| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 415064 | A. Building<br>B. Wing | 03/25/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Pawtucket Falls Healthcare Center | 70 Gill Avenue<br>Pawtucket, RI 02861 |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES<br>(Each deficiency must be preceded by full regulatory or LSC identifying information) |
|---|---|
| F 0641<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure each resident receives an accurate assessment.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41729<br><br>Based on record review and staff interview, it has been determined that the facility failed to ensure that the assessment accurately reflected the resident's status for 1 of 5 sample residents reviewed relative to elopement, Resident ID #1.<br><br>Findings are as follows:<br><br>Record review revealed the resident was admitted to the facility in October of 2021.<br><br>Record review of a facility document tilted Admission Record: Diagnosis Information dated 10/6/2021 revealed the resident has diagnoses of dementia in other diseases classified elsewhere with behavioral disturbance, anxiety, and other symptoms and signs involving cognitive functions.<br><br>Record review of the facility's wander risk assessment reveal this is an assessment that the facility uses to determine if a resident is at risk for elopement and/or wandering.<br><br>Record review of the resident's admission Wandering Risk assessment dated [DATE] failed to reveal evidence that the resident has diagnoses of dementia, cognitive impairment, and anxiety. Further record review revealed an additional wander risk assessment was completed on 1/6/2022 and failed to reveal evidence that the resident has diagnoses of dementia, cognitive impairment, and anxiety.<br><br>Record review of the resident's progress notes revealed the following:<br><br>- On 3/20/2022 at 3:36 PM .On the above day this writer confirms [resident] left the building, and [s/he] walked all the way to [coffee shop], CNA [Certified Nursing Assistant] called me on the front phone and informed me that [resident] was in [coffee shop] .I saw [resident] walk out the front door, but [s/he] was sitting on the bench and I let [him/her] be, but I got up to use the ladies' room and I did not see [him/her] out there, I thought [s/he] got cold and [s/he] went back to [his/her] room .<br><br>- On 3/20/2022 at 3:40 PM It was reported that [resident] was seen at [coffee shop] by second shift staff member .This writer spoke to [resident] to inform [him/her] that it is not safe for [him/her] to leave the building alone .[S/he] was reminded that [s/he] needs to inform staff if [s/he] wants to sit outside because it is not safe for [him/her] to be alone. Nursing staff made aware that [resident] needs a wander guard .<br><br>(continued on next page) |



| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 415064 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 03/25/2022 |
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| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Pawtucket Falls Healthcare Center | 70 Gill Avenue<br>Pawtucket, RI 02861 |

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| F 0641<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During a surveyor interview on 3/24/2022 at 2:01 PM with the Director of Nursing Services (DNS) in the presence of the Administrator, she could not provide evidence as to why the resident was inaccurately assessed. The DNS indicated that she would expect the assessment to reflect the resident diagnoses and orders and it did not reflect such. |

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| NAME OF PROVIDER OR SUPPLIER Pawtucket Falls Healthcare Center | | STREET ADDRESS, CITY, STATE, ZIP CODE 70 Gill Avenue Pawtucket, RI 02861 | |

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| F 0658<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure services provided by the nursing facility meet professional standards of quality.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41729<br><br>Based on record review and staff interview, it has been determined that the facility failed to provide services that meet professional standards of quality relative to following physician's order for 1 of 5 sample residents, Resident ID #1.<br><br>Findings are as follows:<br><br>According to Mosby's 4th Edition, Fundamentals of Nursing page 314 states in part .The physician is responsible for directing medical treatment. Nurses are obligated to follow physician's orders unless they believe the orders are in error or would harm the clients .<br><br>Record review revealed the resident was admitted to the facility in October of 2021 with diagnoses which include but are not limited to dementia in other diseases classified elsewhere with behavioral disturbance, other symptoms and signs involving cognitive functions and awareness, muscle weakness, anxiety, and abnormality of gait and mobility.<br><br>Record review of the resident's admission Minimum Data Set (MDS; an assessment that provides a multidimensional view of the patient's functional capacities and needs), dated 10/12/2021 revealed s/he had a brief interview for mental status (BIMS) score of 6 out of 15, indicating s/he had a severe cognitive impairment.<br><br>Record review revealed the resident's quarterly MDS dated [DATE] revealed a BIMS score of 7 out of 15, indicating s/he had severe cognitive impairment.<br><br>Additional review of both the admission and quarterly MDS indicates the resident requires supervision with locomotion off the unit.<br><br>Record review of an active physician's order dated 10/12/2021 states in part, Please place wander guard - elopement risk, Status: Active, Revision Date: 10/12/2021<br><br>Record review of the Treatment Administration Record (TAR) for October, November, and December 2021, and for January, February, and up to March 22, 2022, failed to reveal evidence of this order, or that it was being administered to the resident.<br><br>Record review of the resident's progress notes revealed the following:<br><br>- On 3/20/2022 at 3:36 PM .On the above day this writer confirms [resident] left the building, and [s/he] walked all the way to [coffee shop], CNA [Certified Nursing Assistant] called me on the front phone and informed me that [resident] was in [coffee shop] .I saw [resident] walk out the front door, but [s/he] was sitting on the bench and I let [him/her] be, but I got up to use the ladies' room and I did not see [him/her] out there, I thought [s/he] got cold and [s/he] went back to [his/her] room .<br><br>(continued on next page) |

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| Pawtucket Falls Healthcare Center | 70 Gill Avenue<br>Pawtucket, RI 02861 |

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| F 0658<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | - On 3/20/2022 at 3:40 PM It was reported that [resident] was seen at [coffee shop] by second shift staff member .This writer spoke to [resident] to inform [him/her] that it is not safe for [him/her] to leave the building alone .[S/he] was reminded that [s/he] needs to inform staff if [s/he] wants to sit outside because it is not safe for [him/her] to be alone. Nursing staff made aware that [resident] needs a wander guard .<br><br>Further record review failed to reveal evidence the wander guard was in place as ordered since it was ordered on 10/12/2021. Additionally, the wander guard was placed on the resident after s/he eloped which was 159 days after it was ordered.<br><br>During surveyor interview with the Director of Nursing Services on 3/23/2022 at 1:23 PM and at 1:44 PM, she indicated that she was not aware of the resident's order for the wander guard dated 10/12/2021 until it was brought to her attention by the surveyor. Additionally, she acknowledged that the resident did not have a wander guard on at the time of his/her elopement from the facility. |

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| Pawtucket Falls Healthcare Center | 70 Gill Avenue Pawtucket, RI 02861 |

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|---|---|
| F 0689<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41729<br><br>Based on record review, resident and staff interview, it has been determined that the facility failed to provide adequate supervision and assistance devices to prevent an accident for 1 of 5 sample residents reviewed for elopement, Resident ID #1.<br><br>Findings are as follows:<br><br>Review of the facility policy titled, Resident Elopement Policy states in part, .Procedure: Residents that may be at a higher risk for elopement include but are not limited to confused, resistive .if a resident is found to be at risk for wandering, a wander guard bracelet will be placed on resident .staff interventions to prevent an elopement should include but may not be limited to: staff to respond immediately, as indicated .assess surrounding for any sign of resident elopement .Notify Charge Nurse .Charge Nurse to notify MD [medical doctor] and/or family .if resident does exit the building, staff person to stay with resident to maintain safety .In an event of actual elopement .notify the MD, Director of Nursing and the family .Once the resident has been located and returned to the facility: Perform a complete assessment and document .complete an Incident Report .<br><br>Record review of a community reported complaint submitted to the Rhode Island Department of Health, dated 3/22/2022 revealed this resident eloped from the facility and was found at a coffee shop on 3/20/2022 and the facility was unaware that s/he was missing.<br><br>Record review revealed the resident was admitted to the facility in October of 2021 with diagnoses which include but are not limited to dementia in other diseases classified elsewhere with behavioral disturbance, other symptoms and signs involving cognitive functions and awareness, muscle weakness, anxiety, and abnormality of gait and mobility.<br><br>Record review of the resident's admission Minimum Data Set (MDS; an assessment that provides a multidimensional view of the patient's functional capacities and needs), dated 10/12/2021 revealed s/he had a brief interview for mental status (BIMS) score of 6 out of 15, indicating s/he had a severe cognitive impairment.<br><br>Record review revealed the resident's quarterly MDS dated [DATE] revealed a BIMS score of 7 out of 15, indicating s/he had severe cognitive impairment.<br><br>Additional review of both the admission and quarterly MDS indicated the resident requires supervision with locomotion off the unit.<br><br>Record review of the resident's care plan dated 10/7/2021 which was last revised on 10/16/2021, revealed the resident is at increased risk for falls related to gait and balance problems, poor communication, and comprehension and unaware of safety needs.<br><br>Record review of an active physician's order dated 10/12/2021 states in part, Please place wander guard - elopement risk, Status: Active, Revision Date: 10/12/2021.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Record review revealed this resident left the faciity on [DATE]. The exact time could not be established by the facility. The resident was seen by Certified Nursing Assistant, Staff C, in the parking lot of a coffee shop that is located on a highly traveled main road. Staff C proceeded to the facility and reported this to the receptionist, Staff A. Staff A then reported this information to the Licensed Practical Nurse, Staff B, who proceeded to bring the resident back to the facility. Additionally, this resident had an order for a wander guard which was never initiated until s/he had successfully eloped.<br><br>Further record review of the resident's progress notes revealed the following:<br><br>- On 3/20/2022 at 3:36 PM .On the above day this writer confirms [resident] left the building, and [s/he] walked all the way to [coffee shop], CNA [Certified Nursing Assistant] called me on the front phone and informed me that [resident] was in [coffee shop] .I saw [resident] walk out the front door, but [s/he] was sitting on the bench and I let [him/her] be, but I got up to use the ladies' room and I did not see [him/her] out there, I thought [s/he] got cold and [s/he] went back to [his/her] room .<br><br>- On 3/20/2022 at 3:40 PM It was reported that [resident] was seen at [coffee shop] by second shift staff member .This writer spoke to [resident] to inform [him/her] that it is not safe for [him/her] to leave the building alone .[S/he] was reminded that [s/he] needs to inform staff if [s/he] wants to sit outside because it is not safe for [him/her] to be alone. Nursing staff made aware that [resident] needs a wander guard .<br><br>Further record review failed to reveal evidence that the wander guard was in place as ordered on 10/12/2021. Additionally, the wander guard was placed on the resident after s/he eloped which was 159 days after it was ordered.<br><br>Further record review failed to reveal evidence that an assessment of the resident was completed upon his/her return to the facility following the elopement.<br><br>Additionally, the record failed to reveal evidence that the resident's physician was notified of his/her elopement as indicated in the facility's policy.<br><br>During a surveyor interview with the resident on 3/23/2022 at 11:50 AM, s/he stated, I just walked out. S/he indicated that s/he was not aware that s/he could not leave the facility unattended and refused to answer any further questions.<br><br>During a surveyor interview on 3/23/2022 at 1:05 PM with Staff A, she revealed that on 3/20/2022 between the hours of 2:00 PM to 3:35 PM she indicated that she observed the resident walking out of the building and sat on a bench. She indicated that she was unaware that the resident required supervision while outside. She revealed that she left the reception area twice, and upon her return the resident was not observed where she last saw him/her. She acknowledged that she did not locate the resident and did not notify the nurse when the resident was not where she had last seen him/her.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | During a surveyor interview on 3/25/2022 at 8:40 AM with Staff B, he indicated that on 3/20/2022 at approximately between 3:30 PM-3:45 PM he was notified by Staff A that the resident had eloped. He acknowledged that the resident was observed in the parking lot of a coffee shop located on a busy avenue. Additionally, he indicated that the resident was confused and upset when s/he was found at that location. He also revealed that the staff on the resident's unit were not aware s/he was not on the unit or how long s/he was gone, until they were notified that s/he was found at the coffee shop. He further acknowledged that he did not notify the physician, family, and did not do an incident report as indicated in the facility's policy.<br><br>During a surveyor interview with the Director of Nursing Services on 3/23/2022 at 1:23 PM and at 1:44 PM, she indicated that she was not aware of the resident's order for the wander guard until it was brought to her attention by the surveyor. She acknowledged that the resident did not have a wander guard on at the time of his/her elopement. She further indicated that she would have expected the resident to be supervised and within sight of the staff while off the unit. |