AGENCY OF HUMAN SERVICES
DEPARTMENT OF DISABILITIES, AGING AND INDEPENDENT LIVING

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

December 5, 2024

Ms. Christine Marek
Woodridge Nursing Home
142 Woodridge Drive
Barre, VT 05641-0550

Dear Ms. Marek:

Enclosed is a copy of your acceptable plans of correction for the recertification survey conducted on **November 6, 2024.** 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

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

PRINTED: 11/22/2024
FORM APPROVED
OMB NO. 0938-0391

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 11/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODRIDGE NURSING HOME	**142 WOODRIDGE DRIVE** **BARRE, VT 05641**

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E 000	Initial Comments The Division of Licensing and Protection conducted an annual emergency preparedness survey on 11/6/24. The facility was found in substantial compliance with emergency preparedness regulations.	E 000		
F 000	INITIAL COMMENTS An unannounced, on-site re-certification survey was conducted by the Division of Licensing and Protection on 11/4/24 through 11/6/24 at Woodridge Rehabiliation and Nursing to determine compliance with 42 CFR Part 483 requirements for Long Term Care Facilities. Five facility reported incidents were also investigated (ACTS #22892, #22753, #23260, #23207, and #22822). The following regulatory violations were 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; Type text here This REQUIREMENT is not met as evidenced by:	F 600	1.) The Prevention of Abuse Policy was reviewed and updated by the Administrator and the Director of Nursing to include the identified missing components for Screening, Training, Prevention, and Identification on 11-18-2024. 2.) Resident #25's plan of care was reviewed and updated by the Clinical Nurse Coordinator to identify behaviors, and the care plan was updated on 11-7-2024. Resident #84's care plan was reviewed by Clinical Nurse Coordinator specific to the risk of resident-to-resident encounters from Resident #21, for include interventions to the prevention of physical and/or verbal altercation with Resident #84 and other residents. 3.) The clinical and ancillary staff were re-educated by the Staff Educators and Directors to the revised Prevention of Abuse policy via a combination of electronic, huddles, and meetings by 12-18-2024.	Type text here

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Debbie Reynolds, RN — TITLE: Director of Nursing — (X6) DATE: 12-4-24

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 FOR APPROVED

CENTERS FOR MEDICARE & MEDICAID SERVICES OMB N 0938-0391

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F 600	Continued From page 1 Based on interview and record review, the facility failed to ensure two residents [Resident #73, and Resident #84] of three sampled residents remained free from physical abuse. Findings include: Per record review of Resident #73's progress notes, on 4/1/24 at approximately 1:00 PM, Resident #25 entered Resident #73's room and struck Resident #73. Resident #73 pushed the emergency light in his/her room and staff intervened. Resident #73 had their vital signs taken and was assessed by nursing staff. Per record review of Resident #73's progress notes, the resident sustained scratches on the right side of his/her neck and right elbow and was "shaken by the incident." An interview was conducted on 11/6/24 at 2:07 PM with LNA#1, who was the caregiver during the incident. LNA #1 stated the emergency light went off in Resident #73's room. LNA #1 ran down the hall and found Resident #25 at doorway of Resident #73's room. S/he was attempting to push through, and the two residents began fighting. Per record review of Resident #25's care plan, there are no updated interventions after the incident to discuss how to prevent further physical altercations with other residents or staff. An interview was conducted with the DON [Director of Nursing] on 11/6/24 at 3:59 PM. The DON [Director of Nursing] substantiated the incident and confirmed that Resident #73 was not free from abuse. The DON confirmed that Resident #25's care plan was not updated with any additional interventions following the incident	F 600	4.) Audits will be conducted by Staff Educators and Unit Managers to ensure that staff can demonstrate knowledge of the revised Prevention of Abuse Policy; findings will be reviewed by the Quality Assurance Committee / Quality Assurance Performance Improvement Committee until such time compliance has been achieved as determined by the Committee. 5.) Compliance completion by 12-18-2024. **Tag F 600 POC accepted on 12/5/24 by C. Howard/P. Cota**	

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F 600	Continued From page 2 with Resident #73. 2. Per Nursing note dated on 8/19/2024, Resident #21 punched Resident #84 in the upper arm. Resident #21 then began using profanity toward Resident #84. Per Resident #84 medical record and care plan initiated on 5/26/2024 S/he is at risk for inappropriate interactions with other residents related to his/ her impaired cognition and history of resident to resident altercation on 4/21/2022. Resident #84 has the following Intervention dated 5/21/2021 "Anticipate and meet The resident needs." Per observation of Resident #84 in the common area on 11/05/24 at 03:25 PM, this writer observed Resident #21 sit down next to Resident #84 and reached over and placed his/her hand on Resident #84's arm. Per observation there was no staff redirection. Staff did not attempt to separate the two residents or place in different areas of the room. Per record review of Resident # 84 care plan there is no evidence of revision after the altercation on 8/19/2024 or education to staff related to the past actual and risk of further altercation between Resident # 84 and Resident # 21. Per interview with the LNA on 11/5/2024 at 3:30 PM stated S/he is not aware of any interventions to maintain distance or observe the two residents when in the common areas together. Per Interview of the Unit Manager on 11/5/2024 at 3:45 PM confirmed that there are no interventions to maintain distance between the two residents and that it would be difficult to separate them in the common area. UM confirmed that both	F 600		

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F 600	Continued From page 3 residents have been involved in other resident to resident altercations and are at risk. Per interview with the Administrator On 11/11/06/24 at 5:00 PM S/he stated that the incident did occur between Resident #21 and Resident #84 and confirmed that Resident #84 was not free from abuse while at the facility.	F 600		
F 607 SS=C	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(5)(ii)(iii) §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, §483.12(b)(4) Establish coordination with the QAPI program required under §483.75. §483.12(b)(5) Ensure reporting of crimes occurring in federally-funded long-term care facilities in accordance with section 1150B of the Act. The policies and procedures must include but are not limited to the following elements. §483.12(b)(5)(ii) Posting a conspicuous notice of employee rights, as defined at section 1150B(d)(3) of the Act. §483.12(b)(5)(iii) Prohibiting and preventing	F 607	1.) The Prevention of Abuse Policy was reviewed and updated by the Administrator and Director of Nursing on 11-18-2024 to include components for Screening, Training, Prevention, and Identification. 2.) The Prevention of Abuse Policy was updated to include Screening, Training, Prevention, Identification, Investigation, Protection and Reporting completed on 11-18-2024. 3.) Clinical and ancillary staff were re-educated to the revised Prevention of Abuse Policy by the Staff Educators and Directors beginning 11-27-2024. 4.) Audits will be conducted by Staff Educators and Unit Managers to ensure that staff can demonstrate knowledge of the revised Prevention of Abuse Policy; findings will be reviewed by the Quality Assurance Committee / Quality Assurance Performance Improvement Committee until such time compliance has been achieved as determined by the Committee. 5.) Compliance completion by 12-18-2024. **Tag F 607 POC accepted on 12/5/24 by C. Howard/P. Cota**	

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F 607	Continued From page 4 retaliation, as defined at section 1150B(d)(1) and (2) of the Act. This REQUIREMENT is not met as evidenced by: Based on facility policy review and staff interview, the facility failed to develop written policies and procedures that include all the required regulatory topics related to screening, training, prevention, and identification. Findings include: Per review of facility policy titled, "Preventing, Reporting, and Investigating Resident Abuse, Mistreatment, Exploitation and Neglect," published on 3/14/24, the following required components are missing: Screening, -screening potential employees for a history of abuse, neglect, exploitation, or misappropriation of resident property in order to prohibit abuse, neglect, and exploitation of resident property; and -screening prospective residents to determine whether the facility has the capability and capacity to provide the necessary care and services for each resident admitted to the facility Training -training new and existing nursing home staff and in-service training for nurse aides in the following topics which include: o Prohibiting and preventing all forms of abuse, neglect, misappropriation of resident property, and exploitation; o Identifying what constitutes abuse, neglect, exploitation, and misappropriation of resident property; o Recognizing signs of abuse, neglect, exploitation and misappropriation of resident property, such as physical or psychosocial	F 607		

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F 607	Continued From page 5 indicators; o Reporting abuse, neglect, exploitation, and misappropriation of resident property, including injuries of unknown sources, and to whom and when staff and others must report their knowledge related to any alleged violation without fear of reprisal; and o Understanding behavioral symptoms of residents that may increase the risk of abuse and neglect and how to respond. Prevention -prevent and prohibit all types of abuse, neglect, misappropriation of resident property, and exploitation that achieves (but is not limited to): o Establishing a safe environment that supports, to the extent possible, a resident's consensual sexual relationship and by establishing policies and protocols for preventing sexual abuse, such as the identify when, how, and by whom determinations of capacity to consent to a sexual contact will be made and where this documentation will be recorded; and the resident's right to establish a relationship with another individual, which may include the development of or the presence of an ongoing sexually intimate relationship; o Identifying, correcting and intervening in situations in which abuse, neglect, exploitation, and/or misappropriation of resident property is more likely to occur. This includes the implementation of policies that address the deployment of trained and qualified, registered, licensed, and certified staff on each shift in sufficient numbers to meet the needs of the residents, and assure that the staff assigned have knowledge of the individual residents' care needs and behavioral symptoms, if any (see also F727 related to proficiency of nurse aides);	F 607	Type text here	

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F 607	Continued From page 6 o Assuring that residents are free from neglect by having the structures and processes to provide needed care and services to all residents, which includes, but is not limited to, the provision of a facility assessment to determine what resources are necessary to care for its residents competently; o The identification, ongoing assessment, care planning for appropriate interventions, and monitoring of residents with needs and behaviors which might lead to conflict or neglect, such as: Verbally aggressive behavior, such as screaming, cursing, bossing around/demanding, insulting to race or ethnic group, intimidating; Physically aggressive behavior, such as hitting, kicking, grabbing, scratching, pushing/shoving, biting, spitting, threatening gestures, throwing objects; Sexually aggressive behavior such as saying sexual things, inappropriate touching/grabbing; Taking, touching, or rummaging through other's property; Wandering into other's rooms/space; Residents with a history of self-injurious behaviors; Residents with communication disorders or who speak a different language; and Residents that require extensive nursing care and/or are totally dependent on staff for the provision of care. o Ensuring the health and safety of each resident with regard to visitors such as family members or resident representatives, friends, or other individuals subject to the resident's right to deny or withdraw consent at any time and to reasonable clinical and safety restrictions; o Providing residents and representatives, information on how and to whom they may report concerns, incidents and grievances without the fear of retribution; and providing feedback regarding the concerns that have been expressed. (See F585 for further information	F 607	Type text here	

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F 607	Continued From page 7 regarding grievances). Identification -Identifying the different types of abuse-mental/verbal abuse, sexual abuse, physical abuse, and the deprivation by an individual of goods and services. The request for additional abuse policies and procedures was made to the Director of Nursing on 11/5/24. Per interview on 11/6/24 at 3:52 PM, the Director of Nursing confirmed that there were no additional policies or procedures related to abuse and the above topics.	F 607		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized	F 656	1.) Resident #47 had a complete skin assessment with no findings. The associated plan of care was updated by the Clinical Nurse Coordinator on 11-28-2024. 2.) Skin assessments were conducted at the facility by Clinical Nurse Coordinators and staff nurses on 12-1-2024 to identify pressure wounds. Orders were obtained and care plans were updated as applicable. 3.) Nursing staff will be re-educated on Woodridge Wound Care Policy and implementation of skin prevention interventions by the Staff Educators by 12-18-2024. 4.) Clinical Nurse Coordinators will conduct audits of high-risk residents and findings will be reviewed by the Quality Assurance Committee / Quality Assurance Performance Improvement Committee until such time compliance has been achieved as determined by the Committee. 5.) Compliance completion by 12-18-2024. **Tag F 656 POC accepted on 12/5/24 by C. Howard/P. Cota**	

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F 656	Continued From page 8 rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to revise a Resident's care plan to include interventions needed to prevent pressure injury for 1 out of 5 residents in the sample (Resident # 47) who was identified as a high risk for pressure injury. Findings include: Per record review Emergency Department notes dated 1/19/2024 Resident #47 fell and sustained a fractured right hip on 1/19/2024. S/He was treated for pain at the hospital then returned to facility for comfort focused care Per the MDS [Minimum Data Set - a	F 656		

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Continued From page 9 comprehensive resident assessment tool] dated 1/30/2024, the Resident was identified as a high risk for pressure injury. The MDS Coordinator documented the following assessment "[Resident #47] has no PI [pressure injury] at this time.
Braden score of 14 [per facility definition the Braden Scale is a "validated pressure injury risk assessment tool used by RNs (Registered Nurse) and LPNs (Licensed Practical Nurse) to assign a level of pressure injury risk to trigger appropriate interventions for pressure injury prevention"].
[S/he] is at high risk for skin integ [integrity] due to her spell of illness, decreased mobility, and reliant on staff for repositioning ..." Per Resident #47 care plan dated 8/4/2023 'Resident is dependent for bed mobility. [S/He] requires assist of x2 to roll in bed ..."

Per facility policy titled "Woodridge Wound Care Protocol" last reviewed 1/16/2024 the following interventions should be in place for those who are identified at risk for pressure injuries:

-Turning, Positioning
-Re-position/turn in bed at least every two hours, more often as needed; avoid positioning directly on pressure areas.
-After positioning, place a hand underneath the sacrum to determine if the sacrum offloaded. -Heel elevation -Elevate heels off all surfaces by placing pillows lengthwise under calves to Achilles tendon, using heel bolster.

A nursing assessment "skin check" dated 2/20/2024, reveals that Resident #47 was identified to have pressure injury in the form of a deep tissue injury (DTI) to his/her sacrum. According to the National Institute of Medicine (2015) a deep tissue injury (DTI) is a form of

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F 656	Continued From page 10 pressure injury that is deep purple or maroon in color, the area of skin may be intact skin or have a blood?filled blister due to damage of underlying soft tissue from pressure and/or shear. There is no evidence that the facility updated the care plan at that time or implemented frequent repositioning or offloading the sacrum. There were also no interventions to elevate the heels with pillows or heel bolsters to prevent pressure injury to the Resident #47's heels. There is no evidence of new interventions after actual pressure injury occurred on 2/20/2024, until 7/18/2024. Per nursing assessment "skin check" dated on 7/18/2024, Resident #47 was identified to have a second DTI to the right heel. Per physician orders dated 7/18/2024 "Nursing order PI [pressure injury] prevention and bilateral black booties when in bed." LNA (Licensed Nursing Assistant) task documentation record and Resident #47's care plan reveals that the intervention to apply heel off-loading device was not initiated until 7/18/2024 again after the pressure injury developed. Per care plan the intervention to turn and reposition was not added until 8/7/2024, six months after the pressure injury occurred. Per review of Resident #47's care plan dated 8/14/2023, reveals the following focus "At risk for further alteration in skin integrity/PI [related to/history] of pressure injury to the sacrum, [history] of pressure injury to (r) heel. Decreased mobility, requiring staff assistance with transfers and repositioning, weakness, poor PO intake and bowel /bladder incontinence ..." Interventions dated 1/23/24 include pressure reducing mattress and wheelchair cushion. There were no new interventions related to pressure injury prevention	F 656		

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F 656	Continued From page 11 after the MDS that was completed on 1/30/2024 which identified Resident #47 as high risk for pressure injury. Per interview of the Unit Manager (UM) on 11/6/2024 at approximately 10:00 AM s/he confirmed that there was no documented evidence that Resident #47's care plan was updated to include the prevention measures stated in the facility policy related to specific sacral and heel pressure injury prevention. There was also no documented evidence that these interventions were implemented prior to 7/18/2024.	F 656		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that(i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to prevent pressure injuries caused by deep tissue injury (DTI) (A form of pressure injury that is purple or maroon localized area of discolored intact skin or blood-filled blister due to damage of	F 686	1. Resident #47 had a complete skin assessment with no new findings. The associated plan of care was updated by the Clinical Nurse Coordinator on 11-28-2024. 2. Skin assessments were conducted at the facility by Clinical Nurse Coordinators and staff nurses on 12-1-2024 to identify pressure wounds. Orders were obtained and care plans were updated as applicable. 3. Nursing staff will be re-educated on Woodridge Wound Care Policy and implementation of skin prevention interventions by the Staff Educators by 12-18-2024. 4. Clinical Nurse Coordinators will conduct audits of high-risk residents and findings will be reviewed by the Quality Assurance Committee/Quality Assurance Performance Improvement Committee until such time compliance has been achieved as determined by the Committee. 5. Compliance completion by 12-18-2024 **Tag F 686 POC accepted on 12/5/24 by C. Howard/P. Cota**	

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 C 11/06/2024
NAME OF PROVIDER OR SUPPLIER: **WOODRIDGE NURSING HOME**		STREET ADDRESS, CITY, STATE, ZIP CODE: **142 WOODRIDGE DRIVE BARRE, VT 05641**	

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F 686	Continued From page 12 underlying soft tissue from pressure and/or shear. The area may be preceded by tissue that is painful, firm, mushy, boggy, warmer or cooler as compared to adjacent tissue) by failing to implement preventative measures per facility policy and professional standards, for one of 5 Residents in the sample, (Resident #47). Findings include: Per record review an Emergency Department note dated 1/19/2024 reveals that Resident #47 fell on 1/19/2024 and sustained a fractured hip. S/He was treated for pain at the hospital then returned to facility for comfort focused care on 1/24/2024. On 1/23/24 Resident #47's care plan was updated with the following intervention: pressure reducing mattress and wheelchair cushion. Per the MDS [Minimum Data Set - a comprehensive resident assessment tool] dated 1/30/2024, the Resident was identified as a high risk for pressure injury. The MDS Coordinator documented the following assessment "[Resident #47] has no PI [pressure injury] at this time. Braden score of 14 [per facility definition the Braden Scale is a "validated pressure injury risk assessment tool used by RNs (Registered Nurse) and LPNs (Licensed Practical Nurse) to assign a level of pressure injury risk to trigger appropriate interventions for pressure injury prevention]." [S/he] is at high risk for skin integ [integrity] due to her spell of illness, decreased mobility, and reliant on staff for repositioning..." A nursing assessment "skin check" dated 2/20/2024 states that Resident #47 was identified to have a pressure injury in the form of a deep tissue injury (DTI) to his/her sacrum. There is no	F 686		

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F 686	Continued From page 13 evidence that the facility updated the care plan at that time, and no evidence of any further interventions to treat the new DTI or prevent further skin breakdown. Per nursing assessment "skin check" dated 7/18/2024, Resident #47 was identified to have a second DTI to the right heel. Per physician orders dated 7/18/2024, "Nursing order PI [pressure injury] prevention and bilateral black booties when in bed." According to the LNA task documentation record and Resident #47's care plan the intervention to apply heel off-loading device was not initiated until 7/18/2024 after the pressure injury developed. Per facility policy titled "Woodridge Wound Care Protocol" [last reviewed 1/16/2024] the following interventions should have been implemented on 1/30/24 to prevent pressure injury for Resident #47 when identified by the MDS as high risk for pressure injury: " Turning, Positioning " Re-position/turn in bed at least every two hours, more often as needed; avoid positioning directly on pressure areas. " After positioning, place a hand underneath the sacrum to determine if the sacrum offloaded. " Heel elevation - elevate heels off all surfaces by placing pillows lengthwise under calves to Achilles tendon, using heel bolster. " Lift heels while moving to prevent skin shear. Apply foam dressings to fragile areas for high-risk patients and inspect under dressing daily." Per Resident #47's care plan dated 8/4/2023, "Resident is dependent for bed mobility. [S/He] requires assist of x2 [times two] to roll in bed ..." Per Resident #47's care plan the intervention to	F 686		

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F 686	Continued From page 14 apply heel off-loading device was not initiated until 7/18/2024 after the pressure injury developed. Care plan interventions to turn and reposition the Resident were not added until 8/7/2024, six months after the pressure injury occurred. During an interview with the Unit Manager (UM) on 11/6/2024 at approximately 10:00 AM s/he confirmed that there was no documented evidence that any of the above interventions were implemented prior to 7/18/2024 after the pressure injuries developed. Per interview on 11/6/2024 at approximately 5:30 PM the Director of Nursing confirmed that there was no documented evidence that turning and repositioning or heel protection/elevation was implemented until after Resident #47 developed the pressure injuries to her/his sacrum and right heel. The Director of Nursing confirmed that the facility did not follow all their policy to prevent pressure injury for Resident #47. References Black JM, Brindle CT, Honaker JS. Differential diagnosis of suspected deep tissue injury. Int Wound J. 2016 Aug;13(4):531-9. doi: 10.1111/iwj.12471. Epub 2015 Jun 30. PMID: 26123043; PMCID: PMC7950046.	F 686		
F 699 SS=D	Trauma Informed Care CFR(s): 483.25(m) §483.25(m) Trauma-informed care The facility must ensure that residents who are trauma survivors receive culturally competent, trauma-informed care in accordance with professional standards of practice and accounting for residents' experiences and preferences in	F 699	1.) Resident #10 was re-evaluated by Social Services Staff and the care plan was updated to reflect individual resident behavioral triggers by 12-18-2024. Resident #71 was re-evaluated by Social Service Staff and the care plan updated to reflect individual resident behavioral triggers by 12-18-2024. Psychology referrals obtained for Resident #71. 2.) A review of residents was conducted related to trauma informed care and the care plans were updated by Social Service Staff to reflect individual resident	

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F 699	Continued From page 15 order to eliminate or mitigate triggers that may cause re-traumatization of the resident. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility failed to ensure that residents who are trauma survivors receive trauma informed care that mitigates triggers that may re-traumatize residents for 2 of 4 residents (Resident #10 and #71). Findings Include: 1. Per interview on 11/6/24 at approximately 2:00 PM, Resident #10 stated that s/he has had bad experiences in his/her past that get brought up when other residents say sexual things. Per record review, Resident #10's care plan reads, "The resident has a psychosocial wellbeing problem r/t [related to] trauma of children molested by [spouse]. No triggers recorded ...," revised 6/18/24, and "Resident is at risk for re-traumatization R/T history of past life trauma ...," revised on 9/17/2024. Resident #10's care plan does not include any identified triggers. Facility policy titled "Trauma Informed Care," last reviewed on 7/18/23 reads, "Woodridge will identify triggers which may re-traumatize residents with a history of trauma. Trigger-specific interventions will identify ways to decrease the resident's exposure to triggers which re-traumatize the resident, as well as identify ways to mitigate or decrease the effect of the trigger on the resident, and will be added to the residents care plan." Per interview on 11/06/24 at 1:42 PM with a Social Service Staff, s/he confirmed that Resident #10 does not have triggers identified in his/her	F 699	behavior triggers by 12-182024. Psychology referrals made as indicated by 12-18-2024. 3.) Social Service Staff was re-educated by Director of Nursing regarding care planning to include psychology referrals, care plan trigger approaches and interventions on 12-3-2024. Direct care staff was re-educated by Staff Educators by 12-18-2024 on resident behaviors, triggers and interventions. 4.) Weekly audits of trauma informed care plan triggers will be conducted by the Quality Improvement Coordinator and will include psychology referrals and staff knowledge of the triggers, interventions and approaches. The findings will be reviewed by the Quality Assurance Committee / Quality Assurance Performance Improvement Committee until such time that compliance has been achieved as determined by the Committee. 5.) Compliance completion by 12-18-2024. **Tag F 699 POC accepted on 12/5/24 by C. Howard/P. Cota**	

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F 699	Continued From page 16 care plan about her trauma. At 4:16 PM, the Social Service Staff explained that just looking at specific residents is a trigger for Resident #10. 2. Per record review, Resident #71's care plan reads, "Resident is at risk for re-traumatization [related to] history of Natural and human caused disasters, Accidents, War, Physical and emotional abuse. [Resident #71] voiced [s/he] was hit with a German beer bottle and in lots of fights when [s/he] was in the Army due to [his/her] size," revised 5/23/24. Interventions include "Respond to resident identified triggers that prompt anxiety or symptoms and modify care/environment as needed," initiated on 5/13/2024, and "Social services to initiate referral as appropriate to manage triggers," initiated on 5/13/2024. Resident #71's care plan does not include any identified triggers. Per interview on 11/6/24 at 9:36 AM, a Social Service Staff confirmed that Resident #71 does not have identified triggers in their care plan and a referral for therapy support has not been put in.	F 699		
F 756 SS=D	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing,	F 756	1.) Nursing Managers reviewed the October 2024 and the November 2024 recommendations and follow up will be completed by 12-18-2024. 2.) Nursing Managers and Providers were reeducated by the Director of Nursing regarding the completion of Consulting Pharmacist recommendations to be completed monthly. 3.) A monthly audit of the pharmacy recommendations will be completed by the Nurse Managers to identify that follow up is in place as required. 4.) The audit findings will be reviewed	

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F 756	Continued From page 17 and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure that monthly pharmacist drug regimen reviews, recommendations, and attending physician responses are completed and documented in the resident record for 1 of 5 sampled residents (Resident #71). Findings include: Per record review, Resident #71 has had multiple physician orders over the past year for the antipsychotic quetiapine.	F 756	by the Quality Assurance Committee until such time compliance has been achieved as determined by the Committee. 5.) Compliance completion 12-15-2024. **Tag F 756 POC accepted on 12/5/24 by C. Howard/P. Cota**	

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F 756	Continued From page 18 A pharmacist's medication regime review for Resident #71 in February 2024 recommends the following: "Per the November 2017 Medicare MEGA Rule regulations, PRN [as needed] Antipsychotic orders can only be for 14 days. If order is to be continued, it needs to be reassessed every 14 days and clinical rationale documented every 14 days. Resident has the following order: Quetiapine 12.5 mg [by mouth every 12 hours] prn agitation May we clarify this order to: Quetiapine 12.5 mg [by mouth every 12 hours] prn agitation x 14 days Please document rationale for continuing this order." The pharmacist's medication regime review recommends changing the physician order for PRN Quetiapine to have a duration of 14 days in March, May, June, and July 2024. There is no evidence in Resident #71's medical record that the attending physician reviewed and acted upon pharmacist's recommendations for the five months above. Per interview on 11/06/24 at 1:46 PM, the Clinical Nurse Coordinator confirmed that there was no evidence that a physician reviewed and took action for the pharmacy recommendations made in February, March, May, June, and July 2024 for Resident #71.	F 756		
F 943 SS=C	Abuse, Neglect, and Exploitation Training CFR(s): 483.95(c)(1)-(3)	F 943	1.) The Prevention of Abuse Policy was reviewed and updated by the Administrator and the Director of Nursing to include the identified missing components for	

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F 943	Continued From page 19 §483.95(c) Abuse, neglect, and exploitation. In addition to the freedom from abuse, neglect, and exploitation requirements in § 483.12, facilities must also provide training to their staff that at a minimum educates staff on- §483.95(c)(1) Activities that constitute abuse, neglect, exploitation, and misappropriation of resident property as set forth at § 483.12. §483.95(c)(2) Procedures for reporting incidents of abuse, neglect, exploitation, or the misappropriation of resident property §483.95(c)(3) Dementia management and resident abuse prevention. This REQUIREMENT is not met as evidenced by: Based on interviews and record review, the facility failed to develop and implement an effective abuse, neglect, exploitation, misappropriation of resident property, and dementia management training program for all staff. Findings include: A review of all educational materials used to train staff on abuse, neglect, exploitation, misappropriation of resident property, and dementia management was reviewed while investigating allegations of abuse. The materials provided included a power point titled "Preventing & Reporting Resident Abuse, Misappropriation, Exploitation, and Neglect (AMEN)" and another power point titled Abuse and Neglect. These training materials do not include: - Recognizing signs of abuse, neglect, exploitation and misappropriation of resident property, such as physical or psychosocial	F 943	Screening, Training, Prevention, and Identification on 11-18-2024. 2. The Prevention of Abuse Policy was updated to include Screening, Training, Prevention, Identification, Investigation, Protection and Reporting completed on 11-18-2024. The definition related to abuse and identified behaviors related to sexual abuse were included on 11-18-2024. 3. The clinical and ancillary staff were re-educated to the revised Prevention of Abuse Policy by the Staff Educators and Directors by 12-18-2024. The Unit Managers will conduct random weekly audits to ensure staff has knowledge of the revised Prevention of Abuse Policy. 4. Audits will be reviewed by the Quality Assurance Committee/Quality Assurance Performance Improvement Committee until such time that compliance has been achieved as determined by the Committee. 5. Compliance completion by 12-18-2024. **Tag F 943 POC accepted on 12/5/24 by C. Howard/P. Cota**	

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F 943	Continued From page 20 indicators; - Understanding behavioral symptoms of residents that may increase the risk of abuse and neglect and how to respond. While the training does include definitions of abuse, neglect, exploitation, and misappropriation of resident property, the training materials do not include: - Identifying behavior constituting abuse (including sexual, physical, and mental abuse), neglect, exploitation, and misappropriation of resident property. Per interview on 11/5/24 at 10:32 AM, the Nurse Educator confirmed that the materials reviewed were in totality and had no additional educational materials that would include the above topics.	F 943		