STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	415020	A. Building B. Wing	08/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Grandview Center	100 Chambers Street Cumberland, RI 02864

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46338 Based on surveyor observation, record review, staff and resident interviews, it has been determined that the facility failed to treat each resident with respect and dignity and relative to providing assistance to residents who require supervision and/or one-to-one assistance with eating for 3 of 4 residents reviewed, Residents ID #s 16, 54 and 60. Findings are as follows: 1. Record review revealed that Resident ID #16 was readmitted to the facility in May of 2024 with diagnoses including, but not limited to, osteoarthritis, anemia, and generalized muscle weakness. Record review of the Quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 13 out of 15, indicating the resident's cognition is intact. Record review of a progress note dated 7/16/2024 revealed a hospice recommendation for one-to-one feeding assistance for all meals related to bilateral hand contractures. Review of a physician's order dated 7/30/2024 revealed one-to-one feeding assistance for all meals. During a surveyor observation on 7/30/2024 at 8:40 AM, the resident was observed with his/her breakfast tray in front of him/her without receiving one-to-one feeding assistance. Further, s/he was observed palpating around the plate with his/her right hand attempting to find the food on the plate. Additionally, at 8:55 AM, s/he was observed picking up scrambled eggs with his/her hand. A staff member entered the resident's room to provide assistance with eating at 9:03 AM, 23 minutes after the resident had his/her meal tray in front of him/her. During a surveyor observation on 7/31/2024 at approximately 8:40 AM, Resident ID #16 was observed to be eating his/her breakfast without assistance. Additionally, s/he was observed to be palpating around the plate multiple times with his/her right hand before picking up the food. A staff member entered the resident's room to provide assistance with eating at 9:02 AM, 22 minutes after the resident had his/her meal tray in front of him/her. (continued on next page)

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a surveyor observation on 7/31/2024 at 12:20 PM, the resident was observed feeding him/herself lunch and palpating around the plate before finding a piece of pizza. A staff member entered the resident's room to provide assistance with eating at 12:38 PM, 18 minutes after the resident had his/her meal tray in front of him/her. During a surveyor interview on 7/31/2024 at 12:53 AM with Physical Therapy Assistant, Staff H, she indicated that the resident requires one-to-one staff assistance because s/he can't see. During a surveyor interview on 7/31/2024 at approximately 1:35 PM with the resident, s/he revealed that s/he can't see what is on the meal tray and needs staff to help him/her. 2. Record review revealed that Resident ID #54 was admitted to the facility in February of 2024 with diagnoses including, but not limited to, anxiety disorder and mood disorder. Record review of the Quarterly MDS assessment dated [DATE] revealed a BIMS score of 13 out of 15, indicating the resident's cognition is intact. Further review revealed the resident requires assistance with eating. Review of a physician's order dated 7/2/2024 revealed the resident requires one-to-one assistance with eating for all meals related to weight loss. During a surveyor observation on 8/1/2024 at 8:51 AM, Resident ID #54 was observed with his/her meal tray in front of him/her with the covers still on the food and drinks. A staff member entered the resident's room to provide assistance with eating at 9:05 AM, 14 minutes after the resident had his/her meal tray in front of him/her. During a surveyor interview on 8/1/2024 at 9:11 AM with Licensed Practical Nurse (LPN), Staff A, she indicated that staff usually deliver the meal trays to the residents who require assistance with eating, leave them in the room and go back sometime later when the staff have time to assist the residents. 3. Record review revealed that Resident ID #60 was admitted to the facility in April of 2024 with diagnoses including, but not limited to, abnormal weight loss, dementia, and generalized muscle weakness. Record review of the Quarterly MDS assessment dated [DATE] revealed a BIMS score of 0 out of 15, indicating severe cognitive impairment. Further review revealed the resident requires extensive assistance for eating. Review of a physician's order dated 5/10/2024 indicates that the resident requires supervision for all meals. During a surveyor observation on 7/30/2024 at 8:24 AM, Resident ID #60 was observed with his/her breakfast tray in front of him/her untouched. Additional observations revealed the resident was staring at the tray and falling asleep on and off until approximately 8:40 AM. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a surveyor observation on 7/31/2024 at 8:27 AM, the resident was observed with his/her breakfast tray in front of him/her. Further observation revealed that the plate was opened and untouched with no staff members around. During a surveyor observation on 8/1/2024 at 8:33 AM, the resident's breakfast tray was observed in front of him/her, opened but untouched with no staff members around to supervise him/her as ordered. Further observations revealed the resident was looking at the plate but was not eating. At 8:59 AM, approximately 25 minutes after the resident was observed with his/her tray unattended, a staff member was observed entering the room. During a surveyor interview on 8/1/2024 at 11:20 AM with the Director of Nursing Services, she indicated that she was unaware that residents were not receiving assistance with meals as ordered in a timely manner. She further stated that the food should be kept in the warmer until they are ready to assist the resident.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. 50004 Based on surveyor observation, record review, and staff interview, it has been determined that the facility failed to monitor and assess as outlined by the comprehensive care plan to meet professional standards of quality related to anticoagulant therapy (blood thinner) for 4 of 6 residents reviewed, Resident ID #s 9, 10, 41, and 373. Findings are as follows: 1. Record review revealed Resident ID #9 was readmitted to the facility in August of 2023 with a diagnosis including, but not limited to, atrial fibrillation (an irregular and often very rapid heart rhythm that can lead to a stroke or other serious complications). Record review revealed a physician's order dated 8/7/2023 for Eliquis (a blood thinner that prevents or reduces the coagulation of blood, prolonging the clotting time) 5 milligrams (mg) by mouth two times a day. Review of the care plan last revised on 7/8/2024, states in part, .at risk for injury or complications related to the use of anticoagulation therapy . interventions include, but are not limited to, monitor for signs and symptoms of bleeding. Record review failed to reveal evidence that the resident was being monitored for signs and symptoms of bleeding related to the use of anticoagulation therapy as outlined by the comprehensive care plan. 2. Record review revealed Resident ID #10 was admitted to the facility in May of 2023 with a diagnosis including, but not limited to, atrial fibrillation. Record review revealed a physician's order dated 7/29/2024 for Coumadin (blood thinner) 4.5 mg by mouth in the evening for atrial fibrillation. Review of the resident's care plan last revised on 6/3/2024, states in part, .is at risk for injury or complications related to the use of anticoagulation therapy . Interventions include, but are not limited to, monitor for signs and symptoms of bleeding. Record review failed to reveal evidence that the resident was being monitored for signs and symptoms of bleeding related to the use of anticoagulation therapy as outlined by the comprehensive care plan. During an interview with Licensed Practical Nurse (LPN), Staff A, on 7/31/2024 at 8:53 AM, she revealed that the nurse should monitor for bleeding and bruising for residents that are on anticoagulation therapy. Additionally, she indicated that she would expect a physician's order to be in place to monitor residents for signs and symptoms of bleeding. Furthermore, she acknowledged that there was not an order in place to monitor for signs and symptoms of bleeding for Resident ID #s 9 and 10. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. Record review revealed Resident ID #41 was readmitted to the facility in June of 2024 with a diagnosis including, but not limited to, atrial fibrillation. Record review revealed a physician's order dated 5/23/2024 for Eliquis 5 mg by mouth two times a day for atrial fibrillation. Review of the resident's care plan last revised on 6/19/2024, states in part, .is at risk for injury or complications related to the use of anticoagulation therapy . Interventions include, but are not limited to, monitor for signs and symptoms of bleeding. Record review failed to reveal evidence that the resident was being monitored for signs and symptoms of bleeding related to the use of anticoagulation therapy as outlined by the comprehensive care plan. 4. Record review revealed Resident ID #373 was admitted to the facility in July of 2024 with a diagnosis including, but not limited to, history of venous thrombosis and embolism (a blood clot that blocks the flow of blood through your veins or that can travel through the veins to the lungs). Record review revealed a physician's order dated 7/20/2024 for Xarelto (blood thinner) 20 mg by mouth in the evening. Review of the resident's care plan initiated on 7/21/2024, states in part, .is at risk for injury or complications related to the use of anticoagulation therapy . Interventions include, but are not limited to, monitor for signs and symptoms of bleeding. Record review failed to reveal evidence that the resident was being monitored for signs and symptoms of bleeding related to the use of anticoagulation therapy as outlined by the comprehensive care plan. During a surveyor interview with LPN, Staff B on 7/31/2024 at 10:19 AM, she was unable to provide evidence that Resident ID's 41 and 373 were being monitored related to the use of anticoagulation therapy. During a surveyor interview with the Lead Clinical Specialist, and in the presence of the Director of Nursing Services (DNS) on 7/31/2024 at 11:35 AM, he revealed that for residents receiving anticoagulant therapy the expectation would be that the nurse would monitor for signs and symptoms of bleeding. He further explained that the order would be generated to the treatment administration record (TAR) from the care plan and nurses would sign as completed. He further acknowledged that there was no order in place to monitor residents for signs and symptoms of bruising and bleeding.

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46118 Based on surveyor observation, record review, and staff interview, it has been determined that the facility failed to provide an ongoing program to support a resident in their choice of activities designed to meet the interests of and support the well-being of each resident, based on the comprehensive assessment, care plan and preferences for 1 of 1 resident reviewed for activities who is non English speaking, Resident ID #27. Findings are as follows: Record review revealed the resident was readmitted to the facility in October of 2020 with diagnoses including, but not limited to, major depressive disorder, adjustment disorder, and dementia with agitation. Review of a Minimum Data Set (MDS) assessment dated [DATE], revealed the resident is dependent on staff for all care needs. Review of a care plan dated 4/27/2023, revealed the resident expresses interest in leisure activities with interventions including, but not limited to, providing the resident with magazines, books, materials related to Europe/[NAME]/Spain, Portuguese recipes, spirituality, and to highlight opportunities to participate in music. Further review revealed a care plan dated 11/15/2023, which states in part, the resident .will have opportunities to make decisions/choices .for self-directed involvement in meaningful activities .Encourage and facilitate .activity preferences by offering the chronicle in Spanish/Portuguese, pet visits and spirituality . During surveyor observations on multiple occasions of group activities being conducted from 7/29/2024 through 8/1/2024, this resident was not in attendance. During the following surveyor observations, the resident was awake in his/her room, without a T.V., radio, reading material, or any other activitt: -7/29/2024 at 10:05 AM -7/30/2024 at 11:38 AM -7/31/2024 at 9:03 AM - 8/1/2024 at 8:45 AM During a surveyor interview on 8/1/2024 at 8:45 AM with Licensed Practical Nurse, Staff A, she acknowledged that the resident did not have any activities provided at that time and that there was not a T.V. , radio, or reading material in his/her room. Additionally, she was unaware of the resident's activity preferences or if any activities were regularly provided to the resident. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a surveyor interview on 8/1/2024 at 9:17 AM with the Recreational Director she indicated that the resident enjoys singing and praying. Additionally, she acknowledged that activities had not been provided to the resident in accordance with the plan of care. During a surveyor interview on 8/1/2024 at 10:34 AM with the Director of Nursing Services, she indicated that she was unaware that the resident did not have a T.V., radio, or reading materials in his/her room. Additionally, she indicated that she would expect activities to be provided to the resident.

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Assist a resident in gaining access to vision and hearing services. 46118 Based on surveyor observation, record review, staff and resident representative interviews, it has been determined that the facility failed to ensure that a resident receives proper treatment to maintain hearing abilities for 1 of 1 resident reviewed for hearing concerns, Resident ID #10. Findings are as follows: Record review revealed the resident was admitted to the facility in May of 2023 with diagnoses including, but not limited to, diabetes mellitus type 2 and chronic obstructive pulmonary disease. Record review of a care plan dated 6/1/2023 revealed the resident has impaired communication as evidenced by being hard of hearing. Further record review revealed an intervention for an ears, nose, and throat (ENT) specialist or audiologist (a health-care professional who evaluates, diagnoses, treats, and manages hearing loss) consult to evaluate new hearing loss or progression of deteriorating hearing loss. During a surveyor interview on 7/30/2024 at 1:32 PM with the resident's family member, s/he indicated that the resident has difficulty hearing and increased hearing loss which causes the resident frustration. S/he further indicated that the resident had an appointment for ear wax removal in November of 2023, however, the appointment was cancelled and the facility had not followed up. Record review of the progress notes revealed the resident's family member was concerned with the resident's difficulty hearing in September of 2023. Further review revealed an appointment was scheduled for ear wax removal on 11/16/2023. Additional review revealed that appointment was cancelled and had not been rescheduled. During the following surveyor observations, the resident had difficulty hearing the surveyor as evidenced by the resident pointing and cupping his/her ears: -7/29/2024 at 10:50 AM -7/30/2024 at 1:32 PM -7/31/2024 at 9:36 AM During a surveyor interview on 7/31/2024 at 9:40 AM with Licensed Practical Nurse, Staff A, she acknowledged that the resident has difficulty hearing and indicated that an appointment was made for ear wax removal and cancelled in November of 2023. She could not provide evidence that any follow up or additional interventions were put into place after the appointment had been cancelled. During a surveyor interview on 7/31/2024 at 9:43 AM with the Director of Nursing Services, she indicated that she would expect the facility to follow up with the resident's hearing loss. Additionally, she could not provide evidence that any interventions had been put into place since the appointment had been cancelled in November of 2023. (continued on next page)

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a surveyor interview on 7/31/2024 at 10:06 AM with Nurse Practitioner, Staff C, he indicated that he would expect the resident's hearing difficulty to be addressed.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 46118 Based on surveyor observation, record review, resident and staff interviews, it has been determined that the facility failed to provide adequate supervision to prevent an accident hazard for 1 of 1 resident reviewed who requires the assistance of two staff for transfers with a gait belt, Resident ID #9. Findings are as follows: Record review revealed the resident was originally admitted to the facility in April of 2019, with diagnoses including, but not limited to, hemiplegia and hemiparesis following a cerebral infarction (paralysis and weakness to one side of the body following a stroke), unsteadiness on the feet, and abnormality of gait (walking) and mobility. Record review of the Minimum Data Set (MDS), Optional State Assessment, dated 6/23/2024, revealed a Brief Interview for Mental Status (BIMS) score of 15 out of 15, indicating the resident is cognitively intact. Additionally, the MDS revealed that the resident required extensive assistance of 2 people with transfers. Review of a care plan dated 8/15/2019 revealed the resident is at risk for the decreased ability to perform activities of daily living (ADLs) including transfers. Further review revealed an intervention dated 10/23/2023 that the resident required 2 people for all transfers with a gait belt every shift to prevent falls due to weakness. Record review revealed a physician's order dated 10/29/2023 that the resident requires two staff members to transfer with a gait belt every shift to prevent falls due to weakness. During a surveyor interview on 7/29/2024 at 11:02 AM with the resident, s/he indicated that s/he requires the assistance of 2 staff members to transfer out of bed, however, s/he often feels unsafe because they frequently transfer him/her with only 1 staff member. During a surveyor observation on 8/1/2024 at 10:06 AM, a Nursing Assistant (NA), Staff D, transferred the resident out of bed and into a wheelchair without the assistance of a second staff member. During a surveyor interview on 8/1/2024 at 10:15 AM with NA, Staff D, she acknowledged that she transferred the resident by herself. Additionally, she indicated that the resident only requires the assistance of 2 staff members sometimes if s/he is weak and that she frequently transfers the resident by herself, including the day before. During a surveyor interview on 8/1/2024 at 10:19 AM with Licensed Practical Nurse, Staff A, she indicated that the resident is transferred with the assistance of only 1 staff member at times. Additionally, she acknowledged that the resident has an active care plan and physician's order in place for the assistance of 2 staff members for transfers. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a surveyor interview on 8/1/2024 at 10:32 AM with the Director of Nursing Services, she indicated that the resident should be transferred with the assistance of 2 staff members as ordered.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. 50004 Based on surveyor observation, record review, and staff interview, it has been determined that the facility failed to provide respiratory care consistent with professional standards of practice for 2 of 3 residents reviewed for oxygen use, Resident ID #s 5 and 10. Findings are as follows: 1. Record review revealed that Resident ID #5 was admitted to the facility in November of 2022 with diagnoses including, but not limited to, chronic obstructive pulmonary disease and chronic respiratory failure with acute exacerbation. Record review revealed a physician's order dated 5/25/2024 for oxygen at 2 liters/minute (L/M) via nasal cannula. Change oxygen tubing weekly and label each component with date and initials. During surveyor observations on the following dates and times failed to reveal evidence that the resident's oxygen tubing was labeled with a date: - 7/29/2024 10:29 AM - 7/31/2024 1:48 PM During a surveyor interview with Licensed Practical Nurse (LPN), Staff A, on 7/31/2024 at 1:50 PM, she acknowledged that the above resident's oxygen tubing was not dated per the facility policy. 2. Record review revealed that Resident ID #10 was admitted to the facility in May of 2023 with a diagnosis including, but not limited to, chronic obstructive pulmonary disease. Record review revealed a physician's order dated 5/11/2023 for oxygen at 2 L/M via nasal cannula at bedtime for comfort and remove per schedule. Change oxygen tubing weekly and label each component with date and initials. During surveyor observations on the following dates and times failed to reveal evidence that the resident's oxygen tubing was labeled with a date: - 7/29/2024 at 10:50 AM - 7/30/2024 at 8:38 AM - 7/31/2024 at 9:02 AM - 7/31/2024 at 1:40 PM During a surveyor observation on 7/31/2024 at 1:40 PM, the resident's prongs on the nasal cannula were observed to be discolored and yellow. Further observation revealed the oxygen tubing bag was dated 5/28 and 6/30. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a surveyor interview on 7/31/2024 at 1:41 PM with Staff A, she acknowledged that the Resident ID #10's oxygen tubing was not dated, that the prongs on the nasal cannula were discolored, and the tubing bag was dated 5/28 and 6/30. During a surveyor interview on 7/31/2024 at 2:00 PM with the Director of Nursing Services, she revealed that the oxygen tubing should be changed every Thursday and should be dated. Cross reference F 867

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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 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. 48928 Based on record review and staff interview, it has been determined that the facility failed to ensure that residents who are trauma survivors receive trauma informed care in accordance with professional standards of practice and accounting for the resident's experiences and preferences for 1 of 1 resident reviewed with post-traumatic stress disorder (PTSD, a health condition triggered by a terrifying event causing flashbacks and nightmares), Resident ID #54. Findings are as follows: Record review revealed the resident was admitted to the facility in February of 2024, with diagnoses including, but not limited to, PTSD and anxiety disorder. Review of the care plan dated 4/9/2024, revealed the resident has a diagnosis of a mood disorder related to PTSD. Further review revealed the resident .will be appropriately evaluated and re-evaluated for specialized services as needed and per state requirements .will receive appropriate specialized services to attain or maintain [his/her] highest practicable psychological, physical, functional, and psychosocial well-being . Additional review revealed the resident exhibits, or is at risk for, distressed or fluctuating mood symptoms related to a psychiatric mood disorder. Record review failed to reveal evidence that a Trauma Informed Care evaluation was completed to identify triggers related to PTSD. During a surveyor interview on 8/1/2024 at 10:42 AM with the Director of Nursing Services and the Lead Clinical Specialist, they were unable to provide evidence that a trauma informed care assessment had been completed since the resident was admitted to the facility. Additionally, they acknowledged that an assessment needs to be completed to identify triggers for PTSD. 46118

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	415020	A. Building B. Wing	08/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Grandview Center	100 Chambers Street Cumberland, RI 02864

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 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident's drug regimen must be free from unnecessary drugs. 46338 Based on record review and staff interview, it has been determined that the facility failed to ensure that a resident's drug regimen is free from unnecessary drugs for 1 of 1 resident reviewed relative to medication administration with parameters, Resident ID #20. Findings are as follows: Record review revealed the resident was readmitted to the facility in November of 2023 with diagnoses including, but not limited to, hypertension (high blood pressure), heart murmur (abnormal heart sound), and dementia. Record review revealed a physician's order dated 11/27/2019 for Losartan potassium 25 milligrams (mg) by mouth daily for hypertension. Hold for systolic blood pressure (the pressure in the arteries when the heart beats and pumps blood out, the top number of a standard blood pressure reading) less than 110. Record review revealed a pharmacy consultation report dated 3/18/2024 through 4/1/2024, which indicated the importance of holding the medication within the parameters ordered. Additionally, the document revealed that staff were educated related to the medication parameters as of 4/2/2024. Record review of the resident's May, June, and July 2024 Medication Administration Records revealed that the medication was administered when the systolic blood pressure was less than 110: - 5 of 31 opportunities in May of 2024 - 6 of 30 opportunities in June of 2024 - 9 of 30 opportunities in July of 2024 During a surveyor interview on 7/31/2024 at approximately 11:30 AM with the Director of Nursing Services, she acknowledged that the medication had been administered outside of the ordered parameters.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	415020	A. Building B. Wing	08/01/2024

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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 0810 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide special eating equipment and utensils for residents who need them and appropriate assistance. 48928 46118 Based on surveyor observation, record review, and staff interview, it has been determined that the facility failed to provide special adaptive eating equipment and utensils for a resident who requires a divided lip plate, Resident ID #9. Findings are as follows: Record review revealed the resident was admitted to the facility in April of 2019 with diagnoses including, but are not limited to, hemiplegia (paralysis of partial or total body function), hemiparesis (one sided weakness following a stroke), and muscle weakness. Record review revealed a care plan dated 8/15/2019 indicating the resident has a self-care performance deficit related to having a one sided weakness with interventions including, but not limited to, maintaining the highest capable level of his/her self-care and the use of a divided lip plate and built-up utensils for self-feeding. Record review of the diet slip revealed the resident was to be provided with a divided lip plate for all meals. During surveyor observations on the following dates and times, the resident was observed without a divided lip plate at meals: -7/30/2024 at 8:31 AM -7/31/2024 at 8:42 AM -7/31/2024 at 12:05 PM During a surveyor interview on 7/31/2024 at 12:11 PM with Nursing Assistant, Staff E, she indicated that she was unaware that the resident should be provided with a divided lip plate and that she had not observed the resident's meals served on a divided lip plate in the past. During a surveyor interview on 7/31/2024 at 12:13 PM with Licensed Practical Nurse, Staff A, she acknowledged that the resident should be provided with a divided lip plate as indicated on the diet slip. During a surveyor interview on 7/31/2024 at 12:19 PM with the Director of Nursing Services, she indicated that she would expect that the resident would be provided with a divided lip plate for all meals.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	415020	A. Building B. Wing	08/01/2024

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Grandview Center	100 Chambers Street Cumberland, RI 02864

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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 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. 50004 Based on surveyor observation, record review and staff interview, it has been determined that the facility has failed to measure success and track performance of Quality Assurance and Performance Improvement (QAPI) actions to ensure that improvements are realized and sustained relative to changing and dating oxygen tubing. Findings are as follows: Record review of the QAPI plan and meeting minutes from January 2024 to July 2024 revealed changing and dating oxygen tubing per facility policy was a problem area that required improvement. Record review of a facility document titled, Oxygen Audit with a start date of 1/18/2024, states in part, . oxygen tubing and filters changed on Thursdays per policy . During surveyor observations from 7/29/2024 through 7/31/2024, it was revealed that 2 of 3 residents reviewed for oxygen therapy had oxygen tubing that had not been dated as ordered and were not identified by the QA process or ongoing audits. During a surveyor interview on 8/1/2024 at 10:45 AM with Lead Clinical Specialist he could not provide evidence that the facility successfully implemented a program for monitoring and evaluating oxygen orders. Cross reference F 695 46118