STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	415084	A. Building B. Wing	03/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Elmhurst Rehabilitation & Healthcare Center	50 Maude Street Providence, RI 02908

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 (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46715 Based on surveyor observation, record review, and staff interview, it has been determined that the facility failed to ensure residents have the right to be free from any physical restraint not required to treat the resident's medical symptoms for 1 of 1 sample resident reviewed for restraints, Resident ID #58. Findings are as follows: Review of a facility policy titled, Use of Restraints states in part, .Restraints shall only be used to treat the resident's medical symptom(s) and never for discipline or staff convenience, or for prevention of falls . Record review revealed the resident was admitted to the facility in February of 2023 with diagnoses including, but not limited to, abnormalities of gait and mobility and unsteadiness on feet. Review of a Minimum Data Set assessment dated [DATE] revealed a Brief Interview for Mental Status score of 8 out of 15 indicating moderate cognitive impairment. Review of the care plan revealed the resident requires assistance of one staff member for ambulation and assistance of two staff members for bed mobility. Further review of the care plan revealed the resident is at risk for falls related to deconditioning, weakness, and balance problems. During a surveyor observation on 3/8/2023 at 8:10 AM the resident was in bed with two quarter side rails up and pillows on each side of the resident lining the bed. The pillows were observed to be tucked under the sheet holding them in place. The resident was observed attempting to put his/her legs over the side of the bed but was unable to. Further observation on the below dates and times revealed the resident was in bed with two quarter side rails up and pillows on each side of the resident lining the length of the bed. The pillows were observed to be tucked under the sheet holding them in place: - 3/8/2023 at 8:45 AM - 3/9/2023 at 8:08 AM (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- 3/9/2023 at 8:23 AM During a surveyor interview on 3/9/2023 at 8:25 AM, with Registered Nurse, Staff A, she was unable to provide evidence that the pillows tucked under the sheet on each side of the resident were there to treat a medical symptom. She further revealed that the resident was not able to get out of bed with the pillows on each side of him/her. During a surveyor interview on 3/9/2023 at 8:51 AM, with the Director of Nursing Services (DNS) in the presence of a second surveyor, she revealed that the resident's daughter put the pillows around the resident the previous night and that her staff should have removed them overnight. She was unable to provide evidence that the resident was able to get out of bed with the pillows in place and that they were treating a medical symptom. Directly following the above interview with the DNS, further chart review revealed a care plan put in place with a start date of 3/9/2023 which states in part, .placing pillows to prevent movement is considered a restraint in LTC [long term care] setting.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives an accurate assessment. 46241 Based on record review and staff interview, it has been determined that the facility failed to ensure assessments accurately reflect the resident's status for 3 of 7 residents reviewed for catheters, Resident ID #s 7, 145 and 287. 1 of 3 residents reviewed for wander guards, Resident ID #28 and 1 of 8 residents reviewed for antipsychotic use, Resident ID #28. Findings are as follows: 1. Review of the Resident Assessment Instrument (RAI) Manual, Version 3.0, states in part, .SECTION H: BLADDER AND BOWEL .Steps of Assessment Examine the resident to note the presence of any urinary or bowel appliances .Review the medical record, including bladder and down records for documentation of current or past use of urinary .appliances .Coding Instructions .Check next to each appliance that was used at any time in the past 7 days .Suprapubic catheters [placed directly into the bladder through the abdomen] . should be coded as indwelling catheter [maintained within the bladder for the purpose of continuous drainage of urine] . A. Record review revealed Resident ID #7 was readmitted to the facility in October of 2022 with a diagnosis including, but not limited to, Spina Bifida (a birth defect that occurs when the spine and spinal cord do not form properly). Review of Minimum Data Set (MDS) Assessment, Section H0100, titled, Appliances, dated 1/24/2023, revealed Resident ID #7 does not have any bladder or bowel appliances in use. Review of Resident ID #7's physician orders revealed an order dated 8/5/2022, for Urostomy (opening in the belly, abdominal wall, that's made during surgery and re-directs urine away from a bladder) care, every shift and as needed. During a surveyor interview on 3/9/2023 at 12:43 PM with MDS Coordinators, Staff B, Licensed Practical Nurse (LPN), and Staff C, LPN, they acknowledged that Resident ID #7's urostomy was not coded on the MDS Assessment, and indicated that it should have been. During a surveyor interview on 3/9/2023 at 12:58 PM, with the Administrator and Director of Nursing Services (DNS), they were unable to provide evidence that Resident ID #7's MDS Assessment was accurately coded to reflect the resident's urostomy. B. Record review revealed Resident ID #145 was initially admitted to the facility in May of 2021, and was readmitted in February of 2023, with a diagnosis including, but not limited to, critical illness myopathy (a disease of limb and respiratory muscles). Review of MDS Assessment, Section H0100, titled, Appliances, dated 2/20/2023, revealed Resident ID #145 does not have any bladder or bowel appliances in use. During a surveyor interview on 3/9/2023 at 12:43 PM with MDS Coordinators, Staff B and Staff C, they acknowledged that Resident ID #145's indwelling catheter was not coded on the MDS Assessment, and indicated that it should have been. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a surveyor interview on 3/9/2023 at 12:58 PM, with the Administrator and the DNS, they were unable to provide evidence that Resident ID #145's MDS Assessment was accurately coded to reflect the resident's indwelling catheter. C. Record review revealed Resident ID #287 was admitted to the facility in February of 2023 with a diagnosis that includes, but is not limited to, Multiple Sclerosis (a potentially disabling disease of the brain and spinal cord). Review of MDS Assessment, Section H0100, titled, Appliances, dated 2/23/2023, revealed Resident ID #287 was coded as having an external catheter (device attached to the shaft of the penis like a condom for males or a receptacle pouch that fits around the labia majora for females and connects to a drainage bag). During a surveyor interview on 3/9/2023 at 12:43 PM with MDS Coordinators, Staff B and Staff C, they acknowledged that Resident ID #287's Suprapubic catheter was coded incorrectly on the MDS Assessment and indicated that it should have been coded as an indwelling catheter. During a surveyor interview on 3/9/2023 at 12:58 PM, with the Administrator and the DNS, they were unable to provide evidence that Resident ID #287's MDS Assessment was accurately coded to reflect the resident's Suprapubic catheter. 2. Review of the RAI Manual, Version 3.0, states in part, .Alarms .Steps for Assessment .Review the resident's medical record .to determine if alarms were used during the 7-day look-back period .Code 0, not used: if the device was not used during the 7-day look-back period . Record review revealed Resident ID #28 was readmitted to the facility in February of 2023 with a diagnosis including, but not limited to, vascular dementia. Review of MDS Assessment, Section P0200, titled, Alarms, dated 2/20/2023, revealed a code of 0 for wander/elopement alarm (a device made for the purpose of keeping residents from wandering, the device alerts the caregiver whenever the resident breaches a perimeter or strays too far) indicating the resident does not use a wander guard. Review of Resident ID #28's physician orders revealed an order with a start date of 2/6/2023, for check placement of wander guard every shift. During a surveyor interview on 3/10/2023 at 11:49 AM, with MDS Coordinators, Staff B and Staff C, they acknowledged that the MDS Assessment was coded wrong and indicated a modification should be completed to accurately reflect the resident's use of a wander guard. During a surveyor interview on 3/10/2023 at 11:59 AM, with the DNS, she was unable to provide evidence that Resident ID #28's MDS Assessment was accurately coded to reflect the resident's use of a wander guard. 3. Review of the RAI Manual, Version 3.0, states in part, .N0410: Medications Received .Coding instructions . N0410A, Antipsychotic: Record the number of days an antipsychotic medication was received by the resident at any time during the 7-day look-back period . (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of MDS Assessment, Section N0410, titled, Medications Received, dated 2/20/2023, revealed the resident did not receive any antipsychotics during the 7-day look-back period. Additional review of the MDS Assessment, Section N0450 titled, Antipsychotic Medication Review, dated 2/20/2023, revealed a code of 0, which indicates the resident did not receive any antipsychotics during the 7-day look-back period. Review of Resident ID # 28's physician orders revealed an order for Risperidone (an antipsychotic medication) 0.25 milligrams (mg) twice daily, with a start date of 2/15/2023. Review of Resident ID #28's February 2023 Medication Administration Record revealed the resident received Risperidone 5 out of 7 days during the look back period, on the following dates and times: - 2/15/23 at 4:00 PM - 2/16/23 at 8:00 AM and 4:00 PM - 2/17/23 at 8:00 AM and 4:00 PM - 2/18/23 at 8:00 AM and 4:00 PM - 2/19/23 at 8:00 AM and 4:00 PM During a surveyor interview on 3/10/2023 at 11:49 AM, with MDS Coordinators, Staff B and Staff C, with a second surveyor present, they acknowledged that the MDS Assessment was coded wrong and indicated a modification should be completed to accurately reflect the residents antipsychotic use during the 7-day look-back period. During a surveyor interview on 3/10/2023 at 11:59 AM, with the DNS, with a second surveyor present, she was unable to provide evidence that Resident ID #28's MDS Assessment was accurately coded to reflect the resident's antipsychotic use. 46539 46715

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46539 Based on surveyor observation, record review, resident and staff interview, it has been determined that the facility failed to provide the necessary services to residents who are unable to carry out activities of daily living (ADL), relative to nail care for 1 of 1 residents observed, Resident ID #121. Findings are as follows: Record review revealed the resident was admitted to the facility in January of 2023 with diagnoses including, but not limited to, muscle wasting and atrophy and bacterial infection. Review of a Minimum Data Set assessment dated [DATE] revealed the resident requires extensive assistance with a one-person physical assist for personal hygiene. Review of the resident's care plan revealed a focus area initiated on 1/30/2023, relative to the residents ADL performance deficit, with an intervention that includes, but is not limited to, monitor and record changes in ADL ability, or inability to perform ADL tasks. During surveyor observations on 3/8/2023 at 12:04 PM and on 3/9/2023 at 11:58 AM and 1:34 PM, the resident's fingernails were noted to be long with thick brown and red matter built up underneath his/her nails. During a surveyor interview on 3/9/2023 at 1:34 PM, with Licensed Practical Nurse, Staff D, she acknowledged the red and brown build up noted to be under the resident's long fingernails. During a surveyor interview on 3/9/2023 at 2:00 PM, with the Director of Nursing Services, she was unable to provide evidence that the resident was provided nail care.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44350 Based on surveyor observation, record review, and staff interview, it has been determined that the facility failed to ensure that residents receive treatment and care in accordance with professional standards of practice relative to continuity of care and emergency procedures, for 1 of 1 residents reviewed, Resident ID #291. Findings are as follows: 1. Record review revealed that the resident was admitted to the facility in March of 2023 and has diagnoses including, but not limited to, acute respiratory failure with hypoxia (when your lungs cannot release enough oxygen into your blood, which prevents your organs from properly functioning) and end stage renal disease (when your kidneys can no longer support your body's needs). Additional record review reveals this resident receives hemodialysis (a type of treatment that helps your body remove extra fluid and waste products from your blood when the kidneys are not able to) three times a week. Review of a hospital discharge summary dated [DATE] revealed that the resident was diagnosed with flash pulmonary edema (a condition in which fluid fills the lungs) and was started on dialysis. The summary also indicated that the resident has a physicians order for a 1000 milliliter (mL) fluid restriction. Record review of the Admission Report Sheet dated [DATE] at the facility revealed that the resident was on 1000 mL fluid restriction . Additional record review revealed the fluid restriction was not initiated until [DATE], 6 days after his/her admission to the facility. Review of the resident's [DATE] Medication Administration Record (MAR) revealed that the resident received 1160 ml on [DATE], 160 ml over the ordered fluid restriction. Further record review failed to reveal evidence that the resident's provider was notified that the resident exceeded his/her fluid restriction on [DATE] or a rationale as to why the fluid restriction was not implemented upon the resident's admission to the facility. During a surveyor interview in the presence of an additional surveyor on [DATE] at 10:32 AM with Unit Manager, Registered Nurse, Staff E, she acknowledged that the fluid restriction was not implemented until 6 days after the resident was admitted to the facility. She was unable to provide evidence that the provider was notified of the resident exceeding the fluid restriction on [DATE]. Further review of the hospital Discharge Summary states in part, Discharge Medication Current Discharge Medication List .CONTINUE these medications which have NOT CHANGED .albuterol [is used to treat wheezing and shortness of breath caused by breathing problems] .90 mcg [micrograms] .inhaler inhale 2 (two) puffs by mouth every 6 (six) hours. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Record review of the [DATE] MAR revealed an order dated [DATE] which states in part, .(Albuterol Sulfate) 2 puff inhale orally every 12 hours as needed for SOB [shortness of breath] separate puffs by at least 1 minute. Further record review failed to reveal evidence that the resident's albuterol was transcribed as ordered per the Discharge Summary or that the physician at the facility modified the order. This indicates the resident did not receive his/her ordered inhaler for approximately 20 out of 22 opportunities, as s/he received two as needed doses on [DATE] at 5:32 AM and [DATE] at 6:10 AM. Additional record review of the [DATE] MAR revealed that on [DATE] the resident was not administered the following medications: 1. Alogliptin Benzoate tablet 6.25 MG (Milligram), medication for diabetes 2. amlodipine Besylate tablet 10 MG, medication for hypertension 3. Aspirin tablet 81 MG, medication used as a preventive for blood clots 4. Bactrim DS tablet ,d+[DATE] MG, antibiotic medication 5. Calcitriol capsule 0.25 MG, calcium supplement 6. Ferrous Sulfate tablet 325 MG, iron supplement 7. GlycoLax Powder 17 Gram, Medication used for constipation 8. Isosorbide Mononitrate ER tablet 60 MG, medication used to prevent chest pain 9. Omperazole DR 20 MG Capsule, medication used heartburn 10. PrediSONE tablet 20 MG used for respiratory failure 11. Semglee (insulin) 26 Units medication for diabetes 12. Sertraline Tablet 100 MG medication used for depression 13. Toprol XL Oral Tablet 60 Mg medication used to treat chest pain, heart failure, and high blood pressure 14. Icosapent Ethyl Capsule 1 gram, medication used for cholesterol 15. hydrALAZINE HCl Oral Tablet 50 MG used to treat hypertension 16. NovoLOG Injection Solution medication to help with high blood sugar (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	During a surveyor interview in the presence of an additional surveyor on [DATE] at 10:41 AM with Staff E, she was unable to provide evidence the Albuterol was administered to the resident every six hours as ordered. Additionally, she was unable to provide evidence that the Nurse Practitioner (NP), Staff F was notified of the missed doses of the above mentioned medications on [DATE]. During a surveyor interview in the presence of an additional surveyor on [DATE] at 2:43 PM with Staff Fshe revealed that she would have implemented the discharge orders from the hospital including the orders for standing albuterol and the fluid restriction. Additionally, she revealed she would expect to be notified when a resident misses their scheduled medication or exceeds their fluid restriction. During a surveyor interview in the presence of an additional surveyor on [DATE] at approximately 2:00 PM with the Director of Nursing Services and the Regional Nurse, they were unable to provide evidence that the resident's albuterol inhaler and fluid restriction were implemented per the discharge summary. Additionally, she was unable to provide evidence the NP or physician were notified the resident missed the previously mentioned medications on [DATE] and that the resident exceeded the ordered fluid restriction on [DATE]. 2. Record review of a facility provided policy titled Emergency Procedure- Cardiopulmonary Resuscitation[CPR] states in part, .Sudden cardiac arrest is a loss of heart function due to abnormal heart rhythms .Cardiac arrest occurs soon after symptoms appear .Victims of cardiac arrest may initially have gasping respirations .Training in BLS [Basic Life Support] includes recognizing presentations of SCA [Sudden Cardiac Arrest] .Early delivery of a shock with a defibrillator plus CPR within ,d+[DATE] minutes . can further increase chances of survival . Further review of the facility policy states in part, .Emergency Procedure- Cardiopulmonary Resuscitation .a. Instruct a staff member to activate the emergency response system (code) and call 911. b. Instruct a staff member to retrieve the automatic external defibrillator [AED]. c. Verify or instruct a staff member to verify the . code status of the individual . During surveyor observation on [DATE] at approximately 8:10 AM, Resident ID #291 was observed rocking back and forth in his/her bedside chair pulling at his/her shirt and his/her oxygen tubing gasping for breath. Immediately following the above observation, the surveyor notified a staff member of the resident's condition, resident yelled hurry and staff entered Resident ID #291's room and closed the door. During a surveyor observation in the presence of an additional surveyor at approximately 8:30 AM revealed the facility crash cart (a cart that holds medical equipment needed if someone was in distress) located outside of the resident's room. Further observation revealed the AED remained on the wall down the hall at the nursing station. Record review revealed the resident was a Full Code indicating the resident wanted life sustaining measures to be performed. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Record review of a document titled RI [Rhode Island] EMS [Emergency Medical Services] Patient Care Report dated [DATE] stated in part, Cardiac Arrest: Yes, Prior to EMS Arrival .having difficulty breathing. Engine 12 was on scene first and called a code 99 [cardiac arrest]. According to the medical staff at the rehabilitation facility the pt [patient] woke up this morning, refused [his/her] medication and breakfast, then started complaining of difficulties with [his/her] breathing. Pt was .found slumped over a chair, pulseless, with agonal breathing .Pt was immediately placed on the ground, CPR was resumed immediately .[NAME] Device [machine to provide compression] applied to [his/her] chest .Epi[epinepherine-medication used during a cardiac arrest]1:1000 through IO [Intraosseous, access into a bone to infuse fluids or hydration], patient was worked on scene for 30 minutes .[s/he] then changed to Asystole [type of cardiac arrest, which is when your heart stops beating entirely]. Pt was transported to [hospital]. Record review of the resident progress notes revealed the following. -[DATE] at 9:01 AM This writer ambulated Resident Back from bathroom around 715 am Resident talking able to ambulate with assist and use of RW [rolling walker]. Placed resident in recliner where [s/he] started to Color in [his/her] Coloring Book. Aprox [approximately] at 8 am Resident with Dyspnea [shortness of breath] VS [vital signs]: [blood pressure] ,d+[DATE], [Heart Rate- normal heart rate ,d+[DATE]] ,d+[DATE], [Respirations- normal respirations ,d+[DATE]] 30s. SPO2 [oxygen level- normal level 95%-100%] 69% on 4 L [liters] O2 [oxygen] via N/C [nasal cannula] Spo2. Emergency response initiated. 911 called. Resident Spo2 Remained at 40% Non rebreather[mask is a special medical device that helps provide you with oxygen in emergencies] applied pulse sluggish [abnormal pulse] .[Emergency medical technician] Arrived at approx. 8:20 Am. Resident with loss of VS Resident is a Full Code. EMT initiated CPR. Family Notified. [DNS] and Administrator made aware at time of incident. Family Arrived at facility. EMT transported Resident to [hospital] . -[DATE] at 3:44 PM Called hospital to determine status, resident deceased asystole/cardiac arrest, questioning flash pulmonary edema [a condition in which fluid fills the lungs] with hypoxic respiratory failure. During a surveyor interview in the presence of an additional surveyor on [DATE] at 10:22 AM with Licensed Practical Nurse, Staff G, who was involved in the emergency situation, revealed that the the AED was not retrieved per the facility policy. During a surveyor interview in the presence of an additional surveyor on [DATE] at 10:26 AM with Unit Manager, Staff E, who was also involved in the emergency situation, revealed that the the AED was not retrieved per the facility policy. During a surveyor interview in the presence of an additional surveyor on [DATE] at 2:07 PM with the Director of Nursing and the Regional Nurse they revealed that the the AED was not retrieved per the facility policy. Furthermore, they were unable to provide evidence the facility followed their policy related to emergency procedures and that the resident ultimately expired after sustaining cardiac arrest in the facility. 46539

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. 46241 46715 Based on surveyor observation, record review and staff interview, it has been determined that the facility failed to ensure that a resident who requires catheterization receives appropriate treatment and services for 2 of 7 sample residents reviewed with catheters, Resident ID #s 145 and 52. Findings are as follows: 1. Record review revealed Resident ID #145 was admitted to the facility in February of 2023 with diagnoses including, but not limited to, bacteremia (the presence of bacteria in the blood) and protein calorie malnutrition. During surveyor observations on 3/7/2023 at 11:02 AM and 3/8/2023 at 12:31 PM of the resident, a foley catheter (flexible tube that is inserted through the urethra and into the bladder to drain urine) drainage bag was hanging from the left side of his/her bed. Further record review failed to reveal evidence of a physician's order for the foley catheter or catheter care. Review of the care plan failed to reveal evidence of a care plan in place for the foley catheter. During a surveyor interview on 3/8/2023 at 12:45 PM with the Unit Manager, Registered Nurse (RN) Staff E, she acknowledged that the resident had a foley catheter and did not have orders for the catheter or for catheter care. During a surveyor interview on 3/8/2023 at 1:35 PM with the Director of Nursing Services (DNS) in the presence of the Infection Control Nurse she revealed that she would expect the resident to have a physicians order for the foley catheter, catheter care and a care plan in place for the catheter. 2. Record review revealed Resident ID #52 was admitted to the facility in September of 2021 with diagnoses including, but not limited to, bacteremia and flaccid neuropathic bladder (bladder dysfunction related to neurological damage). Review of the care plan dated 11/19/2022 revealed that the resident has an indwelling urinary catheter with an intervention to provide catheter care every shift and as needed. Record review failed to reveal evidence of a physician's order for catheter care to be performed every shift. During a surveyor interview on 3/10/2023 at approximately 12:00 PM, with the DNS, with a second surveyor present, she was unable to provide evidence that the foley catheter care had been performed every shift per the care plan.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. 46671 Based on surveyor observation, record review, and staff interview, it has been determined that the facility failed to ensure that residents that are fed through a feeding tube receive the appropriate treatment and services to prevent complications for 1 of 1 residents reviewed with a feeding tube, Resident ID #35. Findings are as follows: According to the State Operations Manual Appendix PP - Guidance to Surveyors for Long Term Care Facilities, Revised 10/21/2022, states in part, .Monitoring the feeding tube: How to verify that the tube is functioning .before administering medications, which may include .Checking gastric residual volume (GRV) [the amount aspirated from the stomach following administration of enteral feed] .Observing for changes in external length of tubing may indicate a change in position . Record review revealed the resident was admitted to the facility in March of 2022 with diagnoses including, but not limited to, protein-calorie malnutrition and gastrostomy status (surgical opening through the abdomen into the stomach used to provide a route for tube feeding). Record review revealed the following physician's orders: - Enteral Feed Order every shift .Glucerna .liquid via feeding tube every shift .50 [milliliters] ml/[hour] hr for 22 hours . -Enteral: Check Residual every shift if amount of residual is Greater than 100ml [milliliters] then Hold Feeding for 1 hour and then recheck, if residual remains greater than 100 ml call Physician . - Lexapro .Give 3 tablet via [Gastric]-Tube in the morning . - Loratadine .via .Tube one time a day . - Esomeprazole .Delayed Release .Give .enterally one time a day . - Sodium .Tablet .enterally every 12 hours . During a surveyor observation on 3/7/2023 at 8:46 AM, Licensed Practical Nurse (LPN), Staff H, was observed administering the above medications to the resident and failed to check the GSV or observe for changes in external length of the tubing, before administering the above medications. During a surveyor interview with Staff H, immediately following the above observations she acknowledged that she did not check the GSV or observe for changes in the external length of the tubing prior to administering the medications. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a surveyor interview with the Director of Nursing Services on 3/7/2023 at approximately 12:40 PM, she was unable to provide evidence that LPN, Staff H, checked the GSV or observed for changes in external length of the tubing, before administering the above mentioned medications.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. 46241 Based on surveyor observation, record review and staff interview, it has been determined that the facility failed to ensure that each resident receives necessary respiratory care and services that is in accordance with professional standards of practice for 2 of 6 residents reviewed for respiratory care, relative to incentive spirometer and BIPAP use (a type of ventilator that assists with breathing and provides bilevel positive airway pressure), Resident ID #s 14 and 121. Findings are as follows: 1. Record review revealed Resident ID #14 was admitted to the facility in November of 2022 with diagnoses that include, but are not limited to, unspecified fracture of shaft of humerus in right arm, and cognitive communication deficit. Record review revealed a physician's order dated 12/13/2022, for an incentive spirometer (a device used to help you keep your lungs healthy after surgery or when you have a lung illness, by placing the mouthpiece in your mouth and breathe in slowly and as deeply as possible) which states, exercises done 10x [times] every hour while awake every shift for lung expansion. Record review revealed an order dated 1/19/2023 that revealed the resident required a hoyer lift for transfers. During surveyor observations on the following dates and times, the resident's incentive spirometer was noted not visible: - 3/6/2023 at 10:11 AM - 3/8/2023 at 8:26 AM - 3/9/2023 at 8:24 AM During a surveyor interview on 3/8/2023 at 8:26 AM, with Resident ID #14, s/he revealed s/he has never used the incentive spirometer. During a surveyor interview on 3/9/2023 at 1:20 PM, with Licensed Practical Nurse (LPN), Staff I, s/he indicated that the incentive spirometer is on the resident's bed side table and revealed the resident is able to use it independently. During a surveyor interview on 3/9/2023 at 1:22 PM, with Resident ID #14's family member, they revealed that the incentive spirometer was in the resident's top drawer of his/her dresser, out of reach to the resident. They indicated that s/he has not used it yet. Immediately following the above interview, the resident's family member handed the incentive spiromter to Resident ID #14 who was unsure how to use it and proceeded to blow into the mouthpiece, rather than breathing in. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately following the above observation Staff I acknowledged the incentive spirometer was not on the bedside table and that the resident was unable to use the incentive spirometer as ordered. During a surveyor interview on 3/9/2023 at 2:00 PM, with the Director of Nursing Services, she was unable to provide evidence that the resident could utilize the incentive spirometer as ordered. Furthermore, she was unable to provide evidence that the incentive spirometer is kept at the resident's bedside or within reach. 2. Record review revealed Resident ID #121 was admitted to the facility in January of 2023 with a diagnosis including, but is not limited to, chronic obstructive pulmonary disease (COPD- persistent respiratory symptoms like progressive breathlessness and cough). Review of a care plan dated 1/30/2023, revealed the resident requires supplemental oxygen related to his/her diagnoses of COPD, with an intervention that includes, but is not limited to, BIPAP as ordered. Review of the resident's physician orders revealed an order with a start date of 2/22/2023 for, BIPAP machine use at bedtime and with naps. Review of the progress notes revealed a physician's note dated 3/7/2023, which states in part, .c/w [continue with] bipap as ordered and use for night and naps . During surveyor observations on 3/7/2023 at 8:14 AM, 3/8/2023 at 11:55 AM, and 3/9/2023 at 8:07 AM, 8:53 AM and 1:20 PM, Resident ID #121 was observed sleeping in his/her room without using a BIPAP machine. During a surveyor interview on 3/9/2023 at 1:36 PM, with, Staff D, s/he indicated that she was unaware that the resident was supposed to utilize his/her BIPAP machine during nap times. During a surveyor interview on 3/9/2023 at 2:03 PM with the DNS, she was unable to provide evidence that the resident used his/her BIPAP machine during naps, on the above dates and times. Additional record review revealed the following progress note dated 3/9/2023 at 4:42 PM, after the concerns were identified by the surveyor, which states in part, BIPAP offered to patient during for snaps, [sic] refusing X3. 46539

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F 0698 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44350 Based on record review and staff interview, it has been determined that the facility failed to ensure that residents who require dialysis receive such services consistent with professional standards of practice for 2 of 6 residents reviewed for dialysis, Resident ID #s 291 and 147. Findings are as follows: 1) Record review revealed that the resident ID #291 was admitted to the facility in March of 2023 and has diagnoses including, but not limited to, acute respiratory failure with hypoxia (when your lungs cannot release enough oxygen into your blood, which prevents your organs from properly functioning) and end stage renal disease (when your kidneys can no longer support your body's needs). Additional record review reveals this resident receives hemodialysis (a type of treatment that helps your body remove extra fluid and waste products from your blood when the kidneys are not able to) three times a week. Review of a hospital discharge summary dated [DATE] revealed that the resident was diagnosed with flash pulmonary edema (a condition in which fluid fills the lungs) and was started on dialysis. The summary also indicated that the resident has a physician's order for a 1000 milliliter (ml) fluid restriction. Record review of the Admission Report Sheet dated [DATE] at the facility revealed that the resident was on 1000 ml fluid restriction. Review of a Nutritional Risk assessment dated [DATE] revealed that a 1-liter fluid restriction was recommended, and that the 3rd floor unit manager was made aware. Additional record review revealed the fluid restriction was not initiated until the 3:00 to 11:00 PM shift on [DATE], indicating the resident's fluid intake was not monitored on ,d+[DATE], ,d+[DATE], ,d+[DATE], , d+[DATE], ,d+[DATE] or during the 7:00 AM to 3:00 PM shift on [DATE]. Record review of a physician's order dated [DATE] revealed Fluid Restriction: Breakdown over 24 hour 1000 ml: Nursing/meal time (500 ml ,d+[DATE], 350 ml ,d+[DATE], 150 ml ,d+[DATE]) every shift Further record review revealed a physician's order for Nepro one time a day 240 ml x 1 with a start date of [DATE]. Review of the [DATE] Medication Administration Record (MAR) revealed that the resident received 1160 ml on [DATE], 160 ml over the ordered fluid restriction. (continued on next page)

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F 0698 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of a progress note dated [DATE] at 9:01 AM states .Approx. [approximately] at 8 am Resident with Dyspnea [shortness of breath] VS [vital signs]: [blood pressure] ,d+[DATE], [Heart Rate- normal heart rate ,d+[DATE]] ,d+[DATE], [Respirations- normal respirations ,d+[DATE]] 30s. SPO2 [oxygen level- normal level 95%-100%] 69% on 4 L [liters] O2 [oxygen] via N/C [nasal cannula] Spo2. Emergency response initiated. 911 called. Resident Spo2 Remained at 40% Non rebreather[mask is a special medical device that helps provide you with oxygen in emergencies] applied pulse sluggish [abnormal pulse] .[Emergency medical technician] Arrived at approx. 8:20 Am. Resident with loss of VS Resident is a Full Code. EMT initiated CPR. Family Notified. [DNS] and Administrator made aware at time of incident. Family Arrived at facility. EMT transported Resident to [hospital] . Further review of the progress notes revealed a note dated [DATE] at 3:44 PM stating, Called Hospital to determine status, resident deceased asystole/cardiac arrest, questioning flash pulmonary edema with hypoxic respiratory failure. During a surveyor interview in the presence of an additional surveyor on [DATE] at 10:32 AM with Unit Manager, Registered Nurse, Staff E, she acknowledged that the fluid restriction was not implemented until 6 days after the resident was admitted to the facility. She was unable to provide evidence that the provider was notified of the resident exceeding the fluid restriction on [DATE]. During a surveyor interview on [DATE] at approximately 2:00 PM with the Director of Nursing Services (DNS) and the Regional Nurse, they were unable to explain why the resident's order for a 1000 ml fluid restriction was not implemented upon his/her admittance to the facility. Additionally, they were unable to provide evidence that the provider was notified of the resident exceeding his/her fluid restriction on [DATE]. During a surveyor interview on [DATE] at 2:43 PM with the Nurse Practitioner, Staff F, she revealed that she would expect the facility to notify her of a resident exceeding his/her fluid restriction. 2) Record review revealed that Resident ID #147 was readmitted to the facility in February of 2023 and has diagnoses including, but not limited to, chronic kidney disease stage 4 (when your kidneys can no longer support your body's needs), dependence on renal dialysis, and acute on chronic diastolic (congestive) heart failure. Review of an order by a covering Physician (from a contracted provider) dated [DATE] at 8:56 PM, revealed in part, .orders and medications approved until patient is evaluated by primary team. Obtain and review all acute care documentation/orders with primary team when available .Daily weights. Low sodium diet. 2 Liter Fluid Restriction .Recommend that primary team review medication and eliminate unnecessary medications . The order was signed by the Physician on [DATE] at 9:04 PM. Record review of the resident's physician orders failed to reveal evidence that the 2 Liter fluid restriction, or the daily weights were implemented as per the order on [DATE]. Review of the February and [DATE], Medication and Treatment Administration records (MAR/TAR) failed to reveal evidence that the resident's fluid intake was documented, or that the fluid restriction was implemented. (continued on next page)

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F 0698 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of the physician order summary report for the period of [DATE] through [DATE], (including all active, completed, discontinued or on hold orders) failed to reveal evidence that the 2 Liter fluid restriction, or the daily weights were implemented as per the order on [DATE]. Record review of the physician's orders revealed an order dated [DATE] for Post Dialysis weights Monday, Wednesday, and Friday. Review of a History & Physical note dated [DATE] at 2:03 PM by the resident's attending physician revealed in part, .Pt is seen today for an initial visit and management of medical conditions .Assessment and Plan . ESRD [end stage renal disease] on HD [hemodialysis] .Chronic HF [heart failure] .Cont [continue] diuretics . on non HD days. Fluid restriction. Follow daily wts. [weights] . Review of progress notes signed on [DATE] at 9:17 PM, and [DATE] at 10:02 PM and 12:02 AM by Nurse Practitioner Staff F revealed in part, .Assessment and Plan .continue present diuretics. Follow daily weights . Record review of progress notes from [DATE] through [DATE] failed to reveal evidence that the order for fluid restriction was discussed or discontinued by the physician or the Nurse practitioner. Record review of the Weights and Vitals summary failed to reveal that daily weights were obtained. During a surveyor interview on [DATE] at 12:18 PM with Staff F, she revealed that when things are ordered by the covering physician the expectation is that the orders are put in by the nurse. If it was discontinued, she would expect to see documentation. During a surveyor telephone interview on [DATE] at approximately 10:30 AM with the attending physician, he could not explain why the covering physician's order for fluid restriction was not transcribed or why his note indicated a fluid restriction and daily weights were in place when they were not. During a surveyor interview on [DATE] at approximately 2:00 PM, with the DNS she was unable to provide evidence that a fluid restriction was in place after the order was received on [DATE] or that there was documentation to discontinue the fluid restriction. When asked by surveyor if she would expect physician's notes to accurately reflect the current plan of care for the resident, she acknowledged that she would. During surveyor telephone interview on [DATE] at 1:30 PM with the Director of Quality Assurance of the contracted company for the on call physicians, she revealed that the providers have been educated to include all orders given verbally to the nurse via Zoom (they are a telehealth provider) on the order form. She further revealed that the information contained on the form titled Physician order that is signed by the physician are in fact orders. She revealed the verbal orders are given to the nurse during an unrecorded zoom call and then the written orders are signed and put into the electronic health record. 46539 39496 47939

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F 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the resident's doctor reviews the resident's care, writes, signs and dates progress notes and orders, at each required visit. 39496 47939 Based on record review and staff interview, it has been determined that the facility failed to ensure a physician reviewed the resident's total program of care, including medications and treatments, at each visit, for 1 of 5 residents reviewed, Resident ID #147. Findings are as follows: Record review revealed that Resident ID #147 was readmitted to the facility in February of 2023 and has diagnoses including, but not limited to, chronic kidney disease stage 4 (when your kidneys can no longer support your body's needs), dependence on renal dialysis, and acute on chronic diastolic (congestive) heart failure. Review of an order received by a covering Physician (from a contracted provider) dated 2/24/2023 at 8:56 PM, revealed in part, .orders and medications approved until patient is evaluated by primary team. Obtain and review all acute care documentation/orders with primary team when available .Daily weights. Low sodium diet. 2 Liter Fluid Restriction .Recommend that primary team review medication and eliminate unnecessary medications . The order was signed by the Physician on 2/24/2023 at 9:04 PM. Review of the resident's orders failed to reveal that the orders for daily weights and a 2 liter fluid restriction were implemented or discontinued. Review of the Medication Administration/Treatment Administration Record failed to reveal that the above orders were implemented. Record review of the Weights and Vitals summary failed to reveal that daily weights were obtained. Review of a History & Physical note dated 2/25/2023 at 2:03 PM by the resident's attending physician revealed in part, .Pt is seen today for an initial visit and management of medical conditions .Assessment and Plan .ESRD [end stage renal disease] on HD [hemodialysis] .Chronic HF [heart failure] .Cont [continue] diuretics .on non HD days. Fluid restriction. Follow daily wts. [weights] . Review of progress notes signed on 3/7/2023 at 9:17 PM, and 3/15/2023 at 10:02 PM and 12:02 AM by Nurse Practitioner, Staff F, revealed in part, .Assessment and Plan .continue present diuretics. Follow daily weights .Chronic kidney disease .Encourage fluids . During a surveyor telephone interview on 3/21/2023 at approximately 10:30 AM with the attending physician, he could not explain why the covering physician's order for fluid restriction was not transcribed or why his note indicated a fluid restriction and daily weights were in place when they were not. (continued on next page)

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F 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a surveyor interview on 3/21/2023 at 12:18 PM with Nurse Practitioner, Staff F, she could not explain why her notes dated 3/7 and 3/15/2023 indicated that the resident was on daily weights when s/he was not. During a surveyor interview on 3/22/2023 at approximately 2:00 PM with the Director of Nursing Services and the Administrator, they were unable to provide evidence that the physician and [Nurse Practitioner] reviewed the resident's total program of care. When asked if it was expected that a physician's note would accurately reflect the current plan of care for the resident, they acknowledged that they would.

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F 0760 Level of Harm - Actual harm Residents Affected - Some	Ensure that residents are free from significant medication errors. 46715 Based on record review and staff interview it has been determined that the facility failed to ensure that its residents are kept free from significant medication errors for 1 of 1 residents reviewed for ear drops, Resident ID #150, 1 of 4 residents reviewed for antibiotic use, Resident ID #176 and 1 of 8 residents reviewed for hospitalization and medication reconciliation, Resident ID #291. Findings are as follows: 1. Review of a facility policy titled, Administering Medication states in part, Medications are administered in a safe and timely manner, and as prescribed . Record review revealed Resident ID #150 was admitted to the facility in May of 2022 with diagnoses including, but not limited to, Alzheimer's disease and hearing loss. Review of a complaint received by the Rhode Island Department of Health on 3/10/2023 alleges in part, On 3/7/23 while visiting .a nurse came in to give nightly meds [medication] and ear drops. The nurse put the ear drops in [his/her] eyes. [The resident] immediately began to scream that it hurt .I yelled stop, are those [his/her] ear drops, she stopped and looked at me .I put a cold face cloth on [the resident's] eye and waited for help . Record review revealed the resident had an order for Debrox Solution 6.5% (Carbamide Peroxide, a medication used to treat earwax buildup) Instill 5 drops in both ears two times a day for hearing loss. Record review of the Medication Administration Record (MAR) for March 2023 indicated the medication was signed off as administered on 3/7/2023 by Registered Nurse (RN), Staff J. Review of a progress note dated 3/7/2023 at 8:24 PM revealed a telehealth note that stated in part, . complaining of left eye irritation after accidental administration of carbide peroxide otic gtt [ear drops] was instilled in eye. Eye is irritated. Review of a progress note dated 3/7/2023 at 11:43 PM revealed that a nurse had made a medication error and administered ear drops in the left eye instead of the left ear. The progress note further revealed that the resident was in pain following the administration of the ear drops into the left eye and it was flushed with sterile water and a syringe. Review of a progress note dated 3/8/2023 at 8:00 AM revealed the resident's left eye remained red. During a surveyor interview on 3/13/2023 at 12:14 PM with the resident's family member she revealed that she was visiting the resident on 3/7/2023 and witnessed a nurse administer ear drops into the resident's left eye. Additionally, she revealed the resident was screaming in pain and shaking following the medication administration. The resident's family revealed that she applied a cold compress to the resident's left eye and it took the staff greater than 10 minutes to return to the room. (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Some	During a surveyor interview on 3/13/2023 at 1:47 PM with Staff J she acknowledged that she administered the medication prescribed for the ears into the resident's left eye. Additionally, she revealed the resident was yelling, stop that hurts. She further revealed that she immediately left the room and did not return. During a surveyor interview on 3/13/2023 at 1:57 PM with Licensed Practical Nurse (LPN), Staff K he revealed that he was the nurse working with Staff J and that they prepared the medication outside of the room and that he was not present when she administered the medication incorrectly but that she reported it to him. Additionally, he revealed the resident was in pain when he entered the room and was complaining there is something in his/her eye. Record review revealed an order dated 3/7/2023 for prednisoLONE Acetate Ophthalmic Suspension 1% (a medication used to treat certain eye conditions due to inflammation or injury) Instill 1 drop in left eye two times a day for Irritation. During a surveyor interview with two surveyors on 3/14/2023 at 1:54 PM with the Director of Nursing Services in the presence of the Administrator they acknowledged that the medication error had occurred. 2. Record review revealed Resident ID #176 was admitted to the facility in January of 2023 with diagnoses including, but not limited to, bacteremia (the presence of bacteria in the blood) and osteomyelitis (an infection of the bone) of the spine. Record review revealed a Continuity of Care Consultation and Referral Form dated 3/7/2023 from the Infectious Disease Nurse Practitioner [specialist that treats infections disease] that states in part, continue levofloxacin [antibiotic] 750 daily .call regarding end date of antibiotics . Review of the MAR for February 2023 revealed an order for Levofloxacin 750 mg (milligrams) with the last administration dated 2/21/2023. Review of the MAR for March 2023 failed to reveal evidence that the resident was administered Levofloxacin. During a surveyor interview on 3/8/2023 at 11:02 AM with the Infectious Disease Nurse Practitioner he revealed that the resident was last seen at his office on 2/21/2023 and the resident was to continue taking the Levofloxacin 750 mg from 2/21/2023 until 3/8/2023. Additionally, he revealed that he was unaware the resident had not received the antibiotic as ordered from 2/22/2023 until 3/8/2023 which was brought to his attention by the surveyor. During a surveyor interview on 3/9/2023 at 8:47 AM with Unit Manager, Registered Nurse, Staff E she acknowledged that the resident was not on the antibiotic from 2/22/2023 until 3/8/2023 as ordered by Infectious Disease Nurse Practitioner. During a surveyor interview with two surveyors present on 3/10/2023 at 11:39 AM with the Director of Nursing Services she was unable to provide evidence that the resident received the Levofloxacin as ordered. (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Some	3. Record review revealed that Resident ID #291 was admitted to the facility in March of 2023 and has diagnoses including, but not limited to, acute respiratory failure with hypoxia (when your lungs cannot release enough oxygen into your blood, which prevents your organs from properly functioning) and end stage renal disease (when your kidneys can no longer support your body's needs). Additional record review reveals this resident receives hemodialysis (a type of treatment that helps your body remove extra fluid and waste products from your blood when the kidneys are not able to) three times a week. Review of a hospital discharge summary dated 3/1/2023 revealed Further review of the hospital Discharge Summary states in part, Discharge Medication Current Discharge Medication List .CONTINUE these medications which have NOT CHANGED .albuterol [is used to treat wheezing and shortness of breath caused by breathing problems] .90 mcg [micrograms] .inhaler inhale 2 (two) puffs by mouth every 6 (six) hours. Record review of the March 2023 MAR revealed an order dated 3/1/2023 which states in part, .(Albuterol Sulfate) 2 puff inhale orally every 12 hours as needed for SOB [shortness of breath] separate puffs by at least 1 minute. Further record review failed to reveal evidence that the resident's albuterol was transcribed as ordered per the Discharge Summary or that the physician at the facility modified the order. This indicates the resident did not receive his/her ordered inhaler for approximately 20 out of 22 opportunities, as s/he received two as needed doses on 3/6/2023 at 5:32 AM and 3/8/2023 at 6:10 AM. Additional record review of the March 2023 MAR revealed that on 3/3/2023 the resident was not administered the following medications: 1. Alogliptin Benzoate tablet 6.25 MG (Milligram), medication for diabetes 2. amlodipine Besylate tablet 10 MG, medication for hypertension 3. Aspirin tablet 81 MG, medication used as a preventive for blood clots 4. Bactrim DS tablet 800-160 MG, antibiotic medication 5. Calcitriol capsule 0.25 MG, calcium supplement 6. Ferrous Sulfate tablet 325 MG, iron supplement 7. GlycoLax Powder 17 Gram, Medication used for constipation 8. Isosorbide Mononitrate ER tablet 60 MG, medication used to prevent chest pain 9. Omperazole DR 20 MG Capsule, medication used heartburn 10. PrediSONE tablet 20 MG used for respiratory failure 11. Semglee (insulin) 26 Units medication for diabetes (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Some	12. Sertraline Tablet 100 MG medication used for depression 13. Toprol XL Oral Tablet 60 Mg medication used to treat chest pain, heart failure, and high blood pressure 14. Icosapent Ethyl Capsule 1 gram, medication used for cholesterol 15. hydrALAZINE HCl Oral Tablet 50 MG used to treat hypertension 16. NovoLOG Injection Solution medication to help with high blood sugar During a surveyor interview in the presence of an additional surveyor on 3/15/2023 at 10:41 AM with Unit Manager, Registered Nurse, Staff E, she was unable to provide evidence the Albuterol was administered to the resident every six hours as ordered. Additionally, she was unable to provide evidence that the Nurse Practitioner (NP), Staff F, was notified of the missed doses of the above-mentioned medications on 3/3/2023. During a surveyor interview in the presence of an additional surveyor on 3/14/2023 at 2:43 PM with Staff F she revealed that she would have implemented the discharge orders from the hospital including the orders for standing albuterol. Additionally, she revealed she would expect to be notified when a resident misses their scheduled medication. During a surveyor interview in the presence of an additional surveyor on 3/14/2023 at approximately 2:00 PM with the Director of Nursing Services and the Regional Nurse, they were unable to provide evidence that the resident's albuterol inhaler was implemented per the discharge summary. Additionally, she was unable to provide evidence the NP or physician were notified the resident missed the previously mentioned medications on 3/3/2023. 46539

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 46671 Based on surveyor observation, record review, and staff interview, it has been determined that the facility failed to store and label drugs and biological's in accordance with currently accepted professional principles for 5 of 5 medication carts reviewed, and 2 of 3 medication rooms reviewed. Findings are as follows: Record review of the facility policy titled Storage of Medications states in part, .Drugs and biological's are stored in the packaging, containers or other dispensing systems in which they are received. Only the issuing pharmacy is authorized to transfer medications between containers .Medications that have incorrect labels, are discontinued, outdated .are removed and discarded per facility guidelines . Review of the facility policy titled, Controlled Substances states in part, .The facility complies with all laws, regulations, and other requirements related to handling, storage, disposal, and documentation of controlled medications .Controlled substances are reconciled upon .disposition, at the end of each shift .Upon disposition .Waste and/or disposal of controlled medications are done in the presence of the nurse and a witness .At the End of Each Shift .Controlled Medications are counted .The nurse coming on duty and the nurse going off duty determine the count together .Any discrepancies in the controlled substance count are documented . 1. Medication Carts A. During a surveyor observation on 3/6/2023 at 9:20 AM of the Unit 6 high side medication cart in the presence of Licensed Practical Nurse (LPN), Staff L, revealed the following: - One 30 milliliter (mL) plastic medication cup filled with approximately 25 small white pills with Vit D 1000 u [units] hand written on the outside of the medication cup. - One vial of Humulin Insulin, opened and dated 1/27/2023 with an expiration date of 2/27/2023. - One Incruse Ellipta inhaler with 4 on the counter reader, opened and not dated. Manufacturer's guidance indicates date when opened and discard after 6 weeks. - One glargine insulin pen, opened and not dated. Manufacturer's guidance indicates date when opened and discard after 28 days. - One Lispro insulin pen, opened and not dated. Manufacturer's guidance indicates date when opened and discard after 28 days. - One bottle of Active Liquid Protein, opened and not dated. The manufacturer's label indicates it has a 3 month shelf life from the date opened. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During a surveyor interview with LPN, Staff L immediately following the above-mentioned observations, she acknowledged the findings. B. During a surveyor observation on 3/6/2023 at 10:16 AM of the 3rd floor medication cart in the presence LPN, Staff M revealed the following: - One bottle of Morphine Sulfate 100 milligrams (mg)/5 mL, opened with 12.125 mL remaining in the bottle, and not dated. Manufacturer's guidance indicates to discard 1 year after opening. - Three Arnuity Ellipta inhalers with counter reads of 7, 26, and 28, opened and not dated. Pharmacy guidance indicates the beyond use date is 6 weeks after removal from foil pouch. - One Incruse Ellipta inhaler with a counter read of 23, opened and not dated. Pharmacy guidance indicates the beyond use date is 6 weeks after removal from the foil pouch. - Two Trelegy inhalers with counter reads of 7, and 26, opened and not dated. Manufacturer's guidance indicates date when the foil tray is opened and discard after 6 weeks. - One bottle of Active Liquid Protein, opened and not dated. The manufacturer's label indicates it has a 3 month shelf life from the date opened. During a surveyor interview with LPN, Staff M immediately following the above-mentioned observations, he acknowledged the findings. C. During a surveyor observation on 3/6/2023 at 10:47 AM of the Unit 6 Low Side medication cart in the presence of LPN, Staff N, revealed the following: - One bottle of Active Liquid Protein, opened and not dated. - One bottle of Latanoprost 0.0005% eye drops, opened and not dated. Pharmacy guidance indicates beyond use date is 6 weeks (42 days) after opening or moving to room temperature. During a surveyor interview with LPN, Staff N immediately following the above-mentioned observations, she acknowledged the findings. D. During a surveyor observation on 3/6/2023 at 12:15 PM of the Unit 4 high side medication cart in the presence of LPN, Staff O, revealed the following: - One bottle of Morphine Sulfate 100 mg/5 mL with an expiration date of 8/2025, opened and not dated. - One bottle of Morphine Sulfate 100 mg/5 mL with an expiration date of 6/2025, open and undated. Manufacturer's guidance for Morphine Sulfate indicates discard 1 year after opening or manufacturer's expiration date if sooner. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During a surveyor observation of the controlled medication log book revealed that the Morphine Sulfate with an expiration date of 6/2025 was documented as last administered on 1/9/2023 with 13 mL remaining on count. Additionally, the documentation revealed that on 1/13/2023 the count was corrected from 13 mL to 11 mL with one nurse's signature and no evidence that the adjusted amount of 2 mL was wasted or disposed of in the presence of the nurse and a witness per the facility policy. During a surveyor interview with LPN, Staff O, immediately following the above observations, she acknowledged the findings and was unable to explain why there wasn't a second nurse or witness for the documented count correction. During a surveyor interview with the Director of Nursing Services (DNS) on 3/7/2023 at 12:36 PM, she was unable to provide evidence that the waste or disposal of the controlled medication was done in the presence of the nurse and a witness. E. During a surveyor observation on 3/7/2023 at 8:22 AM of the Unit 1 medication cart in the presence of Registered Nurse (RN), Staff P, revealed the following: - Two bottles of Risperidone oral solution 1 mg/mL, opened and not dated. Manufacturer's guidance indicates use for 3 months after opening. During a surveyor interview with RN, Staff P, immediately following the above-mentioned observations, she acknowledged the findings. 2. Medication Rooms A. During a surveyor observation on 3/6/2023 at 9:48 AM of the 4th floor unit medication room in the presence of LPN, Staff N, revealed the following: - One vial of Tuberculin solution, opened and not dated, was observed in the medication room refrigerator. Manufacturer's guidance indicates to date when opened and to discard the unused portion after 30 days. - Two bottles of Fiber caps with expiration dates of February 2023 were observed in the cabinet with other stock medications in the medication room. During a surveyor interview with LPN, Staff N immediately following the above-mentioned observations, she acknowledged the findings and indicated that the expired medications should be discarded. B. During a surveyor observation on 3/7/2023 at 9:53 AM of the Unit 4 (3rd floor) medication room in the presence of LPN, Staff O, revealed the following: - One box containing Risperdal 25 mg/vial with an expiration date of 2/1/2022 was observed in the medication room refrigerator. During a surveyor interview with Staff O in the presence of the Unit Manager, Staff Q, immediately following the above-mentioned observation, she acknowledged the findings. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	3. During a surveyor observation on 3/6/2023 of the medication administration pass of the Unit 6 High Side with LPN, Staff L, she was observed to hand keys over to an oncoming nurse, LPN, Staff N at approximately 9:15 AM. Additionally, the nurses were not observed to perform count of the controlled medications together per the facility policy. During a surveyor observation on 3/6/2023 at approximately 10:50 AM of the Unit 6 Low Side controlled medication log book failed to reveal evidence that Staff L and Staff N determined the count of the controlled medication when Staff N came on duty. During a surveyor interview with Staff N immediately following the above-mentioned observation, she indicated that she did not perform count of the controlled medication when she came on the unit for duty. Additionally, she acknowledged that the surveyor observed her receive the keys from Staff L at approximately 9:15 AM. Furthermore, she indicated that the normal practice is to count the controlled medications when the keys are exchanged. During a surveyor interview with the Unit Manager, Registered Nurse, Staff E on 3/6/2023 at 10:57 AM, she indicated that she would have expected staff to perform count of the controlled medications when the keys were exchanged. During a surveyor interview with the DNS on 3/7/2023 at 12:36 PM, she indicated that she would have expected the nurses to perform count of the controlled medications when the keys were exchanged. During a surveyor interview with the DNS on 3/7/2023 at approximately 1:30 PM, she was unable to provide evidence that medications and biological's were stored in accordance with currently accepted professional principles.

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F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely, quality laboratory services/tests to meet the needs of residents. 46241 Based on record review and staff interview, it has been determined that the facility failed to obtain laboratory services to meet the needs of its residents for 1 of 1 resident reviewed, Resident ID #46. Findings are as follows: Record review revealed the resident was admitted to the facility in July of 2018 with a diagnosis including, but is not limited to, unspecified convulsions. Review of the resident's physician orders revealed an order, with a start date of 3/9/2022, for Keppra (a medication used to treat seizures) 500 MG (milligrams) twice daily, for unspecified convulsions. Record review revealed a Nurse Practitioner (NP) note dated 4/15/2022, which states in part, .Diagnostic Statement: Unspecified convulsions .Plan .Assess and monitor for seizure/convulsion activity and routine Keppra levels . Record review failed to reveal evidence that a Keppra level was obtained following the 4/15/2022 note. During a surveyor interview on 3/13/2023 at 12:58 PM, with Unit Manager, Registered Nurse, Staff R, with a second surveyor present, she was unable to provide evidence that the Keppra level was obtained. During a surveyor interview on 3/13/2023 at approximately 2:00 PM, with the Director of Nursing Services, with a second surveyor present, she was unable to provide evidence that a Keppra level was obtained. Additional record review revealed a progress note dated 3/13/2023 at 3:52 PM, after the concern was brought to the facility's attention by the surveyor, which states in part, New order from Optum RNP [Registered Nurse Practitioner] to obtain Keppra .levels . 46539

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 42399 46715 Based on surveyor observations and staff interview it has been determined that the facility failed to properly distribute and serve food under sanitary conditions relative to lunch pass on 1 of 6 units, Unit #6. Findings are as follows: During a surveyor observation on 3/6/2023 at approximately 11:55 AM, hotel pan lids were observed on the floor. Dietary Aide, Staff S was then observed picking up the lids and used them to cover the resident's food on the steam table. During a surveyor interview on 3/6/2023 at approximately 12:00 PM with Staff S in the presence of Unit Manager, Staff E, he revealed that he was not finished serving lunch to the resident's from the steam table. Additionally, he acknowledged that he had picked up the lids from the floor and re-covered the food. Directly following the above interview, Staff E instructed Staff S not to serve the food that was covered by the lids that were on the floor. During a surveyor interview on 3/6/2023 at approximately 12:10 PM with the Administrator he acknowledged that the food should not be served due to the lids being on the floor prior to being placed on the food. Additionally, indicated he would provide education to Staff S.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46241 Based on surveyor observation, record review and staff interview, it has been determined that the facility failed to maintain medical records for all residents that are accurately documented in accordance with professional standards and practices for 1 of 3 closed records reviewed, Resident ID # 291. Findings are as follows: Record review revealed the resident was admitted to the facility in March of 2023, with diagnoses including, but not limited to, end stage renal disease (a condition where the kidney reaches an advanced state of loss of function) and acute respiratory failure with hypoxia (below-normal level of oxygen in your blood). Additional record review revealed the following progress notes: - [DATE] at 8:32 AM states in part, .around 810a resident stated [s/he] had some shortness of breath and two nurses were into assess resident. Resident was with vital signs at that time and full code in oxygen via nc [nasal cannula] .911 called. Shortly after 911 arrived resident lost respirations and pulse. Four EMTs [emergency medical technicians] began CPR [cardiopulmonary resuscitation] daughter aware and told her we would keep her updated to which hospital [s/he] would be going to. - [DATE] at 3:44 PM states in part, Called hospital to determine status, resident deceased . Review of a document titled RI EMS [Rhode Island Emergency Medical Services] Care Report, dated [DATE], revealed the resident left the facility and was enroute to the hospital at 9:01 AM and was documented as having an asystole cardiac rhythm (known as flatline, it is a state of cardiac standstill with no cardiac output). Review of the resident's physician orders revealed an order, with a start date of [DATE], for Hydralazine 25 MG [milligrams] twice daily, on Monday, Wednesday, and Friday, with indicated parameters to hold the medication if the resident's systolic blood pressure is less than 100 or when the heart rate less than 60. Review of the [DATE] Medication Administration Record (MAR) revealed the above order was documented as being administered on [DATE] at 10:00 PM, with a recorded blood pressure of ,d+[DATE] and a heart rate of 68, after the resident had expired that morning. Additional review of the resident's physician orders revealed a treatment order, with a start date of [DATE], for diabetic foot care, which includes, Wash and Dry feet, Inspect for blisters, corns, calluses, cuts, cracks, sores, edema, color of skin, and toenail condition and length. Rub lotion to feet. at bedtime. The following codes are used when completing this treatment: App: 1- Blister 2-Corn, 3- Callus, 4-Scaly, Color: 1-Red, 2-Pink, 3-Blue, 4- Color Tone equal, Cond: 1-Intact, 2- Cracked, 3-Dry, 4- Sweaty, Edema: 1-Yes, 2-No, Nails: 1-Long, 2- Short, 3-Cracked. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the [DATE] Treatment Administration Record (TAR) revealed the above treatment order was documented as being completed on [DATE] at 9:00 PM, after the resident had expired that morning. The documentation revealed the following codes: App: 0, Color: 4, Cond: 1, Edema: 2, Nails: 2. Additional review of the resident's physician orders revealed a treatment order, with a start date of [DATE], Behavior monitoring, which includes, Monitor for DEPRESSION/WITHDRAWN INTERVENTION CODES May include but are not limited to: 1.Redirection 2.(1:1) 3.Activity 4.Toilet 5.Food/Fluid Offered 6.Position Change 7.Other Intervention (Specify in Progress Notes) 8. Medication every shift Review of the [DATE] Behavior Monitoring Record revealed the above order was documented as being completed on [DATE] during the 3 PM to 11 PM shift, after the resident had expired. The documentation revealed the following codes: Int[interventions] 2345[1:1, Activity, Toilet, Food/Fluid]. Review of the resident's physician orders revealed an order, with a start date of [DATE], to monitor oxygen saturation percent every shift. Review of the [DATE] TAR revealed the above order was documented as being administered on [DATE] during the 3PM to 11PM shift an and oxygen saturation of 95% after the resident had expired. Review of the resident's physician orders revealed an order, with a start date of [DATE], for Oxygen at 3 liters per minute via nasal cannula (device to deliver oxygen) continuously. Review of the [DATE] TAR revealed the above order was documented as being administered on [DATE] during the 3 PM to 11 PM shift after the resident had expired. Record review revealed the above orders were signed off as being administered by Licensed Practical Nurse (LPN), Staff M. During a surveyor interview on [DATE] at 11:39 AM, with the Director of Nursing Services and the Regional Nurse, with a second surveyor present, they acknowledged the inaccurate documentation in Resident ID # 291's chart and revealed they would have expected the nurse not to document in the resident's chart after s/he has expired. During a surveyor interview on [DATE] at 1:06 PM, with LPN, Staff M, with a second surveyor present, he revealed that he started his shift on [DATE], he was doing rounds and taking residents vital signs. Additionally, he indicated that he had documented the above orders in the wrong resident's chart. 46539

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 46539 Based on surveyor observation, record review and staff interview, it has been determined that the facility failed to ensure appropriate personal protective equipment (PPE) is worn while caring for residents on transmission-based precautions relative to Extended Spectrum Beta Lactamase (ESBL, an infection that is resistant to specific types of antibiotics) for 1 of 2 residents reviewed related to ESBL, Residents ID #287. Findings are as follows: Record review of a facility policy titled, Transmission-Based Precautions states in part, Transmission-based precautions are initiated when a resident .has a laboratory confirmed infection .When a resident is placed on transmission-based precautions, appropriate notification is placed on the room entrance door and on the front of the chart so that personnel and visitors are aware of the need for the type of precautions . Record review revealed Resident ID #287 was admitted to the facility in February of 2023, with diagnoses including, but not limited to, ESBL resistance and bacteremia (blood infection). Record review of the resident's discharge summary revealed the resident has a suprapubic catheter and was admitted to the hospital related to decreased responsiveness and found to have acute kidney injury, sepsis (blood infection) and urine and blood cultures that grew ESBL Klebsiella. Additional record review of the discharge summary revealed a blood culture that was obtained on 1/31/2023 which states in part, .CONFIRMATORY TESTING POSITIVE FOR ESBL . and a urine culture obtained on 1/30/2023 which states in part, .CONFIRMATORY TESTING POSITIVE FOR ESBL . Record review of an Optum Post Hospital Inpatient dated 2/22/2023 states in part, .Bacteremia. Positive ESBL in urine and blood for culture . Record review revealed a care plan dated 2/16/2023 states in part, I have a Urinary Tract Infection ESBL . Record review of the resident's Treatment Administration Record for March of 2023 revealed an order dated 2/19/2023 which states, Contact Precautions [use of gown and gloves when entering a residents room] for ESBL in urine every shift for precautions documented as administered daily from 3/1/2023 through 3/7/2023. Surveyor observations on the following dates and times of the resident revealed: - 3/6/2023 at 9:45 AM, no signage or isolation cart outside of the resident's room to indicate the resident is on contact precautions. - 3/7/2023 8:09 AM, no signage or isolation cart outside of the resident's room to indicate the resident is on contact precautions. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	415084	A. Building B. Wing	03/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Elmhurst Rehabilitation & Healthcare Center	50 Maude Street Providence, RI 02908

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- 3/7/2023 at 8:57 AM, no signage or isolation cart outside of the resident's room to indicate the resident is on contact precautions, and one staff member was in the room, Nursing Assistant, Staff T, with Resident ID #287 without a gown or gloves. - 3/8/2023 at 8:46 AM, no signage or isolation cart outside of the resident's room to indicate the resident is on contact precautions. During a surveyor interview on 3/8/2023 at 10:18 AM with the Infection Preventionist in the presence of the Regional Infection Preventionist, she revealed that if the resident has an active Multidrug Resistant Organism and was being treated with antibiotics the resident should be on contact precautions. During a subsequent interview on 3/8/2023 at 10:33 AM with Infection Preventionist in the presence of the Regional Infection Preventionist, she revealed that she would expect the staff to follow the order for contact precautions. During a surveyor interview on 3/8/2023 at 2:19 PM with the Regional Nurse, she acknowledged that the resident did have a positive urine culture and blood culture in January 2023 for ESBL. Additionally, she was unable to provide evidence that the resident was placed on contact precautions as ordered.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46539 Based on record review and staff interview, it has been determined that the facility failed to ensure the resident's medical record includes documentation that the resident either received the pneumococcal vaccination or did not receive the vaccination due to medical contraindications or refusal, for 4 of 8 residents reviewed, Residents ID #'s 1, 27, 62 and 89. Findings are follows: According to the State Operations Manual Appendix PP - Guidance to Surveyors for Long Term Care Facilities, Revised 10/21/2022 states in part, .The resident's medical record includes documentation that indicates, at a minimum, the following: .That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal . According to the Centers for Disease Control and Prevention (CDC), pneumococcal vaccination for all adults 19 through [AGE] years old who have certain chronic medical conditions or [AGE] years or older who have only received PPSV23 [23 vaccination], the PVC15 [type of pneumococcal conjugate vaccine] or PVC20 [type of pneumococcal conjugate vaccine] dose should be administered at least one year after the most recent PPSV23 vaccination. For adults 19 through [AGE] years old who have certain chronic medical who have only received PVC13 [type of pneumococcal conjugate vaccine], give 1 dose of the PCV20 at least 1 year after PCV13 or give 1 dose of PPSV23 at least 8 weeks after PCV13. For adults [AGE] years or older who have only received PVC13 [type of pneumococcal conjugate vaccine], give PPSV23 or PCV20 as previously recommended. 1. Record review for Resident ID #1 revealed the resident was admitted to the facility in October of 2019. Record review of the resident's immunization records failed to reveal evidence that the PPSV23 or PCV20 was offered, received, or declined. 2. Record review for Resident ID #27 revealed the resident was initially admitted to the facility in October of 2015. Record review of the resident's immunization records failed to reveal evidence that the PCV15 or PCV20 was offered, received, or declined. 3. Record review for Resident ID #62 revealed the resident was admitted to the facility in September of 2014. Record review of the resident's immunization records failed to reveal evidence that the PCV15 or PCV20 was offered, received, or declined. 4. Record review for Resident ID #89 revealed the resident was admitted to the facility in October of 2020. Record review of the resident's immunization records failed to reveal evidence that the PPSV23 or PCV20 was offered, received, or declined. During an interview on 3/10/2023 at 1:14 PM with the Infection Preventionist, she was unable to provide evidence that Resident ID #s 1, 27, 62 and 89 medical records included documentation that indicates, at a minimum, if the residents either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal until brought to the attention of the facility by the surveyor.