lists the resident's last fall as occurring on 9/11/20, two months prior to this fall on 11/15/20, and not in May 2020. After the fall, Res. #1 was again assessed using the Morse Fall Risk Assessment Scale. The scale rates the resident as a High Risk if they score 45 or higher. Res. #1's score after the fall on 11/15/20 was again 75. Review of Res. #1's Care Plan after the fall on 11/15/20 reveals no new interventions added to		

F 689

Continued From page 14

prevent future falls.

Review of Nursing Notes dated 12/12/20 reveal 'At 07:30 A.M. [Res.#!] was found on the side of her bed sitting up. It appears that she was trying to get up and slid right out of bed.'
Nurses Notes dated 12/14/20 further reveal '[after Res. #1's] fall daughter very upset since resident has fallen, and that she has frequent falls. Resident is 97-year-old with advanced dementia, poor safety awareness ... she is also at a high fall risk if staff were to put her in bed in the afternoon, since she recently had a fall and was sitting on the side of her bed on her floor ...'
Review of the resident's medical record reveals no fall assessment completed after the fall on 12/12/20, no documentation noted on the resident's care plan, and no new interventions added to prevent future falls.
Nurse Practitioner Note dated 12/14/20 relates Res. #1 'has had gradual ongoing decline over the past 8 months with recurrent falls and progressive advanced vascular dementia ... Patient also sustained a mechanical fall on 12/14/2020.' Per review of Res. #1's Care Plan, there is a notation that on 12/14/20 the resident sustained a 'laceration to forehead, subdural hematoma'.

An interview was conducted with the Director of Nursing Services [DNS] on 3/23/21 at 11:50 A.M. The DNS confirmed that Res. #1 underwent multiple falls with injuries while at the facility. The DNS stated that Res. #1's Care Plan should have been reviewed and revised to include new interventions to prevent future falls after each fall Res. #1 experienced. The DNS confirmed that consecutive falls on 9/11/20, 11/15/20, and 12/12/20 revealed no new interventions noted or implemented to prevent injuries and/or the next

F 689

F 689	Continued From page 15 fall from happening.	F 689	