STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	415014	A. Building B. Wing	02/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Grace Barker Nursing Center	54 Barker Avenue Warren, RI 02885

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. 21613 Based on surveyor observation, record review, and staff interview, it has been determined that the facility failed to provide services that meet professional standards of practice for 1 of 1 resident observed relative to wound care, Resident ID #23. Findings are as follows: According to Mosby's 4th Edition, Fundamentals of Nursing, page 314 states, .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 with diagnoses including, but not limited to, dementia and skin cancer. Record review revealed a physician's order dated 1/6/2025, to cleanse the open area to the left side of the face with normal saline (NS), pat dry, apply A&D ointment (a treatment used to treat minor skin irritations), followed by a non-adhesive pad and a transparent dressing, once daily. Review of the Treatment Administration Record (TAR) revealed the treatment order was signed off as completed on 2/3 and 2/4/2025. During a surveyor observation of the resident on 2/5/2025 at 3:09 PM, the dressing to the left side of his/her face revealed the initials EJS with a date of 2/3. During a surveyor observation of the resident on 2/5/2025 at 3:13 PM in the presence of Registered Nurse, Staff A, she acknowledged the dressing to his/her face was dated 2/3, with the initials EJS. Staff A removed the dressing to the resident's face and the wound bed was observed to be approximately 1.5 centimeters (cm) x 1.5 cm and there was a light yellow drainage observed in the wound bed and on the dressing. During a surveyor interview on 2/5/2025 at 3:10 PM with Licensed Practical Nurse (LPN), Staff B, he revealed that he worked on the evening of 2/3/2025, but he did not work on 2/4/2025. Additionally, he confirmed that the initials EJS were his initials and that he completed the dressing change on 2/3/2025. (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

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a surveyor interview on 2/5/2025 at 3:13 PM with Staff A, she acknowledged although the TAR indicates that the treatment to the resident's face was signed off as completed on 2/4/2025 by LPN, Staff C, the dressing was dated 2/3/2025 with Staff B's initials, indicating that the treatment was not completed on 2/4/2025. During a surveyor observation of the resident on 2/5/2025 at 3:29 PM in the presence of Staff A and Staff B, they acknowledged the resident had a dressing on his/her right elbow with a date of 2/1. Additionally, when Staff B removed the resident's elbow dressing, a bruise was noted with an approximate size of 4.5 cm x 4.5 cm and a small, scabbed area was adjacent to the bruise. Record review failed to reveal evidence of a physician's order for a treatment to the right elbow. Further review failed to reveal evidence of any documentation indicating a skin impairment to the resident's right elbow. During a surveyor interview with the Director of Nursing Services on 2/5/2025 at the time of the observation, she revealed that she was not aware of the bruise and scab to the resident's elbow. Additionally, she revealed staff should have notified the resident's physician and obtained a treatment order for the right elbow. Further, she could not provide evidence that the dressing to the left side of the resident's was completed, as ordered on 2/4/2025.

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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 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. 37158 Based on record review, and staff interview, it has been determined that the facility failed to provide respiratory care consistent with professional standards of practice for 1 of 3 residents reviewed with a respiratory illness, Resident ID #13. Findings are as follows: Review of an undated facility policy titled, Practice for Change in Condition states in part, .Suspected Respiratory Illness .follow physician orders .test as ordered .follow order set for [positive] + virus .follow respiratory event orders .all other respiratory illness follow respiratory event and order set .document . Record review revealed Resident ID #13 was readmitted to the facility with a diagnosis including, but not limited to, asthma. Record review of a chest x-ray completed on 1/28/2025 indicated the resident had pneumonia. Record review of the physician's orders revealed an order, with a start date of 1/29/2025 for Levaquin (an antibiotic prescribed to treat infections), 500 mg daily for 10 days. Record review failed to reveal evidence that a Respiratory Event document was completed for the resident once s/he was diagnosed with pneumonia. Additional review of the record failed to reveal any order sets to follow for the resident, per facility policy. During a surveyor interview on 2/4/2025 at 11:38 AM with Registered Nurse, Staff E, she acknowledged that a Respiratory Event document was not completed for the resident when s/he was diagnosed with pneumonia on 1/28/2025, as per the facility's policy. Staff E revealted that a Respiratory Event document triggers for physician orders that include; obtaining a temperature, oxygen saturation levels, to assess lung sounds every shift and to document the findings in the progress notes until the antibiotics are completed. Record review of a Respiratory Event document completed by Staff E on 2/4/2025, after it was brought to her attention by the surveyor, indicates the following physician's orders: - obtain oxygen saturation levels, temperature, and lung sounds every shift and document under progress notes. Additional record review failed to reveal evidence that a care plan was developed for pneumonia. During a surveyor interview on 2/4/2025 at 12:26 PM with Registered Nurse, Staff F, she acknowledged that a care plan had not developed for the resident relative to his/her diagnosis of pneumonia. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a surveyor interview on 2/4/2025 at 12:03 PM with the Director of Nursing Services (DNS), she revealed that the Respiratory Event document should have been completed for the resident when s/he was diagnosed with pneumonia and that s/he should have had his/her temperature, oxygen saturation level and lung sounds assessed every shift. Additionally, the DNS acknowledged that a care plan was not developed for pneumonia.

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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 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 21613 Based on surveyor observation, record review and staff interview, it has been determined that the facility failed to provide the appropriate treatment and services to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being for 1 of 4 residents reviewed with a diagnosis of dementia, Resident ID #23. Findings are as follows: Record review revealed the resident was admitted to the facility with a diagnosis including, but not limited to, dementia. Record review of a Quarterly Minimum Data Set assessment dated [DATE], revealed a Brief Interview for Mental Status score of 0 out of 15, indicating s/he has severe cognitive impairment. Record review revealed a physician's order dated 8/2/2024, to administer Trazodone (a medication prescribed to treat depression and other conditions determined by health care providers) 25 milligrams (mg) by mouth prior to morning care. Further review revealed the Trazodone is scheduled to be administered between 7:00 AM to 9:00 AM daily. Record review revealed a physician's order dated 1/17/2025 for Trazodone 25 mg by mouth every 8 hours PRN (as needed) for restlessness, anxiety, irritability, or inconsolable crying. During a surveyor observation of the resident on 2/4/2025 at approximately 11:00 AM, s/he was observed lying in his/her bed quietly with his/her eyes closed. Nursing Assistant (NA), Staff G, was observed entering the resident's room shortly after and drew the curtain closed. At 11:15 AM, the resident was overheard crying and sobbing in his/her room while Staff G was assisting the resident. Staff G opened the curtain, the resident was now observed sitting in a shower chair (a chair used to transport residents and shower them in) crying and sobbing. Record review of the Medication Administration Record (MAR) revealed the resident received his/her standing order for Trazodone 25 mg at 8:03 AM on 2/4/2025. Further review of the MAR failed to reveal evidence that the resident received a PRN dose of Trazodone on 2/4/2025 for his/her crying. During a surveyor interview on 2/5/2025 at 2:34 PM with Registered Nurse (RN), Staff E and RN, Staff A, they revealed that they both worked during the day on 2/4/2025. Additionally, both Staff A and Staff E revealed that they were not made aware that the resident was crying that morning. If they had been made aware, they would have administered the resident his/her PRN Trazodone. During a surveyor interview on 2/5/2025 at 3:39 PM with Staff G, she revealed that she provided morning care for the resident on 2/4/2025 and that the resident was crying out during care, she tried to console the resident but s/he would not stop crying. Staff G further revealed that she did not notify any of the nurses that the resident was crying, because this was common behavior for the resident. (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a surveyor interview on 2/5/2025 at 2:54 PM with the Director of Nursing Services, she revealed that she would have expected the NA to notify the nurse when the resident was crying so that the resident could have received his/her PRN Trazodone, as ordered.

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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 - Some	Provide and implement an infection prevention and control program. 21613 Based on surveyor observation, record review, and staff interview, it has been determined that the facility failed to maintain an infection prevention and control program designed to provide a safe, sanitary environment, and to help prevent the development and transmission of communicable diseases and infections for 2 of 2 residents observed during the use of a glucose meter to obtain a blood sugar, Resident ID #s 52 and 48, for 1 of 1 resident observed during a dressing change, Resident ID #179 and for 1 of 1 resident receiving an inhaler, Resident ID #278. Findings are as follows: 1. Review of the facility's policy titled CLEANING AND DISINFECTING THE [glucose] METER, provided to the surveyor on 2/5/2025, revealed two disposable wipes are needed for the meter, one wipe for cleaning and the second wipe for disinfecting the meter. 1a. Record review revealed Resident ID #52 was admitted to the facility with a diagnosis including, but not limited to, diabetes. Record review revealed a physician's order dated 6/25/2024 to administer Admelog SoloStar insulin per the sliding scale, before meals and at bedtime. During a surveyor observation on 2/4/2025 at 11:02 AM revealed Licensed Practical Nurse (LPN), Staff D using the glucose meter to obtain the resident's blood sugar. Staff D then placed the used meter on top of the treatment cart without cleaning and disinfecting the glucose meter. Staff D removed her gloves and performed hand hygiene and then touched the used glucose meter again. Staff D continued to touch multiple items and surfaces including the treatment cart, computer, the computer mouse and a set of keys prior to cleaning the meter. Further observation revealed Staff D cleaned the glucose meter using only 1 disposable wipe and not 2, per the facility's policy. Additionally, Staff D failed to clean and disinfect the top of the treatment cart, the computer, the computer mouse, and keys. 1b. Record review revealed Resident ID #48 was admitted to the facility with a diagnosis including, but not limited to, diabetes. Record review revealed a physician's order dated 4/24/2024 to obtain a fingerstick blood sugar (FSBS) twice daily, 6:00 AM and 12:00 PM. During a surveyor observation on 2/4/2025 at 11:16 AM revealed LPN, Staff D using the glucose meter to obtain the resident's FSBS. Staff D then placed the used meter on top of the treatment cart without cleaning and disinfecting the glucose meter. Staff D removed her gloves and performed hand hygiene and then touched the used glucose meter again. Staff D continued to touch multiple items and surfaces including the treatment cart, computer, the computer mouse. Further observation revealed Staff D cleaned the glucose meter using only 1 disposable wipe and not 2, per the facility's policy. Additionally, Staff D failed to clean and disinfect the top of the treatment cart, the computer, the computer mouse. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a surveyor interview on 2/5/2025 at 12:36 PM with the Education Coordinator, she revealed that she would have expected Staff D to follow the facility policy and use 2 disposable wipes to clean and disinfect the glucose meter. She further revealed that she would have expected Staff D to disinfect the glucose meter after obtaining the resident's blood sugar and to disinfect the top of the medication cart, the computer and the computer mouse after handling the used glucose meter. 2. Review of the facility document titled, Competency Validation for A Clean Dressing Change revealed the following procedure actions which include, but are not limited to: -wash hands and don (put on) disposable clean gloves -remove old dressing -dispose the soiled dressing in a waterproof bag -clean the area as per the physician's order, discard contaminated material into the waterproof bag -remove gloves and perform hand hygiene -prepare sterile or clean dressing supplies as appropriate -don clean gloves -apply dressing and fasten the dressing a. Record review revealed Resident ID #179 was admitted to the facility with diagnoses including, but not limited to, stroke, gastrostomy tube (g-tube, a tube that is inserted into the stomach through the abdominal wall to provide nutritional support, medication and hydration) and two stage 4 ulcers (the most serious pressure ulcer that extends below the subcutaneous fat into deep tissues, including muscle, tendons, and ligaments) to the coccyx and left ankle. Record review revealed a physician's order dated 12/2/2024 to cleanse the area around the G-tube site and to change the dressing daily and as needed. During a surveyor observation of the dressing change on 2/5/2025 at 9:55 AM with LPN, Staff D, she removed the old dressing from the G-tube site then with the same used gloves, she proceeded to clean the g-tube site with Normal Saline (NS), dried the skin and then applied the drainage gauze dressing. Staff D failed to remove the used gloves and perform hand hygiene after removing the old g-tube dressing and prior to applying the new treatment and dressing. b. Record review for Resident ID #179 revealed a physician's order dated 1/22/2025, to cleanse the stage 4 left lateral ankle wound with NS, pat dry, apply collagen (treatment that promotes wound healing), then apply Hydrofera blue (absorbent dressing) moistened with NS, and cover the area with a bordered gauze dressing daily. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a surveyor observation of of the dressing change with Staff D on 2/5/2025 at 10:05 AM, she removed the old dressing, which had a small amount of yellow and green drainage, from the resident's left ankle. While wearing the same used gloves, she proceeded to clean the wound with NS, pat the wound dry, apply the collagen and the Hydrofera blue, and lastly apply the bordered gauze dressing to the wound. Staff D failed to remove the used gloves and perform hand hygiene after cleaning the wound and prior to applying the new treatment and dressing. c. Record review for Resident ID #179 revealed a physician's order dated 1/22/2025, to cleanse the coccyx wound with NS, pat dry, apply collagen, then apply Hydrofera blue moistened with NS, and cover the area with a foam dressing daily. During a surveyor observation of the dressing change with Staff D on 2/5/2025 at 10:14 AM, she cleansed the wound with NS, patted the wound dry and did not change her gloves or perform hand hygiene before applying the collagen, Hydrofera blue treatments, or the foam dressing to the wound. During a surveyor interview on 2/5/2025 at 12:08 PM with the Director of Nursing Services (DNS), she acknowledged that Staff D should have removed her gloves and washed her hands after she removed the old dressings from the g-tube site and the left ankle. The DNS further revealed that Staff D should have removed her gloves and washed her hands after cleaning the g-tube site, left ankle, and coccyx wounds and before applying a new treatment and dressing. 3. During the medication administration pass on 2/2/2025 at 11:08 AM with Medication Technician, Staff I, she was observed preparing to administer Resident ID #268 his/her inhaler. A sign was observed affixed to the wall outside of the resident's room, indicating the resident's roommate was on Contact Precautions (a means to prevent transmission of infections through direct contact by wearing personal protective equipment such as a gown and gloves when performing care). Staff I donned a gown and gloves and proceeded to enter the resident's room with his/her inhaler to administer the medication. Staff I administered the inhaler and then placed the inhaler on the only bureau in the room. She then removed her gown and gloves, removed the inhaler from the bureau, exited the room and placed the inhaler on top of the medication cart. Staff I performed hand hygiene, then removed the inhaler from the top of the cart and placed the inhaler in its box and into the med cart drawer, without disinfecting the inhaler and without disinfecting the medication cart. During a surveyor interview immediately following the observation with Staff I, she revealed that she should have placed a barrier down prior to placing the resident's inhaler on the bureau. Additionally, she acknowledged she should have cleaned the inhaler prior to returning it to the cart. During a surveyor interview on 2/4/2025 at approximately 12:00 PM with the DNS, she revealed that Staff I should have used a barrier prior to placing the inhaler down on the resident's bureau. Additionally, she acknowledged that Staff I should have disinfected the inhaler prior to placing it back to the cart. 37158