STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	415002	A. Building B. Wing	06/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hattie Ide Chaffee Home	200 Wampanoag Trail East Providence, RI 02914

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. 41542 Based on record review, resident, and staff interview, it has been determined that the facility failed to ensure that services being provided meet professional standards of practice relative to following a physician's order for 1 of 2 residents reviewed for nutrition, Resident ID #1. Findings are as follows: Record review of an anonymous reported complaint submitted to The Rhode Island Department of Health on 6/26/2024, alleges that Resident ID #1 was served food when s/he had an order for nothing by mouth (NPO). The complaint alleges that the resident's family member arrived to find Resident ID #1 choking. 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. Record review revealed the resident was admitted to the facility in June of 2024 with diagnoses including, but not limited to, cerebral infarction (stroke), flaccid hemiparesis (decreased muscle tone and inability to actively move the muscles of the affected side), dysarthria (a condition that causes problems with the muscles that help produce speech), and dysphagia (difficulty swallowing). Review of a care plan focus area dated 6/25/2024 revealed the resident is at risk for alteration in nutrition secondary to gastrostomy tube (G tube-a tube that is inserted into your stomach through your abdomen to supply nutrition) feeding and dysphagia. Review of the hospital paperwork revealed the resident was NPO with a G-tube feeding order in place for Jevity 1.5, 110 cc/hr. (cubic centimeters per hour) continuously from 6:00PM - 8:00AM. Review of the June 2024 Treatment Administration Record revealed a dietary order with Special Instructions: NPO dated 6/24/2024. Review of a progress notes authored by the Assistant Director of Nursing (ADON), dated 6/22/2024 at 8:46 PM revealed in part, .[S/he] did receive meal tray this a.m. at which time [s/he] did consume a few bites of scrambled eggs. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a surveyor interview on 6/26/2024 at 2:00 PM with Nursing Assistant (NA), Staff A, she acknowledged on the morning of 6/22/2024 Resident ID #1 had a breakfast tray on his/her bedside table. She further revealed that at the same time, the resident's family member arrived and saw that the resident was served breakfast. S/he went directly to the ADON to question why Resident ID #1 was served breakfast when they are NPO. During a surveyor interview on 6/26/2024 at 2:10 PM with NA, Staff B she acknowledged that on the morning of 6/22/2024 Resident ID #1 had a breakfast tray on his/her bedside table. She indicated s/he was unaware of who provided Resident ID #1 the tray. During a surveyor phone interview on 6/26/2024 at 2:30 PM with the resident's family member, s/he revealed that the resident ate some of the scrambled eggs as s/he had eggs on their clothing. She also revealed that the resident was coughing when s/he arrived. Additionally, s/he revealed that when s/he asked the if s/he ate any of the food the resident responded Yes, I did. During a surveyor telephone interview on 6/26/2024 at 4:15 PM with the ADON, she revealed that she observed the resident with a breakfast tray and asked staff to remove it. During a surveyor interview with the Director of Nursing on 6/26/2024 at approximately 4:20 PM, she revealed that the NA taking care of the resident on the morning of 6/22/2024 was unaware the resident had an order for NPO and when the resident was not served a breakfast tray she went to the kitchen and obtained a tray for Resident ID #1.